Practice Improvement Framework

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Kent Safeguarding Children multi-agency partnership

NHS

Kent County Council kent.gov.uk

Kent Police

1. Introduction

1.1 Context

The Children and Social Work Act 2017 introduced a new legal framework in respect of local safeguarding arrangements for children. Responsibility for how a system learns lessons from serious child safeguarding incidents rests at a national level with the Child Safeguarding Practice Review Panel, and at a local level with Local Child Safeguarding Partnerships.

The Kent Safeguarding Children Multi-agency Partnership (KSCMP) has a responsibility to identify improvements that can be made to safeguard and promote the welfare of children. Understanding whether there are systemic issues, and whether and how policy and practice need to change is critical to the multi-agency Partnership being dynamic and self-improving.

1.2 About this framework

This framework should be read by local Safeguarding Partners and all agencies involved in the KSCMP. The guidance is particularly aimed at those involved in undertaking or contributing to Local Child Safeguarding Practice Reviews (LCSPRs), such as Rapid Review members, authors of agency summaries of involvement or Independent Management Reports (IMRs), and LCSPR panel members, as well as those responsible for quality assuring and ensuring learning from the review process is embedded.

The guidance outlines the KSCMP approach to identifying and responding to Serious Incident Notifications (SINs), commissioning and undertaking LCSPRs, and disseminating and embedding learning from reviews. It should be read alongside:

- Working Together to Safeguard Children 2023
- Child Safeguarding Practice Review Panel guidance for safeguarding partners

This framework has been endorsed by the KSCMP Lead Safeguarding Partners. It will be reviewed and updated to reflect changes in national guidance and local processes.

2. Serious Incident Notifications

2.1 Duty to notify

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

Where a local authority in England knows or suspects that a child has been abused or neglected, the local authority must notify the Child Safeguarding Practice Review Panel if:

The child dies or is seriously harmed in the local authority's area

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

Kent County Council is the responsible body for submitting a Serious Incident Notification to the CSPRP relating to any incident that meets the above criteria within five working days of becoming aware that it has occurred. Though the local authority makes the notification, it is the responsibility of all three Safeguarding Partners to agree which incidents meet the threshold for submission.

The local authority **must** also notify the Secretary of State for Education and Ofsted when a Looked After Child has died, whether or not abuse or neglect is known or suspected. The local authority **should** also notify the Secretary of State for Education and Ofsted of the death of a care leaver up to and including the age of 24. A Rapid Review is only a statutory requirement when the SIN criteria is met, however, KSCMP has agreed a protocol to consider undertaking a Rapid Review and consider a potential subsequent LCSPR for an individual up to the age of 18+6 months, where: the SIN criteria is met, the majority of service involvement and thus potential learning has been whilst the individual was aged under 18 years old, and another review process (such as a Safeguarding Adults Review) is not also being conducted.

2.2 Criteria

Serious incidents (or serious child safeguarding cases) are those in which:

- A child has died or has been seriously harmed, and,
- Abuse or neglect of the child is known or suspected and is directly linked to the serious harm or death.

Serious harm can be difficult to define. In cases of physical injury, serious harm is that which is life-threatening or life-changing (e.g. catastrophic brain injury), though the persistence, severity and context of wider neglect should also be considered. Fractures would not ordinarily be considered serious unless accompanied by other injuries. Emotional abuse, sexual abuse, and neglect may also reach the threshold for serious harm. Consideration should be given to the severity, extent, and persistence of the abuse, as well as to the impact this is likely to have had on the child's current and future wellbeing and development.

2.3 Referral to KSCMP

Those who have roles or functions supporting or working with children should inform the KSCMP of any incident they think should be considered for a child safeguarding practice review. Any partner who is aware of a serious incident that meets the criteria and should be considered for notification to the Child Safeguarding Practice Review Panel must have the agreement of their agency's KSCMP Executive representative (for Health providers, Kent Police and Kent County Council) or senior safeguarding lead (if a non-Safeguarding Partner agency).

A referral for consideration of a notification should be made via the KSCMP referral form online. The referral will be quality assured by the KSCMP Business Team to ensure it:

- Meets the criteria,
- Has the requisite authorisation,
- Includes all necessary detail.

Where there is evidence these are met, or are likely to be met, confirmation of receipt will be provided to the referrer.

The KSCMP Executive will consider all referrals where there is evidence the criteria is met, or likely to be met, to determine whether a Serious Incident Notification should be made. On receipt of a relevant referral an Executive Discussion will be arranged at the earliest opportunity, usually within 3 working days.

Where it is agreed by the KSCMP Executive that the SIN criteria is met, KCC will make the notification to the CSPRP and progress will be made to a Rapid Review. Where it is agreed that the criteria is not met, the referrer will be advised of the outcome and the referral closed to the KSCMP.

In some cases, the SIN criteria may not be met but issues of importance to the KSCMP are raised, such as in relation to an emerging theme of concern. The KSCMP Executive may then choose to notify the incident and progress to a Rapid Review for consideration of an LCSPR.

2.4 Learning from non-SIN cases

Where the KSCMP Executive determine that a SIN will not be made, or where a case does not meet the SIN criteria, there may still be learning that agencies believe can be derived. The KSCMP does not undertake practice reviews outside of the Rapid Review & LCSPR process as there is no legal framework for the sharing of information in this manner. Individual agencies, however, can still undertake internal reviews of any incidents or cases (such as near-misses) where they believe there is potential learning and may wish to include multi-agency partners. This is the responsibility of the individual agency to coordinate. Learning can be shared as appropriate with the KSCMP.

3. Rapid Reviews

3.1 Purpose of Rapid Reviews

Rapid Reviews should assemble the facts of the case as they are known at the time as quickly as possible in order to establish whether there is any immediate action needed to ensure a child's safety and potential for practice learning.

The aim of the Rapid Review is to enable Safeguarding Partners to:

- Gather the facts about the case, as far as they can be readily established at the time,
- Discuss whether there is any immediate action needed to ensure children's safety and share any learning appropriately,
- Consider the potential for identifying improvements to safeguard and promote the welfare of children,
- Decide what steps they should take next, including whether or not to undertake a child safeguarding practice review.

The meeting must take into account whether the case:

- Highlights or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have previously been identified,
- Highlights or may highlight recurrent themes in the safeguarding and promotion of the welfare of children,
- Highlights or may highlight concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children,
- Is one which that the Child Safeguarding Practice Review Panel have considered and concluded that a local review may be more appropriate.

Regard should also be given to the following circumstances:

- Where the Safeguarding Partners have cause for concern about the actions of a single agency,
- Where there has been no agency involvement, and this gives the Safeguarding Partners cause for concern,
- Where more than one local authority, police area or health integrated care board is involved, including in cases where families have moved around,
- Where the case may raise issues relating to safeguarding or promoting the welfare of children in institutional settings.

Meeting the criteria does not mean an LCSPR must automatically be undertaken. Where a review meets the criteria, but the learning is likely to replicate that already discovered or being considered by an existing LCSPR, it will not be necessary to undertake a further review.

LCSPRs may also be undertaken for cases which do not meet the definition of a SIN but which raise issues of importance to the local area. The Rapid Review Group may choose to undertake an LCSPR in these circumstances, where the KSCMP Executive have determined a Rapid Review should be held despite the SIN criteria not being met. In these circumstances the Rapid Review Group must be clear about the rationale for undertaking such a review and what its focus will be.

The Rapid Review should conclude with a recognition of the learning that the case offers, (both repeated learning from previous reviews, and new learning specific to this case), what actions have already been taken to address this learning, any recommendations for further activity to address the learning and a decision about whether or not to commission a LCSPR.

3.2 How Rapid Reviews are conducted in Kent

Following a decision from the KSCMP Executive to notify an incident the Rapid Review Group will be convened. The KSCMP aim to convene this within 13 working days of the notification being made.

Agency summaries

All agencies that have had involvement with the subject child(ren), or family, will be required to contribute to the Rapid Review. An initial scoping of agencies' involvement will, therefore, need to be completed and other relevant information gathered.

Requests for agency summaries will be made by the KSCMP Business Team to the named agency contact. Requests should be completed on the KSCMP agency summary template provided and returned by the deadline set.

The summaries should enable the Rapid Review Group to understand:

- What services have or have not been received by the family during the timeframe outlined, and any pertinent information to this.
- Any relevant history or context for the family, including that which is outside of the specific timeframe being reviewed or related to broader family members not named on the summary request.
- What learning may be determined and what the scope of any LCSPR should be.

The summaries should not (only) be a chronology of events and contacts, but should provide analysis of what has happened, capture the child(ren)'s lived experience, and identify single agency recommendations and actions. Actions may be tracked via the Rapid Review action plan and therefore must have sign-off and agreement by the submitting organisation.

Membership

The Rapid Review Group is made up of:

Chair:	**KSCMP Business Team (usually, Practice Review Manager)**
Decision makers:	Director, Integrated Children's Services, KCC Detective Superintendent, Protecting Vulnerable People Command, Kent Police Designated Nurse for Safeguarding Children, NHS Kent and Medway ICB
Others:	Up to three additional attendees (on a case-by-case basis) to provide information and guidance. A Domestic Abuse (DA) specialist where DA is known or suspected. A Kent Community Health Foundation Trust representative (as the provider of Health Visiting Services) where the child is aged under 5. KSCMP Business Team members

All three decision makers (or representatives of the named decision makers) must be present for the Rapid Review to be quorate. If any decision maker (or their nominated representative) does not attend, the Rapid Review must be reconvened.

3.3 Rapid Review outcomes

There are three potential outcomes from a Rapid Review:

- Recommendation to the CSPRP for a national review to be undertaken,
- Decision to undertake an LCSPR, including recommendation on the methodology to be used and key lines of enquiry,
- No further action beyond the Rapid Review action plan.

The decision will be made by the nominated decision makers. Where there is not agreement amongst the decision makers, the majority vote will be the outcome, but the dissenting view will be clearly recorded within the minutes.

The decision of the Rapid Review Group will be shared with the CSPRP within 15 days of the SIN, with supporting documentation. If a decision has not been unanimous or the outcome is to recommend a national review, the decision will be shared with the KSCMP Executive prior to the CSPRP. The KSCMP Business Team will act as the liaison between the Rapid Review Group and the CSPRP.

The CSPRP will respond to indicate whether they agree with the proposed outcome or suggest an alternative course of action. Where the CSPRP disagrees with the outcome the Rapid Review Group will be reconvened to consider the feedback and whether an alternative course of action should be taken. The CSPRP does not have the power to require partnerships to undertake reviews. The decision to proceed to an LCSPR is always a local decision for which the Safeguarding Partners are accountable.

3.4 Notifying families

The CSPRP guidance for safeguarding partners confirms that there is no expectation to involve families in Rapid Reviews. However, the guidance suggests that when making a notification,

1. Local authority partners should consider whether and how to inform families of the notification, and further,
2. Whether and how any learning/recommendations arising from the Rapid Review should be shared with the family.

Decisions in relation to point 1 should be made and clearly recorded on the 'Safeguarding Incident/Rapid Review Fact-Finding and Decision-Making Template' during Executive discussion of KSCMP referrals for consideration of notification. Any decision to inform families will be progressed via the KSCMP Business Team with the support of partners.

Decisions in relation to point 2 should be made, clearly recorded and responded to by the Rapid Review Group.

The wider professional network should not discuss with families that a notification and Rapid Review is taking place, as this needs to be carefully managed in conjunction with, for example, criminal investigations.

4. Local Child Safeguarding Practice Reviews

4.1 Purpose of LCSPRs

The purpose of a LCSPR is to explore how practice can be improved through changes to the system itself. Reviews should seek to understand the context in which the child came to harm and what changes are required to the system to ensure the risk of something similar happening again in future to another child is reduced.

It is not the purpose of a LCSPR to apportion blame or evaluate the practice of individual professionals. There are separate internal processes within organisations which serve this purpose. Holding organisations and their leaders to account for the quality of services, and individuals to account for not meeting professional standards are essential prerequisites for public confidence in the national safeguarding system. Regulatory bodies for the professions hold this key role.

4.2 How LCSPRs are conducted in Kent

The KSCMP's approach to LCSPRs is 'systems based'. Each case will, however, be examined individually to determine the most appropriate methodology to identify and maximise the learning. LCSPRs will be conducted in line with good practice and the principles of the systems methodology recommended by the Munro Report.

Decisions on whether to undertake a Review will be made transparently and the rationale shared with all relevant partners, including families.

The child or children will be at the centre of the LCSPR process. All Reviews will be proportionate to the circumstances of the case and focus on the potential learning. All Reviews will be conducted in a way which:

- Reflects the child's perspective and family context,
- Considers and analyses frontline practice as well as organisational structures and learning,
- Establishes the reasons why events occurred as they did, and
- Reaches recommendations that will improve outcomes for children.

Families, including surviving children depending on their age, will be invited to contribute to Reviews unless there is a strong reason not to. Steps will be taken to sensitively manage their expectations and ensure they understand how they are going to be involved.

Practitioners will be fully involved in Reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith. All participants in the review process will be asked to declare any potential conflicts of interest and will be expected to adhere to the required confidentiality.

Agencies relevant to the Review will be identified and may be required to form the membership of the LCSPR Panel. The LCSPR will be conducted in line with the methodology and terms of reference agreed for the Review. The Panel will be responsible for oversight of the Review as it progresses and quality assuring the final report and recommendations. The final report should include:

- A summary of recommended improvements to be made to safeguard and promote the welfare of children,
- An analysis of any systemic or underlying reasons why actions were taken or not in respect of matters covered by the report.

Recommendations should be clear regarding what is required of Relevant Agencies and others, both collectively and individually and focussed on improving outcomes for children. Once the final report has been agreed by the LCSPR Panel, it will be shared with the KSCMP Executive for sign-off. The KSCMP Executive should be appraised of the progress and recommendations throughout by their Panel representative, so that concerns or challenges can be considered prior to the sign-off stage. Where the KSCMP Executive requests substantial changes to the conclusions or recommendations of a Review, a further panel meeting will need to be convened. Once sign-off has been agreed, the recommendations should not be subject to further change.

4.3 LCSPR methodologies

The Rapid Review Group should agree the method by which the Review should be conducted. The methodology should provide a way of looking at and analysing frontline practice as well as organisational structures and learning. The methodology should be able to reach recommendations that will improve outcomes for children. All Reviews should reflect the child's perspective and the family context. The Review should be proportionate to the circumstances of the case, focus on potential learning, and establish and explain the reasons why the events occurred as they did.

The KSCMP has developed a range of flexible methodologies for LCSPRs to identify the pertinent case learning, enable the best use of resources and to ensure that learning that can be practically acted upon. Current methodologies include:

- **Benchmarking:** Comparing the events or characteristics of the incident or practice with the child/family, to national or existing studies, standards and reviews, to identify if national recommendations are responsive enough to the local picture, or if Kent requires additional, specific recommendations.
- **Campaign:** Identifying learning from an incident to develop a campaign which seeks to affect system-wide change for children. This methodology focuses on the thematic area or sector relevant to the incident, rather than a detailed exploration of system-wide interaction with a single child or family.
- **Impact:** Comparing practice demonstrated in the incident against the current knowledge and practice standards. This methodology seeks to understand the impact of change that has already been made within the system, to identify whether children in similar circumstances would be safeguarded, and whether there are further improvements required.

- **Traditional:** Exploring the events, circumstances, and practice in respect of a particular child or family, to understand how and why events unfolded, and what system learning there is.
- **Window on the system:** Using a single child or family's experiences to provide insight into how the system responds and operates, to draw broader conclusions and learning. This methodology focuses on a particular theme or service area and involves bringing together relevant professionals to understand how the system responds to children with particular needs or in specific circumstances.
- **Appreciative inquiry:** Reviewing case learning through a strengths-based approach, identifying good practice and offering proposals as to how this could be built upon/expanded to wider benefit.

4.4 Commissioning a reviewer

An independent reviewer maybe commissioned to undertake the LCSPR. The KSCMP Business Team will work to identify a relevant reviewer, taking into consideration whether the reviewer has:

- Professional knowledge, understanding and practice relevant to LCSPRs, including the ability to engage both with practitioners and children and families.
- Knowledge and understanding of research relevant to children's safeguarding issues.
- The ability to recognise the complex circumstances in which practitioners work together to safeguard children.
- The ability to understand practice from the viewpoint of the individuals, organisations or agencies involved at the time rather than using hindsight.
- The ability to communicate findings effectively.
- Expert knowledge or experience relevant to the specific learning themes identified at Rapid Review.

4.5 Engaging with families

The KSCMP recognises the integral role that families play in an LCSPR's effectiveness, regardless of the methodology employed. Experience shows us that LCSPRs afford richer learning when the families they are about engage in the Review process, as this leads to more meaningful recommendations. Family members are often able to provide important contextual information not captured in records and can clarify gaps in knowledge about the child's circumstances. In recognition of this important role, the KSCMP has developed 'Engagement with Families in LCSPRs' guidance.

The KSCMP's aspiration is always to engage families in their Reviews wherever possible and to explore all reasonable avenues to facilitate this, such as, but not limited to:

- Collaboration with subject children and/or their families in writing the Terms of Reference for their Review to ensure any questions they have about services provided to them are explored, where appropriate.
- The opportunity to meet with the (Independent) Reviewer to discuss the circumstances of their case and share learning from their perspective.

- Choosing the pseudonym for the report.
- The possibility of actively participating in learning events or contributing to learning briefings, to share learning from reviews, where appropriate.

4.6 Publication of LCSPRs

LCSPRs are about identifying and promoting improvements to the local safeguarding system, however, findings may also be relevant to professionals with safeguarding responsibilities in other parts of the country. Therefore, Safeguarding Partners must publish the learning and recommendations from Reviews as a minimum. The full LCSPR report should be publish, unless it is considered inappropriate to do so. In such circumstances the Partnership may published the learning and recommendations only, without specific details or context of the case. The name of the reviewer(s) should be included. Published reports or information must be publicly available for at least one year.

The KSCMP LCSPR reports and learning are published on the KSCMP website. They are also shared with the NSPCC for inclusion into the national case review repository. Where it is not appropriate to publish a report on the KSCMP website e.g. for anonymity of surviving children, the report will only be published in the NSPCC repository, with references to KSCMP and other identifying information removed.

The impact of publication of a LCSPR on children, family members, professionals and others affected by the case will be considered. Families should always have the opportunity to see a copy of the final report prior to publication and to make comments for the Reviewer's consideration. Families should be made aware of the intended publication date and any requests to avoid or schedule publication for specific dates should be considered.

Publication of a LCSPR will be scheduled at the earliest suitable opportunity following sign-off of the final report. The date will be informed by family preferences as above, as well as other ongoing processes, for example criminal investigations. There will be times where ongoing investigations or processes delay the publication of an LCSPR. However, this will not delay the enactment of the identified learning (see section 5 on implementation of learning).

5. Implementing Learning

5.1 Rapid Review action plans

An action plan will be produced from each Rapid Review which incorporates actions agreed by the Rapid Review Group. The action plans are monitored and tracked by the KSCMP Business Team. Agencies are required to update on their actions at timely intervals. A practice review case will only be closed to the KSCMP once the Rapid Review action plan is completed. Where updates are not received or actions are not completed, this will be escalated to the KSCMP Executive for consideration and action.

5.2 Learning & Improvement Group

LCSPR recommendations are monitored and overseen by the KSCMP Learning & Improvement Group (LIG). Key agency representatives offer insight into how recommendations can be translated into action in a meaningful and achievable way for their organisation and commit to owning and following up on action implementation and the measuring of impact. An LCSPR Recommendations Tracker provides members with a real time account of their organisation's performance against agreed actions. Recommendations and actions are only signed-off by LIG as completed when evidence has been provided by the Relevant Agencies of implementation.

LIG uses a case matrix to assist in prioritising and timetabling completed LCSPRs for consideration, enabling the KSCMP to respond to learning of relevance at any given time. An LCSPR will be added to the matrix for discussion at LIG once it has been signed-off by the KSCMP Executive. This may happen prior to publication of the report.

5.3 Dissemination of learning

Individual agencies are responsible for ensuring that their staff are fully briefed on learning arising from Rapid Reviews and LCSPRs.

6. Other reviews

6.1 KSCMP thematic reviews

On occasion the KSCMP may identify the need for thematic reviews to be undertaken, in response to emerging risk or need. Where a particular practice theme has been prevalent it may be determined that a thematic overview could provide insight into system learning. These reviews do not replace the LCSPR process and may in fact build upon multiple reviews that have been undertaken. Thematic reviews are undertaken separately to LCSPRs and do not require the gathering of personal information that is not already available to the KSCMP for practice review purposes.

6.2 Safeguarding Adult Reviews and Domestic Abuse Related Death Review

Due regard will be given to links with the Kent and Medway Safeguarding Adults Board and their undertaking of Safeguarding Adult Reviews, alongside Kent Community Safety Partnership and their undertaking of Domestic Abuse Related Death Review.

A Review being undertaken as a result of a serious incident through an alternative process does not mean that a Rapid Review or LCSPR will not be undertaken by KSCMP. This is because these review processes have different areas of focus and so the commissioning of another review cannot be assumed to mean that relevant systemic learning for the safeguarding of children will be identified. The KSCMP Business Team will work with the relevant partnership or team to understand the scope of any alternative review, to be able to identify whether there is cross-over in learning and to avoid duplication.

7. Information sharing

Information sharing is essential to safeguard and promote the welfare of children and young people. Effective LCSPRs are equally dependent on all relevant partners sharing the information they hold about the case and associated professional practice.

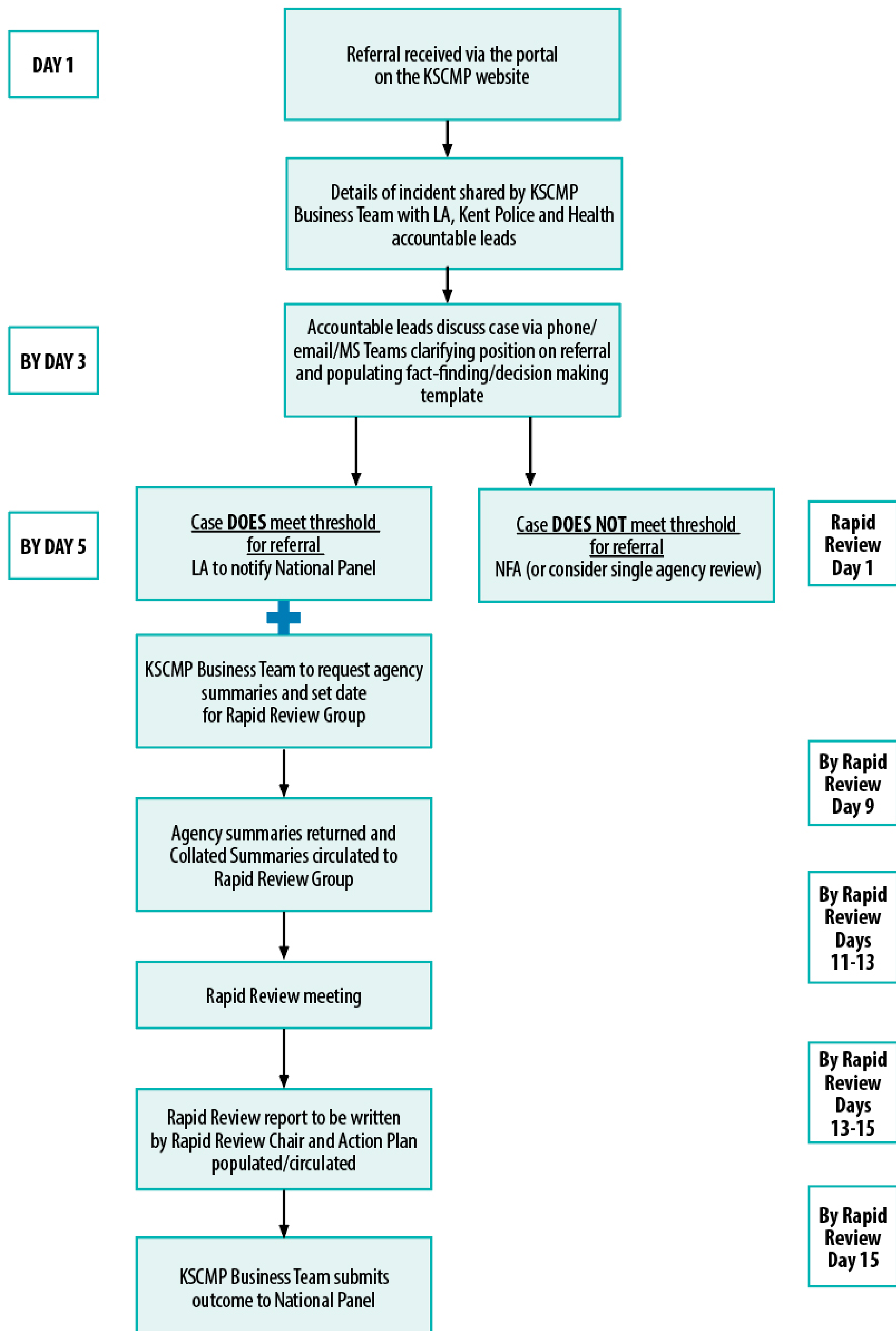
The Safeguarding Partners have the formal authority to request information to support both national and local Child Safeguarding Practice Reviews, and the power to take legal action if information is withheld without good reason.

All agencies are expected to share relevant information within the timescales requested. This may, when necessary, include sharing information without consent. This includes information about parents, guardians and other family members, as well as the child(ren) who are the subject of the review.

Where a request is for health records, this applies to all records of NHS commissioned care, whether provided under the NHS or in the independent or voluntary sector.

In the case of any disagreement or failure to comply with a formal information request, this will be referred to the Rapid Review Group, who will seek to resolve this with the strategic Safeguarding Lead for the agency concerned. If a prompt resolution cannot be found, the issue will be escalated to the KSCMP Executive for formal action.

Appendix One - Rapid Review Flowchart



Appendix Two – Cases referred to KSCMP where the subject individual is beyond their 18th birthday