Learning Together
The experience of using the SCIE model for reviews

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WithScotland
Social Care Institute of Excellence (SCIE) and
North East of Scotland Child Protection Committee

1. Introduction

Significant Case Reviews are conducted regularly across Britain using differing approaches to a variable degree of quality. These reports often identify common themes and make similar recommendations that focus around improving communication, increasing training and production of practice guidance. Despite a long history of undertaking reviews the number of cases involving the death and/or serious injury to children from abuse remains relatively constant indicating that the review process and recommendations might not have sufficient impact on professional practice to protect children. Child protection practice is a complex area of work and abuse, in many cases, is actively hidden by those adults in close contact with the child. Many reports indicate that no single agency or individual could have prevented the abuse though the systems around the child could have functioned better together to identify and prevent abuse at an early stage. It is important, therefore, that when children are seriously injured or die as a result of child abuse or neglect the causal factors are investigated and measures are taken to reduce the likelihood of similar abuses happening to other children.

The Social Care Institute of Excellence (SCIE) has developed a methodology for conducting case reviews in England, applying research and learning from the thinking that underpins models of accident investigation in the aviation, engineering and healthcare sectors. SCIE's review model is called "Learning Together" and is a systems based approach that examines the interconnectedness between individuals and the contexts within which they work.

The former North East of Scotland Child Protection Committee (NESCPC)[1] has been conducting reviews since 2001. The experience has been similar to that of English colleagues that, despite recommendations from reviews being implemented, the same issues recur. The Learning Together model offered a different approach that had the potential to examine and articulate those difficult cultural and organisational issues that impact on practice. The NESCPC was successful in being selected to pilot the Learning Together model in Scotland and was supported with funding from the Scottish Government and WithScotland. This report outlines the experience of the agencies involved in the pilot and gives an indication of potential benefits and challenges of using this model in the longer term.

2. Background/context

The Scottish Government places a high priority on ensuring that children and young people have the opportunity to grow up in safe and nurturing environments and have access to

[1] At the time of the pilot, the three child protection committees in the North East of Scotland (Aberdeen City, Aberdeenshire and Moray) were one single committee referred to as North East Scotland Child Protection Committee (NESCPC).

services and supports that will enable them to fulfil their potential to become active citizens in the future. There are a range of policy directives which support this vision including Getting It Right for Every Child (GIRFEC), and the national Child Protection Guidance adopted by all agencies in Scotland. Within the national guidance, the responsibility to conduct significant case reviews rests with Child Protection Committees and draft guidance was produced in 2007 to support committees with this challenging area of work.

In the North East of Scotland, the Committee has been involved in reviews since 2001 following the death of Carla Nicole Bone. Over the years NESCPC agencies have worked together to adopt standard policies and protocols that comply fully with national guidance. The SCR process is regularly evaluated to improve the review process and take cognisance of developing research and practice. The committee has encountered issues with process similar to other child protection committees and safeguarding boards across Britain:

- recommendations were similar and often difficult to implement;
- the standard of reviews varied depending on who was leading the review;
- reports were structured differently and it was difficult to compare reports to identify trends and themes; and
- there is limited availability of skilled reviewers and no process in place to develop practitioners with these skills.

In response to these challenges, Root Cause Analysis - a systems based adverse event investigation model used widely in the NHS - was considered as a potential model for SCR in Grampian and was used in reviews conducted by the NESCPC from 2008-2011. However its success was limited as the model did not fit completely with the needs of interagency working, though positives were identified in having a solid framework to work within and a standard form of report. The Brandon Muir report released in 2009 asked that Scottish Government give consideration to using a systems based approach to SCR with particular reference to the SCIE Learning Together model. As the NESCPC had well-established processes in place to conduct reviews and an experience of using a systems approach, NESCPC was selected to pilot the model in 2012.

During 2012 local and national organisational structures were undergoing significant change. At the time of selection, the NESCPC was a single committee with three area sub-committees; one sub-committee for each local authority area in Moray, Aberdeenshire, and Aberdeen City. In March 2013, the NESCPC made the decision to disaggregate to form three distinct Child Protection Committees with a transition period during 2013 to enable the newly formed committees to become established. In April 2013, Police Scotland came into being and some restructuring of NHS Grampian and local authority services also took place. Chief Officers at the

time requested that key areas i.e. child protection guidance, training, significant case reviews and maintaining the single child protection register continue to be managed on a Grampian basis. These major structural, organisational and committee changes did not prevent the SCIE pilot from progressing though those involved with the reviews were affected in their day to day work with changing and evolving responsibilities.

During the pilot period, there were additional national developments relating to Significant Case Reviews. A short life working group was established by Scottish Government to take forward earlier work undertaken by WithScotland in 2010. A decision was made to revisit the interim guidance for CPCs for conducting a SCR in order to refresh the guidance and embed it within the national guidance for child protection also published in 2010.

3. About the Learning Together model

The Learning Together model was developed by SCIE based on evidence from research literature and investigation methods used in engineering, health and social care. The model has three key principles:

(a) **Avoid hindsight bias** by understanding how the case unfolded from the viewpoint of those involved. This is done by reviewers being open-minded and empathetic - and having formed no preconceived assessment of the case beforehand. The source of information, or data, comes primarily from conversations with the practitioners and family involved and details are supported from documented evidence. The information is collated into a narrative reconstruction of events as they took place using the perceptions and understanding of people who were there at the time. Although the events taken together run chronologically this is very different from a dated chronology taken from case records alone. It forms the local rationality.

(b) **Provide adequate explanations** by appraising practice and explaining decisions, and actions taken. This is done by using a specific analytical tool of Key Practice Episodes (KPE) that helps us to understand and explain why the case unfolded as it did. It gives an explicit appraisal of practice, good and bad, from the perspective of what was known and/or knowable at the time and identifies the various factors that may have contributed to that by means of an explanation. It is a process that holds people to account for their professional responsibilities but which can also point to the kind of things that make those responsibilities very difficult to carry out at times.

(c) **Move from individual instance to general significance**. This allows the case to provide a 'Window on the System' (Vincent 2004) and tease out issues that replicate more

widely rather than just being relevant to a single case. There is opportunity to expose those hard to articulate practices such as cultures and values within organisations that impact on effective working. These are written as evidenced Findings, which then give rise to issues for the CPC to consider.

The review process aims to be inclusive of the views of the Case Group (those practitioners directly involved in the case) and the Review Team (members include managers from the relevant agencies). The model also includes the role of a Champion who ensures open communication lines between the CPC and the review process – this role is commonly taken by the Lead Officer if they are not part of the Review Team.

(See SCIE website for more information on the detail of the review process and illustrations of how practitioners at different levels are included).

4. Preparing the pilot

Identifying the participants

Preparing for the pilot included engaging with the three area sub-committees to explain the purpose and aims of the project, to identify practitioners to undertake the training, to select cases for review, and to establish a governance and management process to ensure that engagement with key stakeholders was maintained throughout the project period.
A briefing letter was circulated to sub-committee chairs, NHS Grampian and Grampian Police outlining the project and requesting nominations for suitably experienced practitioners to undertake the training. Nominated practitioners were required to complete an application form outlining their qualifications, experience and reason for undertaking the training (Appendix 1). Applications were accepted with agreement from the individual's organisation that they met the person-specific criteria and would be given capacity to commit to the training and supervision required to undertake a review on behalf of their sub-committee. Final selection of trainees was the responsibility of WithScotland and SCIE trainers. Those accepted for the training represented member agencies of the NESCPC and included practitioners with a background in social work, police, health, education, and legal services.

Identifying cases for review

The NESCPC had three outstanding SCR referrals, and Aberdeen City and Moray each selected one for review. Both cases related to deaths of young infants where substance misuse was a factor. Both had been subject to a Sudden Unexpected Death of an Infant (SUDI) review and to single agency reviews. There were no criminal proceedings as a result of the investigations

though significant concerns were expressed about how agencies worked together which meant the cases met the criteria for SCR. This meant that much of the preparation work including identifying those involved and agency notification of the decision to conduct a SCR review had been completed prior to the SCIE project.

Aberdeenshire did have an outstanding referral for a SCR, but had not received permission from the Procurator Fiscal to continue with the review process. Consequently, the sub-committee identified a case where there could be potential learning about interagency working, but there had not been the same opportunity for prior preparation and engagement with all agencies. Though professionals worked together throughout the review, the need for preparation delayed the start of this review and additional time was required to explain the process to services involved with the case. The case related to a young infant residing within the mother and baby unit in Adult Mental Health Services. The mother had significant long term mental ill-health and the infant was placed in emergency foster care at risk of physical and emotional abuse. The incident highlighted poor interagency planning to identify risk and support needs of the infant.

Project board

To oversee the pilot, a project board was established and chaired by WithScotland. Representatives included SCIE, Scottish Government, the NESCPC, Area CPC Sub-committees, Grampian Police and NHS Grampian. The terms of reference for the board, expectations and agency responsibilities were set out in a Memorandum of Understanding (MoU) (Appendix 2). The MoU outlined funding arrangements between Scottish Government, WithScotland, SCIE and the NESCPC, and defined agreed timescales and expected outcomes. A risk register was produced and revised throughout the project period. The project board met on four occasions.

Progress of the pilot was communicated to relevant national groups and briefings were made available through WithScotland's website (see WithScotland e-newsletter April 2013).

5. Training and support

Training and support was provided throughout the project by SCIE. This included a three-day foundation course provided in October 2012 and five single additional training and supervision days throughout 2013. The foundation training gave insight to the theory, detailed methodology and tools used to conduct a Learning Together Review; for example, the tools are specialised, and the construction of the findings and final report are different to other styles of investigation. The single days provided training that related to the progress of the reviews and

issues generated from the needs of the reviewers being supervised. Supervision is an essential to ensure consistent interpretation and application of the methodology.

Following the foundation training the trainees commenced the reviews and held either the role of Lead Reviewer, Reviewer, or Champion. The Champion has an identified responsibility to ensure their Area CPC Sub-Committee is kept up to date with progress/problems. The Champion was also able to report to the project group any challenges or difficulties they encountered.

6. The review process

The reviews commenced formally in January 2013, but progress was affected by several unforeseen factors such as inclement winter weather, changing roles and responsibilities of reviewers, peak holiday periods and absence of some reviewers due to personal circumstances. As the model was new to the reviewers, additional supervision was required from SCIE trainers to enable clarity and adherence to the methodology. Much of this supervision was carried out by email and was highly valued by the review teams. However, at times, this delayed progress as analysis required further thought and rewriting.

At each stage of the review, a log recorded the purpose and outcomes of meetings with Case Group and Review Team members. This enabled clarity about actions required, and the log was shared with SCIE trainers to highlight areas for supervision or where follow up training could reinforce methodology and practice. Despite the delays and additional challenges faced by reviewers, each review team completed their report and presented findings to area CPCs during November 2013.

7. Reports

A Learning Together Report is structured to a standard format to include an overview of the case, an appraisal of professional practice and identify findings rather than list conclusions and recommended actions. The findings articulate succinctly the issues found and record how this is evidenced through answering five key questions:

- How did the issue manifest in this case?
- What makes this an underlying issue rather than an issue particular to the individuals involved?
- How prevalent is the issue?
- How widespread is the pattern?
- What are the implications for the reliability of the system?

Findings are themed together under the following patterns using a systems typology and listed in priority as defined by the review team:

- Management Systems
- Family-Professional Interaction
- Tools (human interaction with)
- Responses to incidents
- Longer term work
- Cognitive/emotional bias

Rather than make recommendations, each finding asks questions of the CPC to help the members come to a decision as to how to resolve the issue and ensure the CPC has measures in place to know when the issue has resolved. The responsibility for implementing change rests within the CPC and its partner agencies.

The following is a summary of each Grampian review and its findings

Case 1

Case 1 met the criteria for significant case review as it involved the death of an infant aged fifteen weeks, who was on the child protection register and there were significant concerns about how agencies worked together. The mother had a twelve year history of alcohol abuse and had been involved with social services across two local authority areas.
The review aimed to establish how agencies responded to pregnant women with substance or alcohol misuse problems?"

The findings are:

Management systems

1. A routine lack of awareness among professionals across the area about who holds case responsibility for transient pregnant women leaves unborn babies vulnerable especially where parents with chronic substance misuse issues are moving around to evade services.
2. Supervision arrangements across agencies are not working to pick up common errors of human reasoning, such as failure to revise judgements and plans despite evidence that undermines their validity.
3. The pattern of interim fixes within child protection management systems, in the face of resource and other pressures, leads to inadequate and short-term solutions impacting

on the quality and reliability of interagency child protection decision making and planning.

Family-professional interaction

4. Over-reliance on current relationships means that the significance of past cycles of behaviour is not sufficiently taken into account and the focus is on parental need rather than risk factors to the Child.

Tools

5. There is no clarity about the purpose of parenting assessments and the routine commissioning of these undermines their status and is an inefficient and ineffective use of resources

Example of finding

Finding 1: a routine lack of awareness among professionals across the area, about who holds case responsibility for 'transient' pregnant women leaves unborn babies vulnerable especially where parents with chronic substance misuse issues are moving around to evade services. The remit of services working to safeguard and protect children and young people starts before children are born. Pre-conception and pregnancy are the earliest, and most critical, stages at which services can put in place effective interventions that will prevent long-term harm to children and young people, especially harm related to chronic parental substance misuse issues. This case review has thrown light on how easily parents can evade professional engagement if they wish to by simply moving. This finding highlights how there is no routine clarity about who holds case responsibility for 'transient' pregnant women. This leaves pregnant women at stressful and difficult times without support and their unborn babies, at one of their most physically vulnerable times, without any protection. In systems terms, this situation effectively creates accident opportunities that are waiting to happen.
ISSUES FOR THE CPC TO CONSIDER • Is lack of case responsibility for vulnerable transient women a known problem within the area and one the Committee was already aware of? • Does the Committee know what numbers of cases we are talking about that are marked by transience and risk to children? • Is there consensus that this is a priority area to tackle? • What would the cost-benefits be of addressing this issue? • What would the options be for how to tackle the lack of awareness? • Does this finding also indicate a wider issue about methods for engaging the workforce in changes to policy or procedures? • How might messages be shared more effectively? • How will the CPC know that the issue has been resolved?

Case 2

Case 2 met the criteria for Significant Case Review as an infant died aged 6 weeks as a result of Sudden Unexplained Death of an Infant and significant concerns were raised about interagency working. Both parents have a long history of criminal behaviour, domestic abuse and substance misuse and had been involved with services for a number of years. The review also considered practice relating to an elder sibling who was removed from the child protection register when mother was pregnant. During mothers pregnancy she sought help for her substance misuse and domestic abuse.

The review aimed to establish the effectiveness of inter-agency practice in identifying and managing risks in the ante-natal and immediate post-natal period.

The findings are:

Family-professional interaction

1. A failure to adequately grasp the complex dynamics of domestic abuse relationships means that professionals can have unrealistic expectations of parent's experience of such abuse and may give inadequate thought to its impact on the care of children.

Management systems

2. There is not always parity in participation amongst those in attendance at child protection case conferences. This may lead to decision-making processes not accurately reflecting all views and opinions.
3. Involvement with families whose children's names have been on the child protection register for three months following de registration is not routinely monitored or overseen. This means that further risks to the children involved during this period may not always be observed or assessed.
4. Supervision arrangements across agencies are not working to pick up common errors of human reasoning such as failure to revise judgements and plans in the face of evidence that undermines their validity.

Responses to incidents

5. There is an assumption in maternity and neonatal services that passing child protection concerns to social work fulfil their child protection responsibilities. This leaves children at risk of being left in unsafe situations.
6. The practice where out of hours social work service does not routinely assume case management responsibility for acute child protection concerns for the period required, may risk children being left in unsafe situations and lead to delay in planning their care.

7. A key system to co-ordinate a multi-agency response to potential risks to unborn children, namely the pregnancy protocol, including guidance about when to hold a mid trimester review, is being inconsistently applied. The consequence is that the risks to some unborn babies are likely to remain unidentified.

Longer term work

8. The role of named person and lead professional as well as the process of establishing responsibility, on both an intra and inter agency basis is not sufficiently understood, creating the opportunity for assumptions to be made about responsibilities for actions and interventions.

Example of finding

Finding 1: a failure to grasp the complex dynamics of domestic abuse relationships highlighted how professionals can make unrealistic expectations of parents experiencing such abuse and can give inadequate thought to its impact on the care of their children. Professionals working with this challenging group of parents require to be attuned to the needs of those abused, to the children living in the household and to the strategies used by perpetrators to control their victims. This case has identified an underlying practice that omits to take full account of the complex nature of abusive relationships and results in children remaining in unsafe situations despite multiagency involvement.
ISSUES FOR THE CPC TO CONSIDER • Has this issue arisen previously? If so, how did it present and what actions were implemented? • Is the CPC aware of strategic planning to respond to this issue and if so what does this entail and is it working? • What does the CPC want to do to support frontline professionals to work better with parents/carers to protect children living with domestic abuse? • How can agencies work together to reduce harm to children affected by domestic abuse? What are the options? • How should prevalence data about domestic abuse be captured in order to not only understand its extent but also how it impacts on both children and a carer's ability to protect their children? • How will the CPC know that professionals are more attuned to the complexities of domestic abuse relationships so that children are safer?

Case 3

Case 3 was selected as a near miss incident where important lessons could be learned about how effectively adult and child focused agencies work together, specifically in situations involving chronic parental mental ill- health. The case referred to a baby residing with mother in the mother and baby unit within adult mental health services. The infant aged eight months

was admitted to the children's hospital distressed as Mother was observed to have handled the baby roughly, was unpredictable and unable to care for the baby's basic needs. The infant was subsequently discharged to foster carers.

The review aimed to establish how effective systems were in supporting mothers' and babies' needs where mothers' have significant mental health issues.

The findings are:

Management systems

1. The arrangements and current practices of the Mother and Baby unit makes them inadequate to ensure the safety and wellbeing of children.

Longer term work

2. The willingness of professionals in universal settings to assume the positive- exacerbated by the presentation of a parent- undermines the procedural tools for information sharing that exist to protect vulnerable adults and children.
3. Community Mental Health Teams do not routinely risk assess the impact on children of parental mental health, so contingency planning that can help anticipate mental health decline or crisis of parents of new babies is not robust.

Tools

4. Electronic GP records of adult patients do not routinely give sufficient information regarding potential risks to children, including previous concerns about parenting capacity linked to mental health problems.

The list above illustrates how findings from reviews can be compared and contrasted to identify common themes such as in this case the need for good supervision for frontline staff across agencies in Grampian. Two of the reviews found the same issue reinforcing the need for long-term solutions to be found.

Example of finding

Finding 1: the arrangements and current practices of the 'Mother and Baby' unit make them inadequate to ensure the safety and wellbeing of children. Where parents have a significant history of mental ill health it is important that a holistic assessment of the family is made and that this assessment considers the impact of parental mental illness upon the children within the household. The infants of mothers admitted to the Mother and Baby unit are recognised as being at increased risk from parents' behaviours and compromised parenting capacity. Young infants are completely dependent upon the adult carers

around them. Specialist care is required that includes collaborative working with other agencies to ensure risks to mothers and babies are recognised and managed effectively. This requires staff who are adequately trained, competent and have experience in dealing with the needs of children and parental mental illness. The review has identified a system that currently lacks adequate interagency collaboration and assessment of infants needs within the mother and baby unit potentially placing them at increased risk. The Review Team consider that in its current format the 'Mother and Baby' unit is inadequate to fully meet the competing demands of the needs of the adult patient while ensuring the safety and welfare of the child is prioritised. Systems are focused on the needs of the adult patient and not the child, despite the wider perception that the unit, given its title, would accommodate both. Where the adult patient does not have the capacity to adequately care for their child due to their mental health, there are no clear systems to assess this and take steps to safeguard the welfare of the child, other than to respond to individual incidents. The capacity of the family health visitor to provide support and advice regarding the infant's health and wellbeing while in the unit is very limited because of the competing demands of the rest of the caseload in the community. This is compounded by the geographical differences that can be involved. Additionally, because of the very low numbers of patients admitted to the 'Mother and Baby' unit, staff skills, training and knowledge is not able to be adequately developed. Even if such specialist training and expertise were available, there would be a considerable challenge in keeping staff's skills current, providing a safe and consistent approach to the care delivered in the unit.
ISSUES FOR THE CPC TO CONSIDER • **Is the situation described in this finding acceptable?** • **Is the Mother and Baby Unit, as described here, the best service that we can offer to mothers and babies in the area? Given the very low admission rate, are the CPC satisfied that the unit is the best way of meeting the needs of this vulnerable group?** • **How accessible is the support and advice of the health visiting service to mothers while they are in patients in the mother and baby unit?**

8. Summary of evaluation of the SCIE Learning Together model

This summary is based on the feedback from a follow-up survey for the Lead Reviewers, which was conducted by SCIE on completion of the reviews. It should be noted that those participating in the training and conducting the reviews were all doing this in addition to their operational roles. The responses to questions are detailed below:

a. **What were the most positive aspects of the case review process?**
   - Using a review team approach encouraged shared ownership
   - Working collaboratively with colleagues across agencies led to a shared appreciation, greater knowledge and understanding
   - Conversations with frontline staff helped the review team to understand their view
   - Systems focus provides a challenge to conventional thinking, helps look beyond the obvious and avoids blame culture

b. **Was there any particular part of the process that you found helpful or useful?**
   - Individual conversations were interesting and helpful to gain a true understanding of how professionals were involved and how they felt.
   - Individual conversations very helpful in focussing on the 'view from tunnel' which moved away from hindsight bias
   - Case group meetings – important in setting the scene and productive and helpful in the process

c. **What were the negative aspects of this case review process?**
   - Seemed very time consuming and intensive at times.
   - There was an enormous amount of data to analyse and make sense of.
   - KPEs and resulting findings proved difficult to write and analyse
   - Capacity issues – getting the right people at the right time in meetings and balancing this with operational workload

d. **Were there any problems relating to the process involved in this model that give you <u>concerns</u> about its future use.**
   - Preparation prior to review taking place is essential so that all staff involved are fully aware of the process
   - Length of time could make it unrealistic and CPCs need to be prepared for this
   - It's important that the methodology is used as it is designed to do otherwise there is danger that review will be superficial and incomplete

e. **How did the experience of the training compare to your expectations?**
   - The training exceeded my expectations and was very comprehensive.
   - More opportunity to practice beforehand would have helped (e.g. KPEs) and would have speeded up the process.
   - More supervision and mentorship from another experienced person would have helped understanding as first time use of tools is difficult.

f. **How effective do you feel it has been overall in preparing you to undertake the review?**
    - Overall effective and certainly essential as was the learning from the practice of reviewing a case
    - Without the direct training input and supervision I would not have been able to fully undertake the review.
    - The grounding in the theoretical framework was very important to understand fully and place the process in context.
    - More 1:1 supervision would add to the effectiveness.

9. Reflection Event

The reflection event was the last formal meeting of the Project Board in October 2013 and included all stakeholders involved in the pilot. The purpose of the day was to provide an opportunity for reflection and learning in terms of the challenges presented by undertaking the pilot and also the opportunities to take forward the development of Learning Together methodology in Scotland.

The event was attended by representatives from:

- WithScotland
- SCIE trainers
- Reviewers who attended the foundation training
- Review Champions
- CPC Lead Officers
- CPC Chairs
- Scottish Government
- Police Scotland
- NHS Grampian

An invitation was extended to the Crown Office and Procurator Fiscal Service who were unable to attend on the day.

The background and context of the event was set out by WithScotland, SCIE, NHS Grampian and Scottish Government. This included the overview of the national picture relating to SCRs and a recognition that the pilot had been conducted during a period of significant change for all agencies working across the three CPC areas.

Feedback from CPC areas

Each CPC area was asked to report back on the summary of findings, the benefits and challenges of the Learning Together approach, and the next steps. The event allowed small groups to work together to discuss the similarities and differences across the three pilot sites. Generally, the feedback from each area was positive and common themes are discussed below.

Theme 1: Review team

- It is important to prepare agencies for the review process and time can be saved with a rigorous approach to administration and working collaboratively to select cases.

- The model allows for inclusion of the child and their family in the process. This occurred in one case though on reflection the reasons for not contacting the family in the others could have been debated more thoroughly. This would have enabled the family to decide whether they wanted to be involved rather than professionals making the decision on their behalf.

- Time to undertake the review is highlighted as a key issue. All of the reviewers continued to work in their substantive posts and managers in all cases supported their staff to complete the pilot. It would be difficult to sustain the process in the longer term without dedicated resource.

- Supervision from SCIE was essential and of most importance during the report writing phase to ensure the methodology is applied and used consistently. A mentor to support the review teams would have enabled opportunity to check out if the methodology was being used correctly as the review process unfolded. There were instances where parts of the analysis and findings had to be rewritten due to reviewers misunderstanding the process and a delay in feedback being provided due to unforeseen circumstances.

- Professionals highlighted the benefit of working with partner agencies during the process and this heightened their understanding of other professions involved in the protection of children.

- Two reviews were subject to a SUDI review and a police investigation. Staff were understandably apprehensive at the thought of going through another investigative process. Further work could be undertaken at a national level to clarify the different review and investigation processes and how these can relate to SCR and be included within the national SCR guidance.

- The training provided by SCIE was well received and an area for improvement was to develop an indexed training manual.

- The identification of a research question at the outset give a clear purpose for the review and a focus when debates around analysis and findings were varied within the team.

- The process was regarded as inclusive and engaged professionals at all levels. Anecdotal comments from staff indicated there was learning by just being part of the process and in meeting other practitioners on an equal professional footing.

Theme 2: Case group

- Case group members reported positively on being included throughout the review process. Even where there were concerns about practice, staff could identify themselves what the issues were.

- Many of the case group indicated that when having conversations with review team members they felt respected, listened to and that their contribution was valued.

Theme 3: Champions

- The Champion role was generally felt to be positive as it allowed issues that impacted on the review to be formally raised and considered. It requires to be held by a practitioner that can influence at the right level within their organisation and with the CPC.

Theme 4: Child Protection Committees

- At the time of the reflection event, the final reports had been presented to two of the CPC areas with the other planned for later in the year. It was recognised that it was too early to gauge how the reports and findings have impacted on systems and practice as each CPC needed time to consider the findings in detail and further long-term evaluation was required.

Feedback from small-group discussions

Listed below are the key learning points from group discussions:

- The Learning Together model is a structured researched methodology which professionals acting as reviewers using the Learning Together model require to practice and demonstrate competence. There is an accreditation process that SCIE has developed and those lead reviewers who have completed the training and the work on the review can undertake this.

- The pilot has demonstrated that having significant case reviews conducted using the same methodology allows reports to more easily identify trends and common themes. This has the ability to prevent examination of the same issues by different CPC's and gives opportunity to drill down to specific lines of inquiry rather than conducting a whole new review that will identify the same issues.

- Completed reports need to go through a validation process to ensure adherence to the methodology and good standard of analysis and assessment so that reports are shared nationally and other CPC's can use the learning. The Scottish Government/Care Inspectorate may have a role in collating SCR reports and quality assurance.

- Creating a learning environment and building capacity for lead reviewers is needed in order to have a sustainable resource. This requires ongoing continuous professional development, mentoring, and opportunity to practice the skills. The number of cases reaching the threshold of SCR is relatively small though unpredictable. As a result of the SCIE training three reviews have been conducted in the North East at the same time which would be unlikely to recur at a future date unless the CPCs agreed to this.

- Learning from reviews takes place on many levels from those directly involved in the case to a national level where they can inform policy and guidance. Learning can also be used to inform Higher Education Establishments' curriculums and inform how professionals are trained in the future. We live in a digital world where new technologies are used to communicate and share best practice. It raises the question are we doing enough to share the experience and learning to inform practice and protect children.

- The focus of reviews is usually when things 'go wrong'. The views of many in the group indicated that this may not be the best cases to examine in detail. If the same level of investigation was applied to instances when things worked well, could this better inform practice development? The SCIE model lends itself to this too. There is always a need to give a proportionate response to a case being considered for review and lower thresholds could allow greater understanding of case work without the professional and organisational anxiety associated with SCR.

- There are areas of work which could be shared between agencies in the North East and wider CPC Consortium and health's Managed Clinical Networks for Child Protection. This could include a shared pool of reviewers and shared guidance and training.

Reflections from SCIE

Reflections

Colleagues from SCIE reflected that first reviews are difficult and can be frustrating, because of the need to limit freedoms to instil the discipline of the model and its methodological heart. Trainee reviewers need to stick to the rules the first time to ensure that they '*get it*' – it is difficult to learn and experiment at the same time.

All sites have learning around the importance of preparation for a review:

- getting the planning right at the start
- involving the right people; securing administrative support
- planning the dates from beginning to end
- putting the right messages out to the Review team about the importance of their consistent involvement

It helps for those beginning the training to know which case will be reviewed and, moving forward, it is important to remember that the model can be applied in different ways to support ongoing learning and improvement.

Questions for SCIE from small-group discussions

a. Can you opt in and opt out of using the model?

Yes, it's not mandatory. It just makes sense in the context of learning and improvement to use a model that is more likely to get underneath the problems that look to need fixing – the potential for change is more profound. Learning Together does that and because of its systems theory roots, shared with other fields, comes with scientific credibility.

b. Is SCIE gathering information about time commitment?

Yes, in the process logs that participants in a cohort of training complete. There is no getting away from the fact that to do it properly will ask more of Review Team and Case Group time than would be the case on a traditional style review – but the benefits in terms of what people 'learn by doing' makes this a good investment. It always takes longer as well when you are learning to do it the first time.

c. Has there been a cost benefit analysis of the model?

Not as such, partly because some of the benefits are more about shifts in people's thinking and therefore more difficult to measure.

d. **Can the model be used for other kinds of review?**
   Yes, it can be used for reviews of all shapes and sizes and on single or multiple cases, brought together under a common theme. SCIE can adapt it to your needs, in terms of the amount of money/time you have to play with

Future actions to be considered

The future actions identified during the event were to:

- Develop a Scottish pool or community of Independent Reviewers. This would require a selection process, supervision and professional development opportunities.

- Create a learning environment within the North East that gives identified reviewers capacity and opportunity to undertake reviews. A process for mentoring reviewers through the review and quality assurance measures would need to be included.

- Extend the criteria of national guidance to include review of good practice and a menu of approved review methods to allow proportionate responses to cases selected for review.

- Clarify the role of lead officers for CPCs in Grampian to perhaps have a defined role in coordinating SCRs in Grampian and sharing learning across the services.

- An annual development event locally and/or nationally could be held to enable frontline practitioners to consider the key messages and findings of completed reviews and how these impact on their own practice.

- Area CPCs could work together to avoid duplication of effort to select themes/research questions they wish to explore, and share the results between them.

- Continued links between with WithScotland and SCIE, and consideration given to establishing a Scottish Learning Together Community of Interest

- Consider the role of the National Learning and Development group in relation to SCRs.

- Long-term evaluation of completed SCIE reports to assess the impact on practice and the protection of children should be made.

Next steps

The next steps were considered at three different levels at a local CPC level, Grampian, and national:

CPC areas

1. Completed SCIE Reports to be presented to CPCs for action and implementation.
   Action: CPC Lead Officers for Aberdeen City, Aberdeenshire and Moray CPC.

Grampian

2. Chief Executive Officers to be informed of the progress, challenges and recommended future planning for SCRs.
   Action: SCR Portfolio Lead Nurse Consultant Child Protection NHS Grampian.
3. Depending on the CEO decisions on future management of SCRs, explore a method to support lead reviewers gain accreditation, and receive experienced and ongoing support through establishing a Community of Interest linked to WithScotland and SCIE.
   Action: To be agreed
4. Establish a mechanism to share evaluate long-term outcomes using the SCIE Learning Together model of review.
   Action: To be agreed
5. SCR protocols and Guidance to be revised taking cognisance of national guidance.
   Action: To be agreed

National

6. A report to be produced detailing the work of the pilot to be made available for dissemination to national groups.
   Action: WithScotland, SCIE and NHS Grampian
7. Second SCIE Cohort Foundation Training
   Action: WithScotland, SCIE and Scottish Government
8. National SCR Guidance to be revised and offered for consultation across Scotland
   Action: Scottish Government

Thank you to everyone who participated in this project, the training and reviews would not have been possible without you. We would also like to thank those who contributed funding and those who supported the process either through their respective CPCs or the Project Board.

Report Authors

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Beth Smith, Director, WithScotland
Sarah Peel, Interim Head of Learning Together, SCIE

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Appendix 1

Briefing letter circulated to sub-committee chairs, NHS Grampian and Grampian Police

Distribution to NESCPC Members:

Alan Pilkington	Malcolm Stewart
Bob Driscoll	Maria Walker
Elinor Smith	Patricia Cassidy
Fred McBride	Phyllis Smart
Heather Hamilton	Ritchie Johnson
Ian Wood	Sandy Riddell

CB/ST/SCR/SCIE-letters

6 August 2012

Dear Colleagues

Applications for 'Learning Together' model of undertaking SCR

Please find an attached application form for this pilot training. A paper on this proposal was submitted to the NESCPC on June 7th outlining the details of the proposal and it was unanimously agreed to take forward the proposal in partnership with the Social Care Institute for Excellence (SCIE), the Scottish Government and the MARS/SCCPN HUB (now WithScotland). The Chief Officer group have fully supported the proposal.

Ten staff from a variety of professional backgrounds across the NESCPC area will be trained in the 'Learning Together' model. The training will consist of a 3 day intensive theory course (**10, 11 &12 October)**, and 6 days group supervision, (**9 November, 3 December, 21, 22, 23 January and 11 March**). There will also be a half day individual supervision session.

The WithScotland submission and verification process for community membership will be used as part of the selection process and WithScotland will support the NESCPC cohort, individually and collectively, during and after the training and in conducting SCRs. Additional support will be provided for the first six months and thereafter as part of the wider WithScotland community.

In partnership with stakeholders, WithScotland will collate a range of 'Learning Together' training support materials which will be hosted on their website. WithScotland will also provide a report on this overall process to Scottish Government and the wider child protection community.

Continued/…

Each agency is asked to

- Nominate suitably experienced professionals who could undertake the role of chair or who have the potential to develop into the role.
- Ensure that the nominees' line manager endorses the nomination and is fully aware of the potential implications of involvement in an SCR
- Give a clear undertaking to release the nominee if, following successful completion of the training, that person is invited to chair an SCR or to be a member of the review team
- Ensure that the nominee has an appropriate understanding of some of the key expectations and demands likely to be faced as a review chair or member of a review team
- Ensure that the line manager has an understanding of the potential time commitments required if the nominee is asked to chair a review or to be a member of the review team

Please can you ask nominees to return application forms to NESCPC GSX e-mailbox (NESCPCGSX@aberdeencity.gsx.gov.uk) by 24 August.

Yours sincerely

Colin McKerracher
Chair NESCPC

Sent by e-mail

Protecting Grampian's Children: It's Everyone's Business

Application for 'Learning Together' model of undertaking SCR

Surname *(BLOCK LETTERS)*

Forenames *(in full)*

Title *(Mr, Mrs, Miss, Ms etc)*

Any other names by which you have been known

Permanent work address *(BLOCK LETTERS)*

Postcode

Telephone number

E-mail address

Address for letters *(if different from above)*

Postcode

Telephone number or number where a message may be left

REGISTRATION DETAILS (if applicable) I would put this section after next

Registration Number	Body	Renewal Date

PROFESSIONAL QUALIFICATIONS RELEVENT TO THIS SUBMISSION

EMPLOYMENT HISTORY RELEVANT TO THIS SUBMISSION

PRESENT EMPLOYMENT

Employer (Name, Address and Location/Institution)	Position Held/Key Achievements

PREVIOUS EMPLOYMENT

Please give the following details concerning any previous employment *(starting with the most recent)*. Please
continue on a separate sheet if necessary. Please add your name to any additional sheets.

Employer (Name, Address and Location/Institution)	Position Held/Key Achievements

STATEMENT IN SUPPORT OF SUBMISSION

In addition to your key achievements noted in the previous section, please outline your reasons for participating in this training and evidence of how you have put your knowledge, skills and training into practice. Please continue on a separate sheet if necessary. Please add your name to any additional sheets.

Strong leadership and motivating others

Handling complex group dynamics

Collaborative problem solving

Good Analytical Skills

Child Protection/Investigation knowledge in a related field

Promoting reflective learning culture

REFERENCE

Please provide one referee who should preferably be a past employer or former colleague with knowledge or experience of your work. If you have changed your name since knowing the referee, please state the name by which you will be known.Why does this have to be a **former** employer/colleague?Need to know about current knowledge/skills/competencies etc

Name:

Position:

Address:

Tel No:

Email Address:

YOU MUST SIGN AND DATE THIS FORM

I declare that the information I have given in support of my submission is, to the best of my knowledge and belief, true and complete. I understand that if it is subsequently discovered that any statement is false or misleading, or that I have withheld relevant information, my submission may be reviewed.

SIGNATURE ____ DATE ____________

IMPORTANT To allow us to process your submission you are required to complete the nomination form set out below (if applicable).

NOMINATION from Employing Organisation

Name:	
Post held:	
Address:	
Contact Telephone No:	

Please verify the 'statement in support of submission' and provide a short statement on how the nominee has put their knowledge, skills, values, understanding, qualifications and training into practice (SSSC/IRISS 2008).[2]

I confirm that to the best of my knowledge the above nominee is appropriately qualified and suitable to participate in the 'Learning Together' model of undertaking SCRs.

Signature: ____

Post: ____

Date:

Please return the completed submission to the address below:

NESCPC secure e-mailbox: NESCPCGSX@aberdeencity.gsx.gov.uk

[2] SSSC & IRISS (2008) *The Framework for Continuous Learning in Social Services*. Edinburgh: Scottish Government

Appendix 2

Memorandum of Understanding between WithScotland, SCIE, Scottish Government and NESCPC

SCIE Learning Together Scottish Cohort

Scottish Government

Social Care Institute for Excellence (SCIE)

North East Scotland Child Protection Committee

and

WithScotland (University of Stirling)

November 2012

Background

The findings of the Short Life Working Group on Significant Case Reviews (June 2010) identified that while some CPC areas had bought in training on the application of Root Cause Analysis (RCA), there was little specific training provision across Scotland for those involved in Significant Case Reviews (SCRs).

In England, Lord Laming (*The Protection of Children in England: A Progress Report,* 2009) concluded that training should be made available nationally for SCR authors and Government Offices should take the lead in ensuring they have enough high quality trained authors in each region. In addition he said that all SCR chairs and authors must complete a training programme that supports their role in undertaking SCRs that has a real impact on learning and improvement. More recently, Eileen Munro (2011) described the SCIE 'Learning Together' as a workable model of a systems approach and is being taken forward as an illustration for future developments.

The paper on *Proposals for Reciprocal Skills transfer in Conducting Significant Case Reviews* (2009) presented to the Scottish Child Protection Committee Chairs Forum (SCPCCF) considered options where Child Protection Committees could identify potential Chairs/Lead Reviewers for SCRs. Potential Chairs/Lead Reviewers would need to have the capacity and capability to undertake the role. In this proposed model participating authorities could lend or borrow a chairperson/lead reviewer from another local authority/CPC area from a list of suitable professionals. Suitable professionals would 'sit' within WithScotland 'communities of expertise' and external training would provide consistency of practice, whether or not this training is accredited.

Achieving sustainable improvement in child protection requires high quality learning about current practice. A central training programme for SCR chairs, lead reviewers and report writers should be based on research that has already been undertaken. The 'Learning Together' model is evidence informed and the Munro review recognises this model as leading this work in the sector.

Project

A collaboration between WithScotland, North East Scotland Child Protection Committee (NES CPC) and the Social Care Institute for Excellence (SCIE) was established to begin the process of creating, training and sustaining a cohort of skilled expertise using the 'Learning Together' model. This is the first Scottish cohort, consisting of ten staff from a variety of professional backgrounds, who will be trained in the 'Learning Together' model, delivered by SCIE. Following the training, it is expected that some individuals will participate in a wider pool and offer support and advice to other Child Protection Committees.

The collaboration is underpinned by partnership funding from NES CPC, WithScotland and Scottish Government. The process will be overseen by a Project Group.

Funding and Costs

The cost of the 'Learning Together' project is £25,000 directly payable to SCIE in two stages: on completion of SCIE feedback on reports (March 2013) and at the end of the project (July 2013)

- Scottish Government will contribute £15,000 to the overall cost, via a grant to WithScotland.
- NES CPC will contribute £5,000 towards the overall costs, via payment to WithScotland
- This will be match funded by WithScotland (£5,000)
- Support from WithScotland staff is at no cost
- Expenses and accommodation costs for trainers and training will be met by NES CPC

Specific Activities

Prior to training
WithScotland will prepare a report and NES CPC Lead officer and Chair of the SCR Portfolio Group will seek approval for this project from NES CPC Chair and Committee. Funding will be agreed in advance and information to relevant managers and staff will be circulated.

The selection process prior to training
WithScotland will devise a submission and verification process for NES CPC, will review all submissions and provide an overview of prospective candidates to NES CPC Lead Officer and Chair of the SCR Portfolio Group.

The selection process and roles and responsibilities after the training
WithScotland has a submission and verification process for community membership and this will be used as part of the selection process for those who can offer support and advice to others involved in SCRs. Individual applications will be reviewed by members of the Project Group including WithScotland and NES CPC Lead Officer and Chair of the SCR Portfolio Group.

Expectations of North East Scotland Child Protection Committee (NES CPC)
NES CPC will approve the project and identify relevant participants who can become Lead Reviewers. By agreeing to the training there is an expectation that participants will undertake reviews, as part of the training process and after accreditation.

NES CPC Lead Officer and the Chair of the SCR Portfolio Group will be Lead Reviewers, linking to the CPC sub-committee structure and be a point of contact for the review teams during the training process.

NES CPC will identify 'Champions' from each CPC area (Aberdeen City, Aberdeenshire, Moray) either from those undertaking training or wider staff group. These 'Champions' can expect support from the Chair of the geographical area sub-committee.

NES CPC will identify review teams and cases to be reviewed.

Expectations of SCIE
The training will consist of a 3-day intensive theory course; 5 days group supervision, half day individual supervision session and quality assurance of a draft final report and feedback. All training will be delivered by Dr Sheila Fish and Sarah Peel, SCIE. SCIE will participate in the Project Group.

Prior to the 3-day intensive theory course, SCIE will provide a range of reading materials and a starter pack for all participants, including hard copies of LT reports. A copy of reading materials will be sent to WithScotland.

SCIE will prepare an implementation plan and an individual MOU to be signed by each participant, identifying relevant dates for guidance and supervision sessions and highlighting the necessity for fidelity to the model.

SCIE will give a formal presentation of the 'Learning Together' model and the progress of the 'cohort' to the NES CPC at agreed intervals.

Expectations of Scottish Government
This proposal begins the process of fulfilling Recommendation 5 from the Report of the SLWG, June 2010. It is expected that Scottish Government will support the 'Learning Together' Scottish cohort as a first step but this does not mean that that the particular model is being endorsed or forms policy. Funding provided is for the training component and evaluation and 'roll out' will require to be resourced separately.

Expectations of WithScotland
WithScotland will support the cohort, individually and collectively, during and after the training and in conducting SCRs. Additional support will be provided for the first six months as required and thereafter as part of the wider WithScotland community.

In partnership with stakeholders, and with agreement of SCIE in accordance to intellectual property rights, WithScotland will collate a range of 'Learning Together' training support materials which will be available to CPCs.

At the end of the project, WithScotland will provide a report to Scottish Government on this overall process and the wider child protection community.

WithScotland Director will chair the Project Group.

Terms of Reference

Purpose
To oversee the delivery of the SCIE Learning Together pilot project

Main activities

- Keeping an overview of case selection, to ensure maximum learning
- Identifying benefits and learning points
- Managing risks
- Ensuring the project keeps within its budget
- 'Unblocking' and troubleshooting if and where needed
- Ensuring interface with other relevant developments
- Building capacity to maintain and develop model into future
- Supporting the reviews through communication with constituent groups represented on the partnership
- Keeping participant CPCs engaged
- Planning and ensuring communication and dissemination of outcomes

Accountability and governance

The Project Group is established as a working group of the Scottish Government, SCIE, NES CPC and WithScotland partnership. It has a direct link through NES CPC and via the CPC Chair to the Scottish Child Protection Committee Chairs Forum. CPC (sub-committee) Chairs and 'Champions' will ensure that future changes to the NES CPC structure will not impact adversely on the project.

Working arrangements

- Group will meet four times over the course of the project (September 2012 – July 2013), at a venue provided by NES CPC, dates to be agreed in advance
- The project will be managed on behalf of the Project Group by Beth Smith in conjunction with the NES CPC Chair (until 31.3.13)
- Local liaison with participants/trainee reviewers will be undertaken by Corinne Begg and Phyllis Smart
- Action minutes to be distributed to members by NES CPC administrator

Quorum

There is no minimum number agreed, however, there needs to be sufficient members attending for the meeting to have significance.

Membership

Colin McKerracher, Chair of NES CPC
Beth Smith, Director, WithScotland
Dr Sheila Fish, Interim Head of SCIE Children & Family Services (job-share) & Head of Learning Together
Eni Bankole, Team Leader, Child Protection Team, Scottish Government
Fred McBride, Director of Social Care and Wellbeing, Aberdeenshire Council
Robert Driscoll, Head of Children's Services, Aberdeenshire Council
Sandy Riddell, Corporate Director (Education & Social Care)
Phyllis Smart, Consultant Nurse Child Protection, Royal Aberdeen Children's Hospital
Corinne Begg, Lead Officer, NES CPC
Elinor Smith, Nurse Director, NHS Grampian

TERMS OF REFERENCE (Signatures of Partners)

North East Scotland Child Protection Committee

Name (print)..…………………………………….

Position………………………………………………

Signature……………………………………………..

Date…………………………………………………..

Scottish Government

Name (print) ……………………………………….

Position………………………………………………

Signature……………………………………………………………

Date…………………………………………………..

Social Care Institute for Excellence (SCIE)

Name (print) ……………………………………….

Position………………………………………………

Signature………………………………………………

Date…………………………………………………..

WithScotland

Name (print) ……………………………………….

Position………………………………………………

Signature……………………………………………..

Date…………………………………………………..

Appendix 1

ABOUT US: INTRODUCTION AND GENERAL PRINCIPLES

WithScotland

WithScotland aims to facilitate agencies to access a continuum of support to assist staff involved in complex and challenging child protection work. Support may be required at a strategic planning, operational management or practitioner level subject to the skills or experience gaps identified by the agency or agencies seeking help.

WithScotland is committed to developing and maximizing partnerships with key child protection organisations, academia and policymakers. The service provides a structured opportunity for practitioners, trainers and managers to analyse the source of the gap in expertise. The aim is to ensure a proportionate response to gaps in expertise and to draw, wherever possible, upon local expertise. It is envisaged that, in a small number of complex and challenging situations, the gap may be filled by bringing in an individual or team to undertake a specific piece of intervention. WithScotland will put communities of expertise in place to facilitate and support access to external skilled practitioners, consultants or trainers with the aim of reinforcing or increasing local levels of expertise.

External expertise will be drawn from across agencies working in child protection, academic or the private sectors and all tiers of access to expertise will be underpinned by the provision of access to research evidence by the Scottish Child Care and Protection Network (SCCPN). The expectations of all parties involved and the framework for working in partnership is set out in this Memorandum of Understanding.

Memorandum of Understanding

A Memorandum of Understanding (MOU) is crucial in brokering or commissioning services. This MOU defines and details the relationship between individuals, organisations and the WithScotland. The purpose is to be clear that all parties know what is and what is not their responsibility.

The MOU is **not** intended to be a legally binding document but a set of principles, an agreement between all parties about what will be delivered. The essence of this agreement is it relies on the integrity of all of the parties involved.

This MOU is in two sections. The first section sets out the general principles and objectives of mutual understanding including:

- A statement of principles for engagement
- Purpose and Objectives of the Community of Expertise that will give advice and support to others
- Expectations for each organisation

The second section, if required, sets out the Terms of Reference for individual projects or cases and will be developed in partnership with the organisation requesting the service.

Process for establishing the MOU

The following process outlines the steps involved in setting, agreeing and 'signing off' a MOU. This process must be led by a member of WithScotland. It may not always be necessary or appropriate to follow each step or in the order described, but this framework is set out to provide clarity and transparency in the process.

Step 1: discussions with the requesting organisation to identify the facts of the case, needs of the situation and possible ways forward

Step 2: identify possible opportunities or individuals/partners to approach

Step 3: opportunities for support or partnership to be sourced by the WithScotland

Step 4: develop terms of reference for working together including objectives, clarifying expectations of all parties and setting out timescales

Step 5: finalise and 'sign-off' MOU

PRINCIPLES OF ENGAGEMENT

This Framework, originally developed by HMIE, has been adapted to underpin the activity related to WithScotland. This framework outlines a set of principles for engagement.

The following principles were identified as underpinning best practice

Purpose – being clear about the overall purpose of planned activity and retaining this throughout. Creating an agreed agenda with staff in the organisation and members of the MARS community

Relationships – building and maintaining constructive relationships throughout

Awareness – maintaining a high level of awareness of the context in which staff are operating, of their feelings and reactions to the process and of the MARS approach and its impact

Information gathering – careful inquiry to gather and analyse evidence. Retaining an objective stance, and helping to test assumptions and assimilating data before evaluating

Sharing information – communicating thoroughly throughout the process to prepare and inform staff. Encouraging staff to be open in providing their perspective and providing appropriate feedback as the inspection/review progresses

Enabling – treating people with respect, engaging them in professional dialogue, recognising their efforts and providing feedback in a constructive way to encourage ownership and learning to take place

[The Keil Centre (2008) reproduced with kind permission of HMIE]

AIMS OF COMMUNITY OF EXPERTISE

Communities of expertise are cultivated or nurtured rather than formally managed and may be involved in: problem-solving; seeking information or experience; sharing and adapting resources; coordinated working; discussing ideas and developments; sharing experiences and learning; and providing information or knowledge. The value of the community comes from bringing together both personal knowledge and explicit or published knowledge to the benefit of others. The benefits of communities are that they can work across geographical regions and disciplinary boundaries (Wenger 1998).

The aims of the community of expertise that will give advice and support to others are to:

- Provide support and advice to individual organizations or to agencies involved in a specific case
- Help develop a sense of cohesion, and consistency of quality among practitioners who specialize in child protection
- Maximize the potential for creating a skilled workforce that can make a positive difference to the protection and welfare of children and young people
- Enhance the development of a confident and competent workforce

Continuum of Support

It is intended that WithScotland will be involved in providing support to organisations along a continuum ranging from advice and information to more intensive activity. There may be times when an agency has a need to reflect on its decisions and actions and particular situations may require input from WithScotland to assess the situation and how best it might give support from those with sufficient knowledge and skills to support the organisation. This could result in WithScotland providing help, support and advice as well as identifying and brokering input from other organisations.

WHO IS PART OF A COMMUNITY OF EXPERTISE?

A member of the community of expertise is someone who is able to contribute to the policy, practice and research in the area of child protection. Members will be able to support organisations because they have specialist knowledge or experience to allow them to give them an opinion on a particular matter, or provide a specialist service directly related to their expertise.

The role of WithScotland is to help organisations identify the areas or gaps in the knowledge of policy and practice, and to broker access to members who may be able to help.

WHAT YOU CAN EXPECT

From WithScotland
WithScotland will support individual members working with organisations, particularly in complex and sensitive cases. WithScotland will:

- Ensure all parties are clear of the expectations, timetable and, where necessary, the budget for the work identified
- Individual members will meet regularly with WithScotland throughout the duration of planned activity
- Organisations or agencies will be offered regular meetings with WithScotland throughout the planned activity
- In some situations, individual members may work in partnership with another community member or with a member from WithScotland
- Manage conflict or difficult situations with partners
- Individual members will be offered the opportunity to feedback and record their experience of working with both the organisation and WithScotland.
- Organisations will be offered the opportunity to feedback and record their experience of working with WithScotland and associated members.

From the organisation requesting assistance
Organisations will have responsibilities to those individuals or agencies with whom they are working to:

- Identify the skills, knowledge and experience required
- Provide WithScotland and the community member with a clear question or problem that requires their expertise
- Provide WithScotland and the community member with all the material or information required
- Respect the objectivity and independence of WithScotland and the community member
- Ensure the community member understands the importance of confidentiality, and their responsibilities
- Develop and maintain clear lines of communication

From the community member

Members of the community have the responsibility to work in accordance with the following principles:

- Prepare – get to know organisation. Do a thorough examination of materials available
- Ensure that you have all the information required
- Ensure fair and thorough coverage of evidence
- Stay open and objective when gathering the facts to provide an objective, unbiased opinion or service with regard to your expertise
- Start with open questions, follow up to probe for evidence
- Ensure no conflict of interest exists that prevents you from working with the agency
- Ensure evidence base for evaluation is sound and will withstand challenge
- Be as constructive as possible
- Ensure feedback is thorough and balanced
- Be able to clearly distinguish facts and opinions
- State the facts or assumptions on which your opinion is based (you should clearly discriminate between opinion based on experience and opinion based on research. The latter should be adequately referenced)
- Ensure that the knowledge, experience, qualifications or professional training are relevant to the circumstances
- Simplify and explain matters specifically relating to your area of expertise
- Carry out your work expeditiously
- Comply with the codes of conduct or practice of any professional body to which you belong
- Inform WithScotland as soon as you can of any disciplinary procedures (pending or past) against you by a professional or trade body of which you are a member. The details of any such actions or judgments should be supplied in writing
- Keep all the material in relation to the situation secure and confidential

Record keeping

Records should be made by members of the community unless community members are involved with individual cases.. The medium used to record information needs to be durable and accessible. All notes should be signed and dated, and be sufficiently detailed so that all involved can follow the nature of the work undertaken and any inferences that may have been made.

All records should (as a minimum) contain details of:

- The collection and movement of material;
- Communications – details of telephone conversations and meetings attended should be kept as well as emails (or copies) and other electronic transmissions, e.g. case records (or copies) sent or received.

Partnership arrangements

The offer and provision of professional support and for mentorship does not negate the responsibility and accountability of the organisation making the request. Accountability and responsibility for actions taken remain with agency as per professional or organisational guidance. Responsibility for acting within national and local agreements and procedures remains that of the organization.

Individual cases will require each party to agree to the *Memorandum of Understanding* (known as the *Memorandum*). Areas of ambiguity or concern must be clarified, and agreed before the *Memorandum* is signed and it should cover the following areas:

- The area of advice or service the community member if providing
- Boundaries of confidentiality will be agreed, but where concerns arise that a child, member of the public or colleague may be at risk from the action or actions of either party, then confidentiality will be breached (as per standard practices within local child protection policies and procedures).

Disclosure obligations

Boundaries of confidentiality will be agreed as part of a *Memorandum*.

Generally confidentiality can be offered and maintained. Any information received is treated in confidence and is not disclosed or distributed to third parties (including for training purposes) without the prior written permission. However, confidentiality cannot always be guaranteed. There may be circumstances in which confidential information needs to be shared.

In deciding whether or not disclosure of information given in confidence is justified, you should consider the harm that might result from failing to disclose the information against the harm that could result from a breach of confidence.

It will be the part of every agreement that where concerns arise that a child, member of the public or colleague may be at risk from the action or actions of either party, then confidentiality will be breached (as per standard practices within organisations). All attempts will be made to inform the relevant party of the intention to breach confidentiality, unless doing so places an individual or individuals at increased risk. This will be in accordance with contemporary legislation and policy.

Costs to organisations

In the first instance, any contact with WithScotland will be cost-free whether this is one phone call or a series of meetings with the team. This includes a range of activity in a number of areas:

- Contact with WithScotland: this includes asking for advice, or signposting agencies to people or organisations who can offer the appropriate support.
- Brokering arrangements: this includes brokering advice and support from one organisation which may amount to no more that one or two calls, an email exchange or a couple of meetings through to brokering intensive support for a period of time such as participating on significant case reviews.
- Advice and support: this includes WithScotland visiting the organisation as often as necessary for the circumstances or complexity of the case.

There may be some cost to the involvement of other agencies, but it is hoped to negotiate or it is anticipated that some activities will be cost-free.

Phone calls or email contact, and perhaps one meeting with employee organisations at their venue may be cost-free, but costs should be anticipated for further contact. The arrangements are set out in this *Memorandum*.

QUALITY ASSURANCE and FEEDBACK

Quality assurance will be required to match the different activity along the continuum of support.

Members of the community providing guidance and support will be asked to submit an application summarizing their relevant experience and a statement of support from their organisation. Individual members also need to be registered with their appropriate professional bodies. For situations that require a committed degree of support from a community member, those members will also be interviewed by WithScotland.

Feedback from organisations

Feedback from organisations will be sought two or three months following the involvement of a community member. Feedback will be asked on:

- Whether the recommended individual or agency was able to provide the required advice?
- Views on helpfulness and, if not, why?
- Whether WithScotland appropriately and helpfully brokered the arrangements? If not, why?
- Whether any unexpected costs, benefits, advantages or disadvantages emerge? If so, what were these?
- What could be done better in the future?
- Would the agency use the individual or approach WithScotland in the future?

Information gathered in this way should inform the development of WithScotland, and fed back to the Steering Group.

Feedback from community members

Feedback will also be sought from the individual community member involved with the specific case, practice development or internal investigation.