

# Learning into Practice Project (LiPP) Project report appendices

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# Appendix 1. Report of practice-focused collation of Serious Case Review reports

## 1. Introduction

This report documents the rationale and methods for a collation of Serious Case Review (SCR) reports conducted as part of the Learning in to Practice Project.

## 2. Aims and rationale

SCR reports are routinely used to inform improvements to services in the locality where they have been conducted. However, the findings of SCRs also have the potential to drive improvement in other localities. That is, services in one local authority *should* be able to learn from an SCR that has happened elsewhere, and make pre-emptive improvements to their own services.

The rationale for this piece of work was that SCR findings from across the country are, however, not currently accessible in a form that is specifically targeted to support local improvement work. This is both in terms of timing – SCR reports are currently only collated on a biennial/triennial basis – and the types of information synthesised from SCR reports.

Our idea was that, to drive improvement activities, local areas should have access to ‘real time’ data about practice problems and their causes, as identified through an ongoing collation of findings from SCR reports. In this workstream, we have aimed to develop and test a method for collating SCR findings that is focused on improvement, and would lend itself to routine, ongoing collation. In doing so, we had also hoped to create a common category scheme of findings. However, as detailed in the ‘What have we learned’ section below, the analysis in the SCR reports was not sufficiently detailed to allow this.

### 3. How was this put in to practice?

The approach to collation was developed and tested by seeking to collate learning about a 'test topic' of 'inter-professional communication and decision making' in a sample of recent SCR reports. Our aim was to explore whether we could develop a method that would support analysis of communication issues and their causes specifically for the purposes of local improvement work. Our thinking on what kind of information this should be were informed by systems approaches, as detailed below.

This was a developmental process, part of which involved responding to the challenges presented by the material, and adapting the method accordingly. Part of our original plan had been to develop a taxonomy of findings that could be used across reports. However, on reading the reports it became clear that the findings were not articulated in sufficient detail to support development of a categorisation scheme. Indeed, in many cases it was difficult to identify what the 'findings' of the report were.

#### 3.1 Applying systems approaches to the collation task

The methodology for the collation was informed by systems approaches and SCIE's Learning Together model<sup>1</sup> - a model for undertaking case reviews based on systems principles.

##### *Systems approaches*

Systems approaches originated in the aviation and engineering industries, and have also informed the approach to incident review in the UK health sector, known as root cause analysis. The application of systems approaches to UK child protection activities was brought to the fore in the *Munro Review of Child Protection*<sup>2</sup>, including a recommendation that systems approaches inform approaches to Serious Case Review.

##### **Influences on practice**

The central concept of a systems approach is that people's ability to work to a high standard results from a combination of their own skill and knowledge, and their organisational context:

*"The crux of a systems approach... is that it examines human performance in its context and recognises that people's competence in carrying out tasks to a high standard is influenced by the whole system around them."*<sup>3</sup>

This means that, where problems in practice are identified, it is important to gain an understanding not just of **what** aspects of practice are currently not working, but **why**

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<sup>1</sup> Fish, S., Munro, E., and Bairstow, S. (2008) *Learning together to safeguard children: developing a multi-agency systems approach for case reviews*. London: Social Care Institute for Excellence.

<sup>2</sup> HM Government (2011) *Munro Review of Child Protection: Final Report – a child-centred system*. London. Department of Education

<sup>3</sup> Munro, E. (2012) *What is a systems approach?*

this is the case, and what aspects of the working environment are contributing to the practice difficulties.

From the perspective of organisational change, this means that efforts to improve the quality of frontline practice should not just be targeted at the practitioners themselves, but also at addressing aspects of their working context which are impeding good practice. These may include elements such as organisational culture, inter-agency relationships, tools given to practitioners to support their work and so on – aspects that it is often now within the gift of individual practitioners to change, but require the involvement of managers and senior managers.

Systems approaches are closely linked to concepts of organisational learning in complex systems and the operation of 'High Reliability Organisations' – organisations in which priority is given to making systems as 'safe' as possible, in conditions where the consequences of errors could be catastrophic. In particular, these approaches suggest that the safe functioning of the system requires continual and 'rich' feedback about the operation of the system, including learning from mistakes and incidents.

Systems approaches have therefore influenced this collation of SCRs in terms of:

- **Focus of the collation**– we aimed to focus the collation on learning about difficulties in multi-agency practice and, crucially, what the underlying reasons were for these. The focus of the collation is therefore on what aspects of the multi-agency context are making it harder for people to do the right thing, and easier to do the wrong thing.
- **Audience for the collation** – a systems approach postulates that many of the factors underlying practice difficulties are not within the gift of individual frontline practitioners to change, but are the province of local managers, and potentially even national policy makers and strategic leaders.
- **How the outputs of the collation might be used** – to help provide managers with a 'close up' view of practice and to inform organisational improvement efforts.

### *Learning Together*

Learning Together<sup>4</sup> is a model for undertaking case reviews and Serious Case Reviews based on systems thinking. The model aims to use a single case as a 'window on the system'<sup>5</sup>, that is, to use the rich description provided by a single case to highlight more common and widespread strengths and weaknesses in a local child protection system.

The model includes a number of tools to support the use of data from a single case as a way of learning about systemic strengths and weaknesses. We have drawn on specific concepts and tools from the model in undertaking this collation in terms of:

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<sup>4</sup> Fish, S., Munro, E., and Bairstow, S. (2008) Op. cit.

<sup>5</sup> Vincent, C. (2008) Analysis of clinical incidents: a window on the system not a search for root causes. *Quality and Safety in Healthcare*, 13(4):242-3.

- Starting from a specific case or instance (the concept of the ‘window on the system’) and using this to develop a detailed description of the nature of the practice difficulty
- A focus on explaining the reasons underlying practice difficulties, and exploring the influences on practice that led to these difficulties
- Testing out whether identified issues are systemic and widespread, or particular to the SCR cases through use of practitioner summits.

## 3.2 Selection and conceptualisation of test topic

### *Using a ‘test topic’*

This synthesis focused on identifying learning within the SCR reports about practice issues in relation to **inter-professional communication and decision making**.

We decided to use a ‘test topic’, rather than looking at all aspects of professional safeguarding practice, as a way of giving focus to our research question. This topic was agreed by the Project Board, as a common challenge experienced across professional practice. This topic also provided a good opportunity to compare the outputs of this collation with others. ‘Problems in inter-professional communication’ are a frequent finding of SCRs and SCR syntheses, but the ways in which these manifest themselves, and their underlying reasons are often not further explored. It was therefore useful to explore whether a different kind of collation could provide a different perspective on a superficially familiar topic.

### *Conceptualisation of test topic*

We took a pragmatic approach to conceptualising inter-professional communication, focusing on allowing the research team to identify instances of inter-professional communication in multi-agency safeguarding. This involved mapping the safeguarding process and identifying points at which inter-professional communication was likely to occur. Other than this, we stipulated only that instances of communication needed to be between two professionals (rather than between professional and family). Failures to communicate were also included in the analysis – that is, examples in which communication should have happened but did not.

## 3.3 Developing and conducting the collation process

The development of the method through the collation process was carried out by a team of five researchers, two of whom were experienced in systems approaches to Serious Case Review.

- *Selection of SCR reports*

The guidance relating to SCRs was revised in 2013, and made clearer that the purpose of SCRs is to understand *why* events occurred, as well as what occurred. Because we had a specific interest in identifying explanations and underlying reasons for problems we therefore decided to include only SCRs which had been undertaken under the 2013 guidance. Our full sample was 38 reports published between May 2014 and April 2015,

with the exception of two published during this period which were undertaken under the 2010 guidance but were delayed in publication.

- *From which parts of the SCR reports were findings taken?*

Identifying the findings of the SCRs was not straightforward. We had hoped to be able to focus our synthesis on particular sections of each report. However, a mapping of the structure of a selection of SCRs found there was little consistency in how reports were structured, what each section was called, and what information was in each section. This process therefore highlighted that the variation in structure and content of SCRs does not currently facilitate national collation of findings.

- *Identifying instances of inter-professional communication and decision making*

The team undertook an initial coding of the reports, identifying instances of inter-professional communication within the reports using the NVivo software package. Throughout the process, we aimed not just to look for problems and difficulties in communication, but also any examples of good practice. However, it was notable that very few SCR reports highlighted examples of good practice. The level of detail about each of these episodes of communication was very variable – some episodes of communication were mentioned only in passing, whereas others were described in more detail.

- *Identification of 'vivid examples' of problems in inter-professional communication and decision making*

Identifying the instances of professional communication showed that some described instances yielded data which was much richer, and more suited to our aims, than others. We decided therefore to focus on what we termed 'vivid examples': described examples of inter-professional communication for which there was a more detailed illustration by the reviewer of an instance (usually a problem) of inter-professional communication, and what factors contributed to this problem.

For each 'vivid example' the research team identified from the SCR report:

- **Case example– the vivid/evocative facts:** a description of the example or incident as it had manifested in that case
- **Broader context of the case:** a brief overview of the case, and where this incident occurred
- **Nature of the communication problem:** a description of the type of problem
- **Analysis:** any analysis contained in the SCR report about the causes or underlying reasons for the observed issue (using analysis within SCR report only - researchers did not add own analysis).

An illustration of a vivid example is given in Box 1 below.

**Box 1: A 'vivid example'**

**Case example/snippet/excerpt – the vivid/evocative facts:** Julia's mother sought advice from the GP when she disclosed that Julia had been raped six weeks before her 13th birthday.

This led to contraceptive advice, and there is no evidence that she was assessed to see whether her experiences had been abusive in line with existing policies and procedures and there was no referral to Children’s Social Care. The focus was on sexual health advice rather than safeguarding.(p.34)

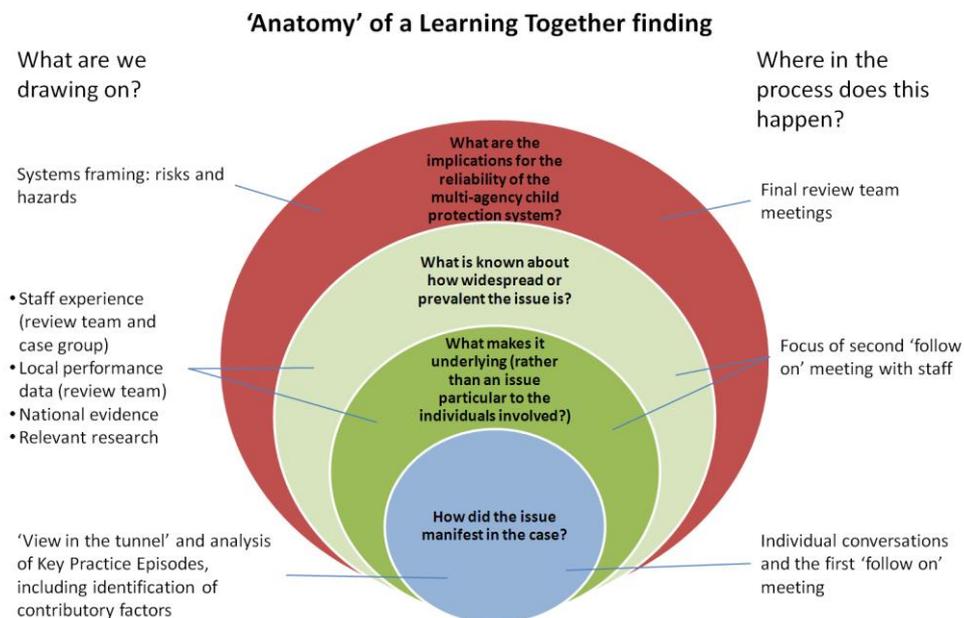
**Broader context of the case:** Julia was a 14 year old child who disclosed, to a number of agencies, that she had been raped. Work with Julia was focused on what was seen as her troubling behaviour. At the time a Child in Need Plan was in place which also focussed on sexual health advice and parenting support.

**Nature of the communication problem** The GP did not make a referral to Children’s Social Care following disclosure of rape as would have been expected in line with existing policies and procedures

**Analysis – anything on what causes/ underlies this type of communication problem:**

“There were numerous occasions on which Julia made allegations and sought sexual health advice, and on each occasion there was a stronger professional focus on advice-giving rather than exploring issues of consent and abuse...The consistency of practice suggests strongly that this was an underlying tension inherent within the different role that professionals play.” (p.35)

This framework drew on analytical tools from SCIE’s Learning Together model, in particular the framework used to develop findings within the model, which is illustrated in the diagram below.



Two researchers extracted vivid examples from each report to ensure that no examples were missed.

## *Synthesis*

We mapped the findings according to the following broad stages of the child protection process.

- A. Communication about safeguarding within universal services (intra or inter-professional);
- B. Early help assessment and services;
- C. Making a referral;
- D. Strategy meeting, S47 investigation or process for rapid response to the unexpected death of a child;
- E. Assessment;
- F. Child Protection Conferences, core groups and Child in Need meetings
- G. Ongoing case work and professionals' meetings.

We grouped the vivid examples in to similar types within the stage of the care pathway, in terms of the nature of the problem, and which professionals were involved. We opted for a higher number of more detailed types, rather than a smaller number of 'high level' types of issue.

For each type of instance, we described:

- How the issue manifests itself in practice.
- In how many SCR reports we found detailed descriptions of this issue.
- Which agencies were involved.
- A summary of the underlying reasons for this issue.

### **3.4 What type of information did the collation produce?**

Our analysis and mapping of the 'vivid examples' of problems in inter-professional communication and decision making resulted in 44 types of instances, which we grouped under the above seven broad stages of the child protection process:

For ease of reading we have split the mapping in to two parts. A printable version of this analysis is available at [www.nspcc.org.uk/lipp](http://www.nspcc.org.uk/lipp) or [www.scie.org.uk/lipp](http://www.scie.org.uk/lipp)

## Overview of findings, groups A-C

A - Communication about safeguarding within universal services (intra or inter-professional)	B - Early help assessment and services	C - Making a referral
<p><b>1. Information relevant to safeguarding is not shared in referrals to antenatal services</b></p> <p>(3 examples: GP - Midwife; Midwife - CSC; Pharmacy - GP/Drug Worker)</p> <p>Underlying reasons include: information not shared due to confidentiality issues, information given by parents was not adequately verified.</p>	<p><b>1. The TAF process is poorly co-ordinated, which inhibits communication</b></p> <p>(1 example: HV as lead professional, working with other agencies)</p> <p>Underlying reasons include: 'Drift' in the process created by a lack of a consistent lead professional, the process not being led by a professional familiar with the case.</p>	<p><b>1. Referring agencies think they are making a referral or requesting action of CSC, but CSC thinks they are only receiving information to be logged</b></p> <p>(3 examples: School - CSC; Police - CSC; School/School Nurse - CSC)</p> <p>Underlying reasons include: Professionals unfamiliar with referral process using incorrect referral process, automatic notifications.</p>
<p><b>2. Information about a parent known to the GP, which is relevant to safeguarding, is not shared with health professionals working with the child</b></p> <p>(1 example: GP - School Nurse)</p> <p>Underlying reasons include: Problems with information-sharing between professionals and a lack of ability of some professionals (e.g. school nurses) to access adult health information</p>	<p><b>2. Agencies do a CAF because they've been told to, even though they don't agree with this suggestion</b></p> <p>(1 example: Children's Social Care (CSC) - HV)</p> <p>Underlying reasons include: Difficulty in challenging the decisions of another professional.</p>	<p><b>2. Referring agencies and CSC disagree about whether cases referred to CSC actually need CSC involvement, and this is not resolved</b></p> <p>(6 examples: School/Health - CSC; HV - CSC; HV - CSC; Police - CSC; HV-CSC; HV/GP - CSC)</p> <p>Underlying reasons include: High workloads negatively impact on decision making, role of 'call handling' staff.</p>

<b>A - Communication about safeguarding within universal services (intra or inter-professional)</b>	<b>B - Early help assessment and services</b>	<b>C - Making a referral</b>
<p><b>3. Information about domestic violence incidents known to the Police is not shared with health visitors</b></p> <p>(1 example: Police - Health Visitor (HV)) Underlying reasons include: Issues with information sharing systems; information entered by one professional not being seen by another.</p>	<p><b>3. A CAF is not used when one is needed</b></p> <p>(1 example: Education) Underlying reasons include: The need for a CAF may not be recognised when the child is perceived as less disadvantaged than others.</p>	<p><b>3. The referral process does not convey the level of risk in the case</b></p> <p>(1 example: Police - CSC - CAMHS) Underlying reasons include: referrals processed as 'for information', subject seen as a young person not a vulnerable child.</p>
<p><b>4. Health visitors do not have access to maternal mental health notes, which are held by Midwives</b></p> <p>(1 example: GP and Midwife - HV) Underlying reasons include: Difficulties in information sharing between health visitor and midwifery services, possible lack of contact between these services.</p>	<p><b>4. No Team Around the Family meetings are held, despite being needed</b></p> <p>(1 example: Adolescent Support Worker in CSC and HV) Underlying reasons include: Multidisciplinary working not embedded, services working under different administrative and IT systems.</p>	<p><b>4. Bruising to non-mobile babies does not trigger referral to CSC</b></p> <p>(3 examples: Health not to CSC) Underlying reasons include: Discrepancies in child protection practices in out of hours services and a lack training for some professionals.</p>
		<p><b>5. Information about YP sexual activity/sexual health relevant to safeguarding does not trigger referral to CSC</b></p> <p>(1 example: GP not to CSC) Underlying reasons include: Misapplication or a lack of awareness of guidance around disclosures of rape or sexual abuse.</p>

## Overview of findings, groups D and E

D - Strategy meeting, S47 investigation or process for rapid response to the unexpected death of a child	E - Assessment
<p><b>1. Lack of Police involvement in a S47 investigation leads to insufficient consideration by other agencies that a crime may have been committed (indirect communication)</b></p> <p>(1 example: Police - CSC)</p> <p>Underlying reasons include: Interviews by police lacking investigative rigour; key individuals not interviewed etc.</p>	<p><b>1. CSC do not check with other relevant agencies as part of their assessment for any information relevant to safeguarding</b></p> <p>(3 examples: EWO - CSC; GP/ASC not to CSC; CSC - HV/Probation)</p> <p>Underlying reasons include: Protocol for only one agency check, no clear continuity in professional involvement or delineated roles and responsibilities</p>
<p><b>2. A strategy meeting is not convened when one is needed</b></p> <p>(6 examples: CSC; Police/CSC; Hospital - CSC/Police; Hospital - CSC; Hospital - Hospital SW; Health - CSC)</p> <p>Underlying reasons include: Information sharing procedures hindering timely action and difficulties in challenging decisions when there is disagreement.</p>	<p><b>2. Probation do not check with CSC as part of their risk assessment for any information relevant to safeguarding children</b></p> <p>(1 example - CSC - HV/Probation)</p> <p>Underlying reasons include: Policy does not require multi-disciplinary working, inadequate risk assessment processes</p>
<p><b>3. Agencies do not proceed with rapid response processes following a child death, inhibiting multi-agency communication</b></p> <p>(1 example: Hospital - Police/CSC)</p> <p>Underlying reasons include: Problems with joint planning and lack of training around rapid response.</p>	
<p><b>4. Agencies interpret Health input about possible causes of injuries as definitive, rather than one of a range of possibilities</b></p> <p>(2 examples: Hospital - Police/CSC, Hospital - Police CSC)</p> <p>Underlying reasons include - An overemphasis on medical conclusions as to the cause of injuries and the pursuit of categorical explanations.</p>	

D - Strategy meeting, S47 investigation or process for rapid response to the unexpected death of a child	E - Assessment
<p><b>5. There is no acknowledgement or resolution of conflicting medical opinion on the cause of physical injury to a child</b></p> <p>(1 example: Hospital - CSC/Police) Underlying reasons include: Inadequate discussion to resolve disagreement, cancellation of strategy meetings, despite guidance.</p>	
<p><b>6. Paediatric conclusion on cause of injury is not challenged by other professionals</b></p> <p>(1 example: Health, CSC, Police) Underlying reasons include: Unknown</p>	
<p><b>7. Professionals only consider a narrow range of presenting issues in the strategy meeting</b></p> <p>(1 example: GP - Police) Underlying reasons include: The absence of a review strategy meeting, hierarchy among professionals inhibiting challenge to decisions.</p>	

## Overview of findings, groups F and G

F - Child Protection Conferences. core groups and Child in Need meetings	G - Ongoing case work and professionals' meetings
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<b>F - Child Protection Conferences. core groups and Child in Need meetings</b>	<b>G - Ongoing case work and professionals' meetings</b>
<p><b>1. In the context of a criminal investigation, Police do not share all relevant information at Child Protection Conference</b></p> <p>(1 example: Police)</p> <p>Underlying reasons include: Assumptions about knowledge of agencies, difficulties of sharing information on live cases.</p>	<p><b>1. Agencies running parallel recording systems, with a time lag in updating from one to the other</b></p> <p>(2 examples: Health; CSC - HV/ Probation)</p> <p>Underlying reasons include: Professionals working on systems in isolation, unaware of other modes of recording, different access levels among professionals to records. transitions from paper to electronic recording</p>
<p><b>2. School giving a positive portrayal of the child and not sharing concerns at Child Protection Conference</b></p> <p>(1 example: School)</p> <p>Underlying reasons include: Education staff wary of sharing concerns in front of family members.</p>	<p><b>2. Agency working with a family currently subject of a CP Plan does not pass on safeguarding information to CSC</b></p> <p>(2 examples: FSW not to CSC; Emergency Clinic not to CSC/HV)</p> <p>Underlying reasons include: Lack of understanding of the role of CSC in the case of a CP plan.</p>
<p><b>3. GPs not attending Child Protection Conferences</b></p> <p>(1 example: GP)</p> <p>Underlying reasons include: Logistical difficulties (timing, location) impede attendance.</p>	<p><b>3. Mutual misunderstandings about who is going to do what following a conversation/Plan</b></p> <p>(1 example: YOS - CSC)</p> <p>Underlying reasons include: Disagreement about roles and responsibilities in multi-agency working.</p>
<p><b>4. Agencies do not convene a CP conference when one is needed</b></p> <p>(2 examples: CSC; CSC to other agencies)</p> <p>Underling reasons include: Deference of other agencies to social work opinion.</p>	<p><b>4. Professionals relying on updates from family members rather than communicating with each other directly</b></p> <p>(1 example:HV/GP/CAMHS not to CSC )</p> <p>Underlying reasons include: A potential lack of information sharing between professionals.</p>

<b>F - Child Protection Conferences. core groups and Child in Need meetings</b>	<b>G - Ongoing case work and professionals' meetings</b>
<p><b>5. Police not pursuing a prosecution is interpreted by other agencies as meaning that child protection procedures are not needed</b></p> <p>(1 example: Police - CSC) Underlying reasons include: An overemphasis on criminal proceedings at the expense of other professional opinion.</p>	<p><b>5. Data management system used by GPs does not allow effective receipt of information from CSC about child protection status</b></p> <p>(1 example: CSC - GP) Underlying reasons include: Systems not capable of flagging events like a CP Plan, busy working schedule retarding professional curiosity.</p>
<p><b>6. All agencies' views are not given equal weight in Conference decision-making</b></p> <p>(2 examples: HV - CSC; Multiple Agencies) Underlying reasons include: Challenges to decisions not made through formal escalation processes, issues of hierarchy in deference to social care decisions.</p>	<p><b>6. The use of euphemistic or misleading language in reports and written records hinders communication</b></p> <p>(2 examples: Multi-Agency network; Police) Underlying reasons include: Fears of damaging relationship with family, tendency to 'sanitise' difficult situations.</p>
<p><b>7. CSC do not communicate legal advice to the Conference</b></p> <p>(1 example: CSC - Legal) Underlying reasons include: Inexperience in workforce around conference process and procedure.</p>	<p><b>7. Professionals in children's and adults' social care do not communicate when needed</b></p> <p>(1 example: CSC to ASC) Underlying reasons include: A lack of understanding of: roles and responsibilities, modes of information- sharing and collaborative working.</p>
<p><b>8. Discussion between agencies in Protection Conferences lacks purpose</b></p> <p>(1 example: ASC/GP not to CSC) Underlying reasons include: Issues with gaining adequate information as evidence and changes of conference chair creating inconsistent processes.</p>	<p><b>8. Non-engagement by parents with substance misuse services not highlighted to other agencies as reason for termination of service</b></p> <p>(1 example: Drug and Adult Team - Midwife) Underlying reasons include: Assumptions about professional roles, overly informal data sharing, inconsistent safeguarding practices.</p>

F - Child Protection Conferences. core groups and Child in Need meetings	G - Ongoing case work and professionals' meetings
<p><b>9. A lack of specificity of language in the Plan document</b></p> <p>(2 examples: ASC/GP not to CSC; School Nurse/YOT - CSC)  Underlying reasons include: Goals of plan lacking clarity, plan secondary to PLO response</p>	
<p><b>10. Professionals experience the participation of families in Conferences as hindering frank exchange of information</b></p> <p>Underlying reasons include: Staff unwilling to share information for fear of upsetting family or inducing aggression.</p>	
<p><b>11. No Child in Need meetings held, despite being needed</b></p> <p>(1 example - CSC and partner agencies)  Underlying reasons include: Unclear</p>	

## 5. What have we learned?

### 5.1 A different type of analysis

This approach has resulted in an analysis which is specific in terms of detailing the nature of the problem, where it occurs and who is involved. Our impression, which was supported by feedback from those involved in the project, was that this ‘unpacked’ the issue of difficulties of inter-professional communication and decision making, and showed the different ways in which these difficulties can become apparent. Elsewhere in the project we tested out whether this type of analysis *is* perceived to be more useful for informing local improvement activities.

### 5.2 The amenability of SCR reports to this type of review

Above we have outlined how a grounding in systems approaches has influenced the focus and methods for the collation we have undertaken. Whilst our intention was to focus on descriptions of practice problems and their underlying reasons, it is worth noting here that the content of the SCR reports were not always amenable to this type of analysis for the following reasons:

#### *Inconsistent structures and organisation*

Ideally, this type of collation would focus largely on the findings of any given review – that is, the analysis of *why* poor (or good) practice occurred. Our initial mapping of the reviews showed that this type of content was frequently either not present, or, where it was present, was difficult to identify within a particular section. There was also significant variation in the headings and terminology used across reports.

#### *A lack of ‘rich’ description*

Given that one of our starting points was that this analysis could be used to inform local (and national) improvement activities, part of our aim was to be as specific as possible about the way that particular problems manifested themselves, who was involved, and at which stage of the ‘care pathway’. This type of information was not readily available in all the reports – it was often unclear which professionals were involved in particular exchanges or meetings, make it difficult to be clear about the nature of the problem.

#### *Variable extent of consideration of underlying reasons*

Despite statutory guidance on SCRs now being clear that SCR reports should ‘provide a sound analysis of what happened in the case, **and why**, and what needs to happen in order to reduce the risk of recurrence’ (emphasis added, p. 79), many of the reports provided little analysis of the reasons why particular mistakes or difficulties had happened.

## Included SCR reports

Bedford LSCB (2014) Serious Case Review in respect of Child A1301

Blackpool LSCB (2015) Baby Q

Blackpool LSCB (2014) Child BR  
Dorset LSCB (2015) Family S15  
Gateshead LSCB (2014) Baby T  
Hampshire LSCB (2014) Baby V  
Harringey LSCB (2015) Child D  
Hertfordshire LSCB (2014) Child X  
Hertfordshire LSCB (2015) Young Person B  
Isle of Wight LSCB (2014) Child Z  
Isle of Wight LSCB (2015) Family Q  
Kirklees LSCB (2015) A young person  
Lambeth LSCB (2014) Child H  
Lancashire LSCB (2014) Child R  
Leeds LSCB (2015) Child Y  
Liverpool LSCB (2015) Maisie  
Liverpool LSCB (2015) Mary  
Norfolk (2014) Family L  
North East Lincolnshire LSCB (2014) Baby H  
Nottingham City LSCB (2015) Child G  
NSPCC on behalf of Unnamed LSCB (2014) Child C  
Oxfordshire LSCB (2014) Child H  
Oxfordshire LSCB (2014) Child N  
Oxfordshire LSCB (2014) Child Y  
Oxfordshire LSCB (2015) Children A, B, C, D, E and F  
Peterborough LSCB (2014) Child A  
South Gloucestershire LSCB (2014) Child C  
Southampton LSCB (2014) Child I and Child M  
Southampton LSCB (2015) Child K  
Southampton LSCB (2014) Child L  
Southampton LSCB (2014) Family A  
Tameside LSCB (2014) Child H

Tameside LSCB (2015) Child M

Thurrock LSCB (2014) Julia

Tower Hamlets LSCB (2014) Jamilla

Walsall LSCB (2015) W4

Wandsworth LSCB (2014) Zara

West Berkshire LSCB (2014) Child G

# Appendix 2. Practitioner summit report

## Executive Summary

Our aim was to test a mechanism for collaborating with multi-agency practitioners and managers to deepen understanding of practice issues, identified through analysis of Serious Case Reviews, and explore potential solutions to those issues.

The mechanism we tested was a series of multi-agency ‘summits’ attended by practitioners and managers, using a briefing based on our SCR analysis as a starting point for discussion. The summits were held in London (25 September 2015), Leeds (28 September 2015) and Birmingham (30 September 2015) and were attended by a total of 194 practitioners and managers from agencies including health, social care, education and police.

The conclusions of the internal evaluation are that:

- The summits fulfilled their intended function in terms of providing a deeper understanding of underlying reasons for the problems identified in the SCRs. These data have gone on to be presented to the national Alliance of strategic leaders, and to local LSCBs.
- Our concerns that attendees would not feel able to speak freely in a multi-agency group of mixed hierarchy were not borne out, and feedback strongly suggested that participants felt able to engage in open and honest discussions. In particular:

**98%** said that in the group they were able to discuss the practice issues openly, and without blame

**97%** felt able to contribute to the discussions and that my perspective was valued, and the examples from the Serious Case Review analysis were a useful starting point for discussion

**96%** reported that the examples discussed resonated with their own experience of practice

- Participants themselves also found the summits useful in terms of sharing experiences of practice, and hearing from other agencies. The ‘wordle’ below represents the feedback about what participants liked about the summits.



underlying practice problems, SCR reports alone are unlikely to provide all the information we need. This is because:

- SCRs will not always 'get to the bottom' of why a particular problem happens. Adequate explanation may improve as quality of reports increases, but still will not happen in every case.
- Some of the underlying reasons may involve 'tacit' knowledge or soft factors such as culture which may be difficult to surface through an SCR process, and may be better tackled in a workshop type process.
- Face to face conversations with practitioners outside the SCR forum may help to surface more nuanced explanations of the practice problems identified.

SCRs also represent a relatively small subset of practice – it is therefore difficult to get a sense of how widespread a problem is. Our assumption is that gathering the views of practitioners will help us to get a better sense of whether the issues identified in SCRs are common across the sector.

## **Aims of the summit**

The purpose of the summits was to get a wider perspective on the issues identified in the analysis from a range of practitioners and managers about the issues identified. We aimed to:

- Check and expand on the examples we have identified from the SCRs
- Identify the blockages and barriers that are causing the kinds of problems identified in SCRs – using the practitioners' own direct experience
- Develop ideas about support and solutions to tackle these issues that would work on the ground.

In order to achieve these aims, it was important to have:

- A wide range of agencies, to bring together the various relevant perspectives
- A mixture of frontline workers and senior managers – again to provide different perspectives on these issues
- A process by which participants could pre-select which issues they wanted to discuss, to ensure that participants were discussing issues about which they had first-hand knowledge.

## **Internal evaluation questions and data collection methods**

We aimed to evaluate how effective the summits were in achieving these aims, as well as participants' experiences of attending. Our specific evaluation questions in relation to the summits were as follows:

- a. Did the SCR collation provide a useful basis for practitioner discussions?
- b. Were summit attendees able to add further detail to the SCR findings regarding an understanding of the problem?

- c. Were summit attendees able to suggest solutions?
- d. Did summit attendees feel they were able to have open and honest conversations?
- e. Did summit attendees gain any other benefits from attending?
- f. What else did attendees think went well / less well about the summits?

We gathered data via feedback forms given to participants, facilitators and note takers on the day of the summits.

## **2. How the summits worked**

### **Application and selection process**

An important aspect of the summits was ensuring a spread of attendees from a range of professions, and with a mixture of frontline, middle and senior managers. For this reason registrations for the event were managed via an application and selection process. The invitation was sent out on 9 of July and was subsequently publicised via various NSPCC and SCIE networks.

Attendees were asked to complete an online form to express their interest in the event, giving information about their role and profession, with initial applications received on 14 August 2015. Applications were then considered by the Programme Manager and events team, aiming to ensure the right balance of attendees.

Applications were confirmed by email on 19th August. We received 457 applications in total, and 240 people were selected to attend:

- London received 209 applications, and the events team accepted 84.
- Leeds received 122 application, and the events team accepted 79.
- Birmingham received 126 applications, and the events team accepted 77.

Applications were prioritised in order to achieve a good balance of agency representation, and the desired ratio of frontline practitioners to managers. Delegates were requested to inform us as a matter of urgency if they were no longer able to attend. These spaces were then offered to people on the waiting list. These were professionals who were relevant to the summit, but were not offered a place in the first instance, due to limited capacity.

Where numbers for particular professions (e.g. probation service) appeared to be low, the Programme Manager contacted senior staff in that region to encourage applications.

### **Background information provided**

The content of the summits was based on analysis of 38 recent SCRs, published between May 2014 and April 2015, with the aim of looking in detail at practice issues described in the SCRs. We looked specifically at issues relating to inter-professional communication and decision-making. This was chosen as a 'test topic' because it is often identified as a high-level theme in SCR reports. The aim of this analysis was to look in closer detail at this topic,

and in particular, the ways that inter-professional communication problems manifest at different stages of involvement and between different professional groups.

Participants were asked to pre-select, from the following fourteen topics, three topics which they would be interested in discussing **and** of which they had direct knowledge and experience.

The topics were as follows:

**Common Assessment Framework**

1. Agencies do a CAF because they've been told to, even though they don't agree with this suggestion

**Making a referral to Children's Social Care (CSC)**

2. Referring agencies think they are making a referral or requesting action of CSC, but CSC thinks they are only receiving information to be logged

3. Bruising to non-mobile babies does not trigger a referral

4. Information about young people's sexual activity/sexual health relevant to safeguarding does not trigger referral

5. Referring agencies and CSC disagree about whether cases referred to CSC actually need CSC involvement, and this is not resolved

**Strategy discussions, Section 47's and rapid responses to the unexpected death of a child**

6. CSC or Police do not convene a Strategy Discussion when one is needed

7. Agencies interpret Health input about possible causes of injuries as definitive, rather than one of a range of possibilities

**Child Protection Conferences, core groups and Child in Need meetings**

8. A school gives a positive portrayal of the child and does not share concerns at Child Protection Conference

9. Other agencies interpret Police not pursuing a prosecution as meaning that child protection procedures are not needed

10. All agencies' views are not given equal weight in Conference decision-making

11. Discussion between agencies in Child Protection Conferences lacks purpose

12. Professionals experience the participation of families in Conferences as hindering frank exchange of information

**Ongoing case work**

13. Professionals use euphemistic or misleading language in reports and written records, which hinders communication

14. Professionals in children's and adults' social care do not communicate when needed.

Participants were then sent a briefing paper prior to the event. This set out, for each of the fourteen topics:

- A brief description of the issue
- An illustration of the issue taken from one of the SCR reports
- What was detailed in the report about the underlying reasons for this issue.

## Agenda for the day

The overview agenda for each day is shown below:

<b>10:00 – 10:30</b>	<b>Registration and refreshments</b>
<b>10:30 – 10:40</b>	<b>Chair - Welcome</b>
<b>10:40 – 10:50</b>	<b>Department for Education - Welcome</b>
<b>10:50 – 11:10</b>	<b>Introduction and overview</b>
<b>11:10 – 11:30</b>	<b>Session 1 - Participant discussion</b>
<b>11.30 – 11:50</b>	<b>Session 1 - Feedback</b>
<b>11:50 – 12:30</b>	<b>Session 2 - Building on SCR findings - Choice of topics</b>
<b>12:30 – 12:40</b>	<b>Session 2 - Feedback</b>
<b>12:40 – 13:40</b>	<b>Lunch</b>
<b>13:40 – 14:20</b>	<b>Session 3 - Building on SCR findings - Choice of topics</b>
<b>14:20 – 14:35</b>	<b>Session 3 - Feedback</b>
<b>14:35 – 14:55</b>	<b>Session 4 - What's missing from the analysis?</b>
<b>14:55 – 15:15</b>	<b>Session 5 - Reflections</b>
<b>15:15 – 15:25</b>	<b>Evaluation forms</b>
<b>15:25 – 15:30</b>	<b>Chair - Close</b>

Most of the morning and afternoon sessions were spent in small group discussions focusing on one of the fourteen issues, depending on participant's preferences. The discussions followed the same broad format of asking participants:

- Is the problem of x familiar to you? Do you have any examples from your own experience?
- Why do you think this kind of problem arises? What are the underlying reasons?
- What solutions do you think would be helpful?

## Who attended?

Of the 239 professionals offered places at the event, 194 attended (see Table 1) from a range of agencies (see Table 2). They represented frontline workers (26%), middle managers (58%) and leaders (28%). The aim was to have a ratio of: 40% frontline workers, 30% middle managers and 30% leaders.

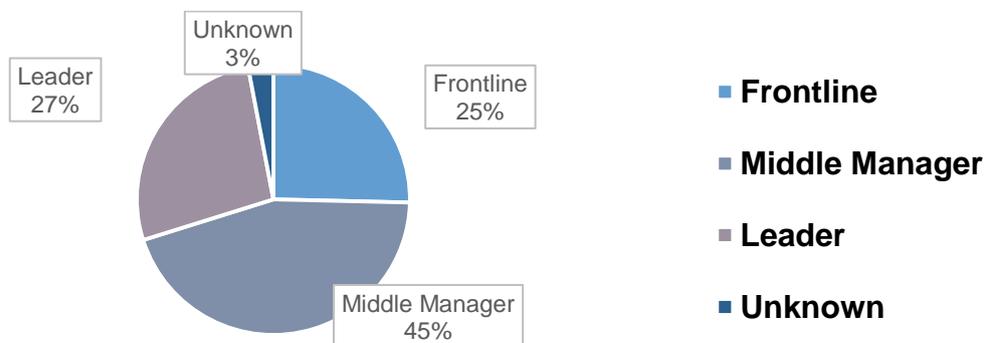
**Table 1: Practitioners involved in each locality**

<b>Summit</b>	<b>Number of practitioners</b>
London – 25 <sup>th</sup> September 2015	<b>67</b> (13 DNA/Apologies)
Leeds – 28 <sup>th</sup> September 2015	<b>66</b> (12 DNA/Apologies)
Birmingham – 30 <sup>th</sup> September 2015	<b>64</b> (12 DNA/Apologies)
	<b>Total: 194</b>

**Table 2: The agency breakdown for each summit is shown below with a chart depicting the role of each participant**

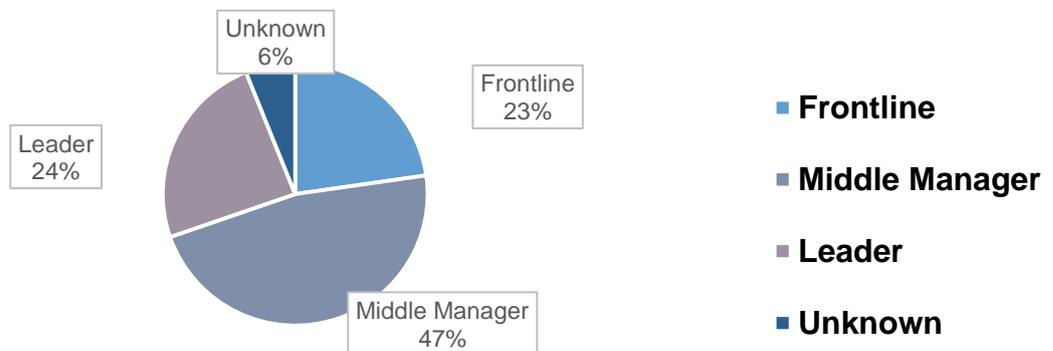
**London Summit**

	Invited	Attended
<b>Total delegates</b>	<b>85</b>	<b>67</b>
Adult's Health	3	2
Adult's Social Care	0	0
CAFCASS	5	4
Children's Health – Community	19	15
Children's Health – Hospital/acute	8	5
Children's Health – other	8	6
Children's Social Care – Local Authority	8	7
Children's Social Care – Private	2	1
Children's Social Care – Voluntary	2	1
Early Years' Service	3	2
Education/Schools	3	3
Fire & Rescue	0	0
Housing	1	1
LSCB	13	12
Police	3	2
Probation	6	4
Other/Unknown	1	2



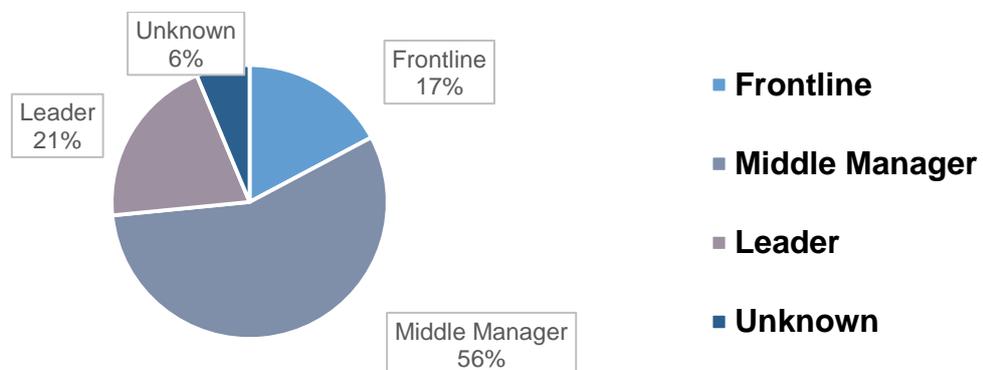
## Leeds Summit

	Invited	Attended
<b>Total delegates</b>	<b>78</b>	<b>66</b>
Adult's Health	2	2
Adult's Social Care	2	2
CAFCASS	4	3
Children's Health – Community	11	9
Children's Health – Hospital/acute	2	2
Children's Health – other	8	8
Children's Social Care – Local Authority	16	13
Children's Social Care – Private	1	0
Children's Social Care – Voluntary	7	6
Early Years' Service	1	1
Education/Schools	4	3
Fire & Rescue	1	1
Housing	1	1
LSCB	11	7
Police	0	0
Probation	4	3
Other/Unknown	3	5



## Birmingham Summit

	Invited	Attended
<b>Total delegates</b>	<b>76</b>	<b>64</b>
Adult's Health	2	2
Adult's Social Care	1	1
CAFCASS	2	2
Children's Health – Community	11	7
Children's Health – Hospital/acute	4	4
Children's Health – other	6	5
Children's Social Care – Local Authority	11	6
Children's Social Care – Private	1	0
Children's Social Care – Voluntary	2	1
Early Years' Service	3	2
Education/Schools	2	1
Fire & Rescue	4	4
Housing	1	1
LSCB	19	18
Police	4	4
Probation	2	2
Other/Unknown	1	4



### 3. Delegate feedback – evaluation forms

Attendees were asked to complete an evaluation form (see appendix 1). The response rate was 87%.

The feedback questionnaire began with three open-ended questions:

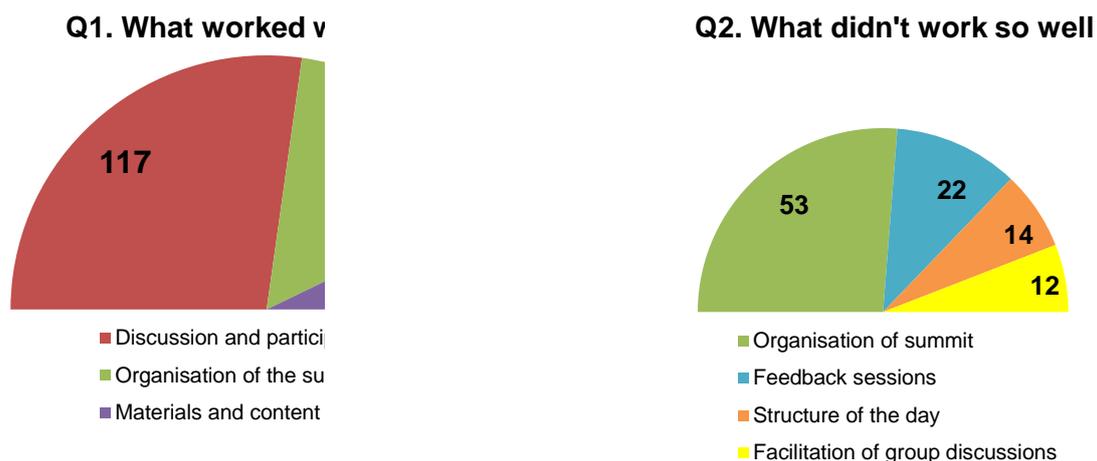
1. What worked well?
2. What didn't work so well?
3. What would you have liked more of?

The following sections are an inductive thematic analysis of participant comments. Where these relate to our evaluation questions, this is highlighted in the text.

#### 3.1 Question 1 and 2: What worked well? What didn't work so well?

The emerging themes in relation to these questions are illustrated in the charts below, where the positive comments far outweighed criticisms. The numbers correlate to how many participants commented on the following themes: discussion and participation; organisation of the summit; materials and content; feedback sessions; structure of the day; facilitation of group discussions. Some participants also alluded to the fact that this was a new approach to thinking about practice problems, with comments including:

*“Pleased to see reference to looking at underlying cultural issues rather than process/compliance review” (Birmingham)*



Note that 100% of participants responded to question 1 and 69% of participants responded to question 2, suggesting that the remaining 31% had no views on 'What went less well?'. Six respondents replied to Q2 expressing that they found “no real issues”.

## Discussion and Participation (117 positive mentions)

The emerging themes in relation to these questions were that participants valued the discussion and participation aspect of the summit, and the opportunities to share and discuss examples. The majority of responses to the question 'What worked well' related to the interactive nature of the day, and the small table discussions.

- **The multi-agency representation (60 positive mentions)**

Many participants valued the opportunity to discuss the issues with a range of agencies, and to bring the perspectives of different agencies to bear on the practice issues at hand.

Participants also commented on the value of the pre-selection process for determining multi-agency attendees, and in ensuring a mixed representation on each table. Although our intention had been largely in ensuring good quality discussions about the practice problems, it was also evident that a 'side benefit' had been opportunities to network and share ways of working on tables. Example comments included:

*"The group discussion on our table was excellent. Different ideas and views were shared and the facilitator was very good at keeping us on track. The broad range of professionals was key to making this work."* (London)

*"The skill mix on each table. Discussion was varied with different perspectives."* (Leeds)

*"Meeting multi-agency colleagues and focussing on specific issues. Splits on the tables were well thought out and contributed to the above."* (London)

*"The mixed 'economy' of professionals on the delegate tables ensured a wide ranging discussion and different perspectives – this was really good."* (Birmingham)

*"Group discussions – assignment of questions. Opportunities to network. Info about new ways working"* (Birmingham)

- **Group discussion (34 positive mentions)**

Related to the above, the most frequent comment from participants was "*participation session*" or "*discussion*". Given that the structure of the day was largely focused around these discussions, it is extremely positive that these were considered to have worked well, and were valued by participants. Comments indicated that participants had found the practice examples a useful starting point for discussion. There were also a number of positive comments relating to the quality of the facilitation:

*"Small groups spending time discussing specific practice issues."* (Leeds)

*"Most things, very interesting discussions, facilitation was good."* (London)

*“Working in groups, examining examples, looking for potential solutions.”*  
(Birmingham)

*“Having a national forum to debate real practice issues and alternative ways of thinking.”* (Leeds)

- **Learning and gaining feedback from each other’s agencies where can highlight common themes and problems (23 positive mentions)**

Participant feedback suggested that they had found the discussions elaborating more detail regarding the practice problems as a useful opportunity to share learning and professional experiences.

*“An opportunity to explore/discuss and learn from professional experiences and new ideas of working”.* (Birmingham)

*“Learning about the work happening across England. Sharing issues and examples in groups.”* (London)

*“The interchange of ideas, sharing practice experiences and openness to new ideas.”*  
(Leeds)

- **The participants commitment and interaction towards discussion (11 positive mentions)**

A number of respondents commented positively on the commitment of other participants to the group discussions where there was enthusiasm, open and honest discussions in accessible language. This was valuable feedback, given that one of our specific evaluation questions related to whether participants would feel able to have open and honest conversations in a multi-agency and cross-hierarchy environment.

*“...Being able to be honest about the more emotional/psychological perspectives.”*  
(London)”

*“Good group discussions, lot of energy, experience & knowledge.”* (Birmingham)

*“Discussion between professionals in a language familiar to all (non-jargon).”* (London)

*“Free discussion between professionals.”* (Birmingham)

## **Organisation of the summit (67 mentions were positive and 57 mentions considered suggestions for improvement)**

The logistics of the summit were considered by participants to be effective, in particular the multi-disciplinary attendees invited and the pre-selection allocation to topics; the use and quality of facilitators and note takers; the structure of the day. The organisation created a useful basis for practitioners to enrich discussions. Some participants, however, felt that the

organisation of the summit such as timing, venue and allocation of participants to tables worked less well.

- **Timing of the day (25 suggestions for improvement)**

Some participants remarked that the summit could have allocated more time for discussion. They suggested shorter breaks or a longer day. This was a popular theme across all three summits:

*“Break time could have been shorter to allow more table time discussion.”* (London)

*“Time compression, so much more time could have been spent on discussions.”*

(Leeds)

*“Not enough time for the discussions.”* (Birmingham)

- **Structure of day (23 positive mentions)**

Participants commented in particular on the value of changing groups, mixing presentations and discussion, focus on specific aspects of SCRs:

*“Format, change in groups halfway through and mixed agency discussions.”* (Leeds)

*“The day was well structured and this helped the groups stay focussed.”* (London)

*“Moving to a different table in the afternoon and having a good skill mix on each table.”*

(Leeds)

- **Quality of venue (20 suggestions for improvement)**

The majority of participants that commented on the venue were in Birmingham, where the room was not effective for attendees to hear one another during discussions.

*“Venue not supportive of group work all in 1 room - very noisy.”* (Birmingham)

*“Acoustics in venue made hearing discussions sometimes problematic in workshop sessions.”* (Birmingham)

- **Facilitation and note-taking was considered to be effective: (17 positive mentions)**

*“Facilitation was excellent thought provoking! Really enjoyed multi-agency stimulating conversation. Made me consider importance of more of a forum for multi-agency meetings needed. Capacity to have transparency! Very important - recognise good/bad and not be ashamed!”* (London)

- **Facilitation of discussions (12 suggestions for improvement)**

Some participants felt that there was not a “*consistency*” in facilitating discussions and that occasionally discussions did not remain on focus and “*manage to ensure that overtly opinionated delegates gave a voice to others on the table*” (Birmingham).

- **Logistics of the summit (8 suggestions for improvement)**

Five participants mentioned that the allocation of professionals on their tables included too many professionals from the same agency, such as health:

*“Group 1 (am) too many health members within focus group”* (Birmingham).

*“Although good to have choice of the questions to be addressed. This possibly led to groups being underrepresented by one group of professionals.”* (London)

Other issues highlighted by participants were that their topic choice was cancelled, and that name badges could have been bigger.

## **Materials and content (31 positive mentions)**

There were a number of positive comments relating to the materials provided at the summit, and the content and focus of the day. Participants commented positively on the usefulness of the information with respect to briefing materials and the approach taken towards addressing issues in SCR.

- **Briefing materials (16 positive mentions)**

Positive comments on the A3 ‘map’ of practice issues, presentations and receiving the briefing materials in advance:

*“A3 mapping of examples helpful as it had given me and idea re presentation + mapping of our learning + improvement framework evidence. Table discussions - picking up examples from elsewhere.”* (Birmingham)

*“Engaging with the findings and information in a different way. Summary of information in a matrix as a reference.”* (London)

*“Information provided - High quality. Issues well set out/case information. Good support for group discussions.”* (Birmingham)

- **Current ways of thinking (13 positive mentions)**

Some participants commented on the approach taken by the LiPP team towards issues highlighted in SCR’s, especially in relation to addressing the “*cultural issues, rather than process compliance reviews*” and how useful this subject is to explore.

*“Reassuring that learning from past errors is continuing big time.”* (Leeds)

*“Hearing about current thinking in learning lessons from SCRs and other information from NSPCC, TCSW, SCIE + DfE.”* (Leeds)

*“Shared reflection on what is needed to prevent repeated learning in future.” (London)*

*“Good topic – very pertinent.” (Birmingham)*

## **Feedback sessions (22 suggestions for improvement)**

In relation to the feedback sessions, participants commented that the session did not effectively gather information from all tables i.e. not everyone fed back, and that the use of a microphone prevented people from giving feedback:

*“Feedback sessions. Too short to be meaningful and too frequent, stopping the flow of discussion.” (Birmingham)*

*“Table feedback was not as detailed as it could be therefore as an attendee it was not possible to widen understanding of issues other than the two discussions” (Birmingham)*

*“People shy to speak through microphone, facilitator should have fed back key points of discussion if no one else volunteered.” (Leeds)*

## **Structure of the day (14 suggestions for improvement)**

A few participants commented on the information provided by the LiPP team in terms of the introductory session and the activity.

- **Introductory Session (8 suggestions for improvement)**

Participants indicated that the presentations from organisers were either too long or unclear:

*“I did struggle to follow some of the introduction - bit strategic for me!” (Leeds)*

*“The introduction regarding methodology wasn't particularly interesting.” (London)*

- **Group activity – topic discussion (6 suggestions for improvement)**

A few participant indicates that they did not enjoy the activity either because the task was repetitive: *“repetitive group exercise - in morning and afternoon” (Leeds)*, or *“the 'analysis' was a 'mapping' or 'index' of outputs from SCRs. Not an analysis. There perhaps wasn't a focus on behaviours, beliefs & cultures. (i.e. outputs & not outcomes)” (London)*.

Some participants requested the opportunity to discuss ‘positive practice examples’, but this featured more in relation to question three, where nine participants mentioned that they would like research to not focus solely on issues, but highlight effective practice too.

## **3.2 Question 3: What would you have liked more of?**

The emerging themes from this question were that participants wanted more time, more information from the organisers on the project, more solution focussed discussions and would like to discuss more than two topics. It is important to note that 54 participants (32%) did not identify anything.

- **More time (46 mentions)**

Allowing more time was a common theme across the summit with 40% of participants who responded to this question asked the organisers for “*more time*”.

- **More information from the organisers (23 mentions)**

This encompasses the following aspects highlighted by participants: “*more presentations on the project* (Leeds)”; “*more info [sic] about the other strands of the project and timeline* (Birmingham)”; the next stages with how this will be taken forward; direction for own organisations on how to implement change i.e. “*the recommendation made in light of the A3 grid* (London)”.

- **More solution after the findings and analysis (19 mentions)**

An aim of the summits was to find solutions to the issues highlighted in Serious Case Reviews, yet some participants remarked that they wanted more opportunity to reflect upon this:

*“More opportunity of developing and hearing about solution focused approaches.”*  
(Birmingham)

*“Solution/problem solving focus.”* (Leeds)

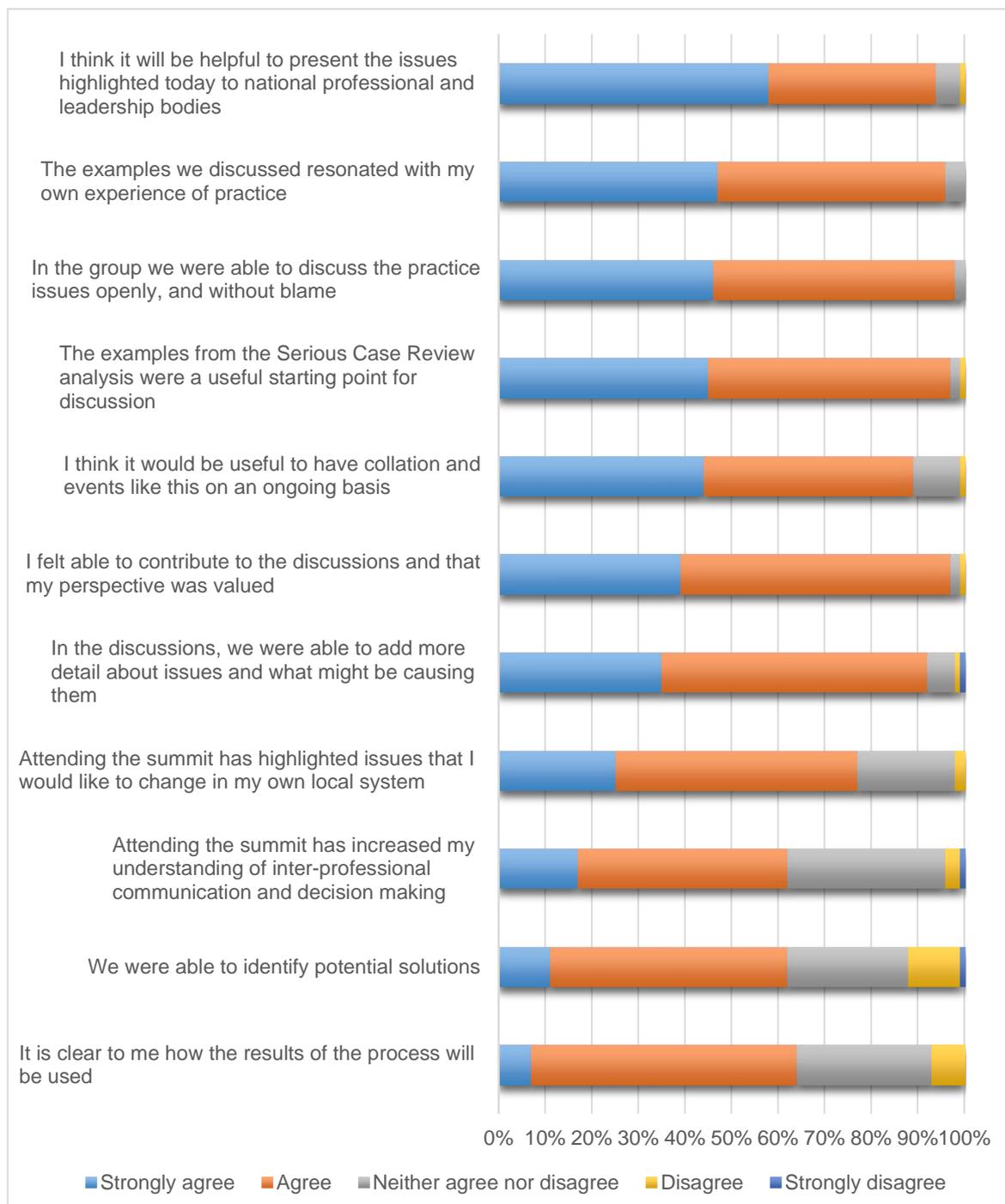
- **More topics to discuss (15 mentions)**

Some participants requested that there was more opportunity to cover other topics than the allocated, pre-selected two. One participant from London expressed that they would like “*to have discussions about more than a couple of specific areas - look at all the questions - while acknowledging this would extend course to probably a full week!*”

### 3.3 Question 4: Do you agree or disagree with these statements about the summit?

Participants were asked to scale on a Likert-style scale as to whether they agreed or disagreed with the following statements (The key headlines where participants strongly agree and agree are illustrated below:

#### 3.4



## Question 5: Anything else you would like to tell us?

Participants were extremely positive and grateful to have had a 'national forum' to discuss SCR's in more depth (26 mentions):

*"Thank you. I appreciate this was just the start, and it will become more clear as you progress. Everyone wants to see progress, but it's not clear what this looks like + how it will be different this time."* (London)

*"I thought this was going to be a learning event, however I am not disappointed to have assisted in the LiPP to develop future learning + improved procedures."* (Birmingham)

The above comment from a participant in London resonated with other participants request for further communication regarding the development of the project (21 mentions). Some participants have requested directly for briefing materials to be emailed, and to be informed of how they can become involved in the project.

On an individual scale, some participants commented that they would be bringing the information they learnt today to inform their own practice:

*"I will be using the scenarios in the briefing for participants in my next training for GPs re: learning the lessons from SCRs."* (Leeds)

*"Very informative & interesting discussions, which I will feedback to colleagues in the Trust & LSCB."* (Birmingham)

## 4. Feedback from facilitators and note takers

Facilitators and note takers were asked to complete an evaluation form (see appendix 2), the responses were collected from 35 facilitators and note takers.

The feedback questionnaire asked eleven questions:

1. What worked well?
2. What didn't work so well?
3. Did you get the impression that delegates had read the briefing and found it useful?
4. Did you get the impression that delegates understood and agreed with the purpose of the day?
5. Were participants able to engage with the examples, and give further detail about the underlying reasons?
6. Were participants able to suggest solutions to the problems identified?
7. Do you have suggestions about how to change the day to make it work better for what we were trying to achieve?
8. Any other comments (either from yourself or from what delegates said in between sessions)?
9. What were the challenges in facilitating discussions between different agencies and staff at different levels of seniority?
10. In what ways could you have been better prepared and supported?
11. Is there anything you would do differently in your role as facilitator next time?

The following sections are an inductive thematic analysis of participant comments. Where these relate to our evaluation questions, this is highlighted in the text.

### 4.1 Question 1: What worked well?

Facilitators and note takers commented positively on the attendee's participation enriching debate and the organisation of the summit itself.

#### **Attendee participation at the summit (33 mentions)**

Responses collected observed the impressive multi-agency presence, how well attended the summits were especially in relation to the expertise and engagement of attendees:

*"The table discussions allowed flowing conversation between different professionals, as intended."* (Note taker, London)

*"Group discussions created good debate, different approaches by sectors & professionals encourage debate....allowing delegates to swap topics, network/share practice and experiences."* (Facilitator, Leeds and Birmingham)

## The purpose and organisation of summit (30 mentions)

Facilitators and note takers reflected positively on the summit being organised well, the ability for participants to change tables and focus on topics they pre-selected:

*“The organisation of the whole event. Table and seating arrangements. Having a chair + DfE attend added helpful context. (Facilitator, Leeds)*

*“None of it was too complex to understand, from an objective person’s viewpoint. (I know something on the subject but I’m not an expert).” (Note taker, Leeds)*

## 4.2 Question 2: What didn’t work so well?

Facilitators and note takers echoed the issues participants found with the venue, i.e. it was quite cramped and the acoustics made hearing discussions, hard to record. 26% facilitators and note takers left this section blank, and the majority of feedback related to quality of venue:

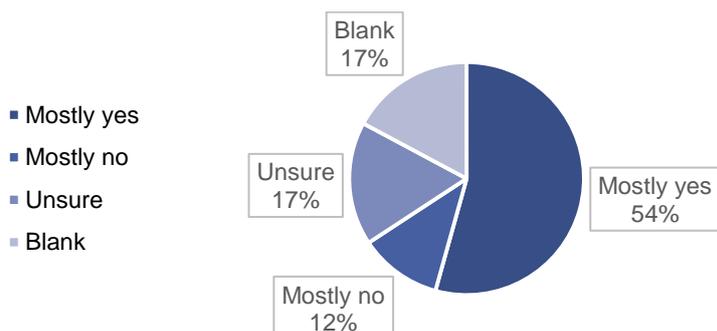
### Quality of venue (12 mentions)

*“As note taker it was difficult to get what people were saying down before someone else began to speak - and more tiring as the day went on.” (Note taker, London)*

*“Noisy and microphone issue/sound.” (Facilitator, Birmingham)*

## 4.3 Question 3: Did you get the impression that delegates had read the briefing and found it useful?

As seen in Chart 1, over half of the facilitator and note takers had the impression that delegates had pre-read the briefing and found it useful (54%). Additional comments that supported this were *“Yes, most delegates had read the briefing, some had discussed with colleagues in advance so they could choose their discussion topics that they thought suited them better”* (note taker, Birmingham). Some were unsure of this (17%) indicating that delegates varied in whether they had or hadn’t read the briefing: *“Mixture around tables (facilitator, Leeds)”*. 12% responded ‘mostly no’, one note taker in Birmingham commented that *“delegates hadn’t read in advance, but had had them”*.



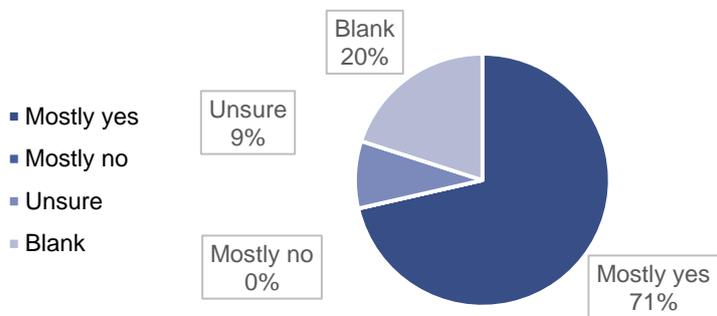
**Chart 1: Facilitator and note takers response to question 3**

## 4.4 Question 4: Did you get the impression that delegates understood and agreed with the purpose of the day?

In reference to Chart 2, facilitators and note takers stated positively that most delegates understood and agreed with the purpose of the day (71%):

*“Yes most delegates were totally engaged and very happy to share their experiences with the table. Some did have reservations about whether it would make a difference in the long run but were willing to try.”* (Note taker, Birmingham)

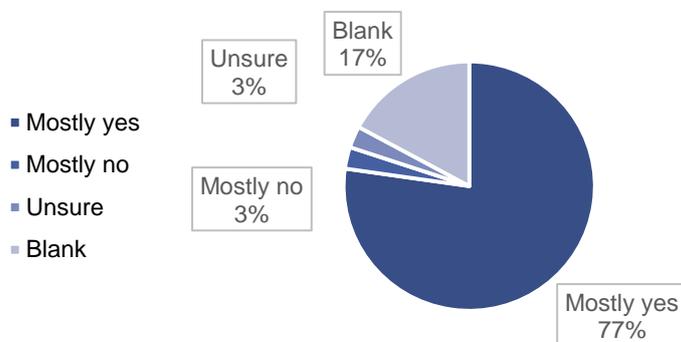
*“Positive feedback about the concept and unpicking the nuts and bolts.”* (Facilitator, Leeds)



**Chart 2: Facilitator and note takers response to question 4**

## 4.5 Question 5: Were participants able to engage with the examples, and give further detail about the underlying reasons?

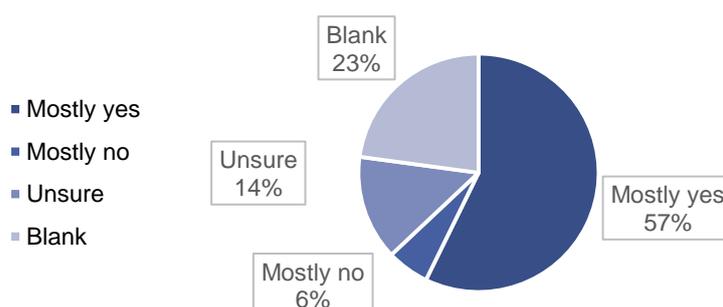
Chart 3 illustrates the facilitators and note takers agreement in delegates being able to add further detail about underlying reasons (77%). An additional comment by a facilitator at all three summits indicated that participants were able to enrich discussions: *“Depending on groups most were able to engage. More senior staff were able to engage less with frontline issues”*. The one note taker to respond ‘mostly no’, commented *“preference was to draw from [own] experience and case examples rather than the examples given in the pack”* (Birmingham). The topic discussion session aimed to elicit underlying reasons in practice examples from frontline professionals own experience.



**Chart 3: Facilitator and note takers response to question 5**

## 4.6 Question 6: Were participants able to suggest solutions to the problems identified?

Chart 4 echoes the issues highlighted by the summits participants where there was not as much focus on solutions. Time constraints was cited by facilitators, note takers and the participants as a reason. A note taker in Birmingham thought participants were not able to suggest solutions stating participants *“were mainly ‘problem identifiers’ rather than solution focussed”*. With facilitator’s guidance, participants were able to suggest solutions but *“this needed encouragement. It seemed best to ask for good practice examples”* (Facilitator, London, Leeds and Birmingham).



**Chart 4: Facilitator and note takers response to question 6**

## 4.7 Question 7: Do you have suggestions about how to change the day to make it work better for what we were trying to achieve?

Facilitators and note takers (63% response rate) remarked on the structure of the summit reiterating earlier comments about the timing and acoustics in the venue. Twelve facilitators and note takers commented on time being an issue and that to improve the summit, we could have a longer day, shorter breaks, no plenary sessions in the afternoon and an opportunity to discuss a third topic:

*“It was mentioned by some participants, that instead of the feedback sessions, participants were given the opportunity to discuss a third topic on the day.”* (Note taker, Birmingham)

*“As a project team we need to think through how effective this model of engagement is. - last 2 sessions were not needed - the discussion on 'what's missing' was in both the morning + afternoon session.”* (Facilitator, London and Birmingham)

## 4.8 Question 8: Any other comments (either from yourself or from what delegates said in between sessions)?

Facilitators and note takers thought that the summits were overall a positive experience for delegates who wanted to attend another similar event:

*“Overall positive and many said they would be keen to attend more events of this nature. It was very good to hear from frontline staff and gain information on real practice.”* (Facilitator, London, Leeds and Birmingham)

However, it was noted by three facilitators and note takers, that it was easy for participants to go off topic as one facilitator in Leeds remarks:

*“Was extremely easy for groups to go off-topic. I don't know how you could encourage people to come more prepared but that would have been helpful. Neither groups were ready & raring to go with their topic discussions so there was a warm-up period & easy wandering.”*

## 4.9 Question 9: What were the challenges in facilitating discussions between different agencies and staff at different levels of seniority?

Facilitators and note takers commented on the general challenges of the overall summit, such as the acoustics making it difficult to hear participants (16 mentions, note takers). Challenges recorded in relation to the question, facilitating discussions between different agencies and staff at different levels of seniority were remarked varyingly by nine facilitators:

*“Assignment of delegates to tables - some not keen to participate as issue not relevant to their role.”* (Facilitator, Leeds)

*“AM - No health practitioners in this group. Quite early on led to a bit of blaming of health colleagues. One instance of tensions between SWs where 1 SW criticised SW practice & 2nd SW took umbrage.”* (Facilitator, Leeds)

*“Didn't experience particular issues regarding [sic] agency or seniority.”* (Facilitator, London, Leeds and Birmingham)

## 4.10 Question 10: In what ways could you have been better prepared and supported?

This question has a high response of ‘none’ (63%), indicating that facilitators and note takers felt well prepared and supported. Those who did respond commented extremely positively on the organisation and information provided by the LiPP team beforehand:

*“I felt very well supported though- there was lots of information and nothing was unclear about the task I was being asked to do.”* (Note taker, Leeds)

*“I think it was very well organised and informed with plenty of organised worksheets.”* (Facilitator, London)

## 4.11 Question 11: Is there anything you would do differently in your role as facilitator next time?

Twenty-two facilitators and note takers felt that there was nothing they would do differently next time. Note takers (4) who did respond felt that next time they would ask participants to clarify what they meant:

*“I would speak up more to get people to clarify terms I didn’t recognise. I thought I was OK with this but when it came to it was quite awkward to interrupt people in full flow.”*  
(Note taker, Birmingham)

Facilitators (2) commented that they would benefit from the delegates list in advance so they could plan and understand roles:

*“Have advanced notice of table allocation to understand roles.”* (Facilitator, Leeds)

## 5. Reflections from project team

The Learning into Practice Project team met on the 25 November 2015 to consider the internal evaluation data collected from delegates who attended the summits and the external feedback produced by OPM. Overarching emerging themes included:

- This process worked, a proof of concept, in that we have been able to use the data we gained at the summits to enrich the data from SCRs – in fact the summit data has added considerably to what came out of the SCRs. We have used the data gathered through the summits as a foundation for discussion with the Alliance, and with the pilot LSCBs.
- The participants were clearly able to engage with the SCR data *“this is our lives, nothing was shocking”*.
- Original apprehensions of professionals wanting to engage in this process were alleviated because the summits were over-subscribed and well attended;
- Important learning to be taken forward where the summits highlighted the difficulty and time constraints in asking delegates to explore solutions, this was then taken to the Alliance for solution focussed discussions;
- The delegates articulated in the evaluation forms that they found the summits helpful and did enable them to discuss openly and honestly issues that arise in Serious Case Reviews, a key aim of the summit.
- The telephone interviews conducted as part of the external evaluation suggested that some participants misunderstood the purpose of the summits, understanding them to be more typical ‘dissemination events’ of the findings of Serious Case Reviews. This highlighted the importance of the information sent out prior to the events, but also that this is a new way of engaging with practitioners in relation to SCRs.

## 6. Conclusions

The conclusions of the internal evaluation are that the summits fulfilled their intended function in terms of providing a deeper understanding of underlying reasons for the problems identified in the SCRs. These data have gone on to be presented to the national Alliance of strategic leaders, and to local LSCBs. Our concerns that attendees would not feel able to

speaking freely in a multi-agency group of mixed hierarchy were not borne out, and feedback strongly suggested that participants felt able to engage in open and honest discussions.

There are a number of amendments we would consider making to the process if we were to run the summits again including:

- Allowing more time in the agenda to discuss solutions
- Consider running of sub-regional rather than national level events, attended by fewer people, to facilitate specific discussion of potential solutions
- Take even more care to ensure that people were in the 'right' group for discussions, so that they are contributing to topics with which they have direct experience – this was not always the case at the summits
- Consider using webinars or similar to 'prime' people before attending
- Considering from the beginning how to maintain and capitalise on people's involvement.

# Appendix 3. Research instruments

## 1. Masterclass feedback form

Name (optional):

Masterclass attended:

Date:

The masterclass you have just participated in, is part of a stream of work designed to improve the quality of SCRs. In order to evaluate this aspect, we would like your feedback on three areas:

- The idea
- How it worked in practice
- Next steps.

### Views on the idea

SCR lead reviewers have a key role in producing high quality SCRs. There are currently limited opportunities for continuing professional development for reviewers. As part of this project, we are proposing that the activity of reviewing needs further **professionalization**. To test this concept, we have developed a set of 'master classes' that introduce knowledge from other fields to support reviewers.

#### 1. To what extent do you agree or disagree with the following statements:

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know
The quality of SCRs would benefit from the role of reviewers being more professionalized than it currently is	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The quality of SCRs would benefit from drawing on knowledge and expertise from other disciplines/sectors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The 'masterclass' format of a single day, interactive session, is a fitting way to introduce key ideas from a different field and give SCR reviewers to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

consider their relevance?						
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**Do you have any comments on the idea behind the masterclasses?**

**Views on whether it worked in practice**

**Specific masterclasses**

Each LiPP masterclasses has focused on sharing expertise from other areas and bodies of knowledge. The aim was to aim to introduce key ideas from a particular field and give SCR reviewers an opportunity to consider their relevance.

**2. What was the most helpful aspect of the masterclass?**

**3. What was the least helpful aspect of the masterclass?**

**4. Do you think you will do anything differently in your work as a SCR reviewer as a result of attending this training?**

- Yes       Partly       No       Not sure

**Please give details:**

**5. To what extent do you agree or disagree with the following statements:**

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know
Key ideas from a different field were successfully introduced	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The masterclass gave sufficient opportunity to consider the relevance of these ideas to SCR practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The ideas we covered were relevant to SCR practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A one-day format was adequate to cover the material and consider its relevance to SCR practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The preparation work/reading before the masterclass was helpful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The style and presentation of delivery was helpful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The number of attendees at the masterclass was appropriate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Do you have any further comments on how the masterclass worked in practice?</b>						

**Sustainability and on-going activity**

**6. To what extent do you think it is important for masterclasses to be available on an ongoing basis to support reviewers in their role?**

Completely	To a large extent	To a moderate	To a small extent	Not at all	Don't know
------------	-------------------	---------------	-------------------	------------	------------

		extent			
<input type="checkbox"/>					

**7. What other activities do you think are necessary to further professionalize the activity of reviewing?**

**8. Is there anything else you would like to tell us?**

**9. Would you be prepared to take part in a brief (20-30 mins) telephone follow-up conversation?** This is part of our evaluation and would be a valuable opportunity for us to explore your views in more detail, and help inform the future direction of the project.

**Yes**                       **No**

If yes, please give your email address below:

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Thank you for completing this evaluation form. Your comments will contribute to the overall evaluation of the Learning into Practice project.

## 2. Practitioner summits feedback form

We would very much appreciate your feedback on today's Learning in to Practice summit on inter-professional communication and decision-making.

**Name (optional):**

**Summit attended:**

London

Leeds

Birmingham

The aim of the summit was to hear from you in order to deepen our understanding of the problems highlighted in SCRs and help to identify solutions.

**Your feedback:**

1. What worked well?

2. What didn't work so well?

3. What would you have liked more of?

#### 4. Do you agree or disagree with these statements about the summit?

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Comments?
<b>Building on the learning from SCRs</b>						
The examples from the Serious Case Review analysis were a useful starting point for discussion						
The examples we discussed resonated with my own experience of practice						
In the discussions, we were able to add more detail about these issues and what might be causing them						
We were able to identify potential solutions						
<b>Experience and contribution</b>						
I felt able to contribute to the discussions, and that my perspective was valued						
In the group, were able to discuss the practice issues openly, and without blame						
Attending the summit has increased my understanding of inter-professional communication and decision-making						
<b>Likely next steps</b>						
It is clear to me how the results of this process will be used						
I think it would be useful to have collation and events like this on an ongoing basis						

I think it will be helpful to present the issues highlighted today to national professional and leadership bodies						
Attending the summit has highlighted issues that I would like to change in my own local system						

4. Anything else you'd like to tell us?

**5. Your agency:**

- |   |  |
|---|--|
| <input type="checkbox"/> Children's social care services – local authority  | <input type="checkbox"/> Adults' health                            |
| <input type="checkbox"/> Children's social care services - Private sector   | <input type="checkbox"/> Adults' social care (LA or care provider) |
| <input type="checkbox"/> Children's social care services - Voluntary sector | <input type="checkbox"/> Housing                                   |
| <input type="checkbox"/> CAFCASS  | <input type="checkbox"/> Education/school                          |
| <input type="checkbox"/> Early years' service                               | <input type="checkbox"/> Police                                    |
| <input type="checkbox"/> Children's health – community                      | <input type="checkbox"/> Probation                                 |
| <input type="checkbox"/> Children's health – hospital/acute                 | <input type="checkbox"/> Fire and rescue services                  |
| <input type="checkbox"/> Children's health – other                          | <input type="checkbox"/> LSCB                                      |
| <input type="checkbox"/> Other (please specify)                             |  |

**6. Your role:**

- |   |  |
|---|--|
| <input type="checkbox"/> Frontline worker (eg social worker, nurse, GP, police officer)   | <input type="checkbox"/> Middle manager (eg team manager, head of service, LSCB manager) |
| <input type="checkbox"/> Leader (eg assistant director, director, inspector, chair of LSCB, designated doctor, designated nurse, head teacher, police force lead) |  |

7. Would you be prepared to take part in a brief (20-30 mins) telephone follow-up conversation? This is part of our evaluation and would be a valuable opportunity for us to explore your views in more detail, and help inform the future direction of the project.

- Yes                       No

If yes, please give your email address below:

### 3. Local pilot site evaluation form

**We would very much appreciate your feedback on today's pilot session. Your thoughts are essential in helping us develop these pilots as a mechanism for promoting local learning and improvement.**

**Name (optional):**

**Local Child Safeguarding Board:**

**The aim of the pilot session was to.**

- Explore how a local response to learning from a national collation of serious case reviews can be achieved, through engaging with an example topic from the analysis of 38 recent reviews.
- Allow the LiP Project the opportunity to test one mechanism for promoting local learning and improvement.

#### **Your feedback:**

1. Have you found today's session helpful?

2. What could be improved?

3. Were the briefing materials helpful?

4. How could the briefing materials could be improved?

5. Would this type of session add anything to what your LSCB and subgroups are doing already?

**Do you agree or disagree with these statements about the pilot session?**

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
The test topic was a good way to explore how serious case review findings can speak to thinking at a local level.					
The session promoted discussion around 'how' change happens.					
The session was structured to					

promote productive reflection.					
Sessions like this could contribute to ongoing learning from serious case review findings.					

Comments on above responses.

## 4. Mini-summits feedback forms

We would very much appreciate your feedback on today's meeting about the Learning in to Practice project.

**Name (optional):**

**Meeting attended:**     **London**                       **Leeds**

We would like use this feedback form as an opportunity to hear any further views on what we have discussed today.

**Based on what you have heard today:**

**1. Do you think a set of Quality Markers for serious case reviews would be useful?**

Yes                       Partly                       No                       Not sure

**Comments:**

**2. If you do think a set of Quality Markers would be useful, what would best support their use?**

**Comments:**

**3. Do you think the Quality Markers you have seen today cover the right issues?**

Yes       Partly       No       Not sure

**Comments:**

**4. Do you think that routine identification of national trends in practice issues revealed by SCRs would be useful?**

Yes       Partly       No       Not sure

**Comments:**

**5. Do you think that getting multi-agency practitioner and manager insight in to the practice issues will be useful?**

Yes       Partly       No       Not sure

**Comments:**

**6. Do you think the results of the SCR analysis plus practitioner insight would be useful in helping local areas to learn and improve?**

Yes       Partly       No       Not sure

**Comments:**

**7. As part of this project, we have proposed an ongoing cycle, in which improving the quality reviews in turn improves the identification of national trends in practice issues through collation of SCRs.**

**What support would be needed to enable this cycle of activities?**

**8. Any other comments?**

**9. Your role(s):**

- LSCB Chair
- LSCB Business Manager
- SCR lead reviewer
- Other (please specify)

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**10. Would you be prepared to take part in a brief (20-30 mins) telephone follow-up conversation?** This is part of our evaluation and would be a valuable opportunity for us to explore your views in more detail, and help inform the future direction of the project.

- Yes**                       **No**

If yes, please give your email address below:

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**Thank you very much for completing this feedback form.**