CHESHIRE WEST & CHESTER LSCB

LEARNING AND IMPROVEMENT FRAMEWORK

CONTENTS

INTRODUCTION

1.1 Working Together 2015 states that the Local Safeguarding Children Board (LSCB) has a statutory responsibility to :

"Monitor and evaluate the effectiveness of what is done by the local authority and Board partners individually and collectively to safeguard and promote the welfare of children and advise them on ways to improve."

1.2 As part of this responsibility Working Together to Safeguard Children, Chapter 4 *(HM Government, 2015)* highlights that "*professionals and organisations protecting children need to reflect on the quality of their services and learn from their own practice and that of others.*" Cheshire West and Chester LSCB supports this ethos and has developed a local learning and improvement framework to be shared across local organisations who work with children and families.

1.3 The framework sets out the ways in which we will review practice and ensure that we identify positive practice and that which requires improvements through regular monitoring and follow up to ensure that learning makes a real impact on improving outcomes for children.

PRINCIPLES FOR LEARNING AND IMPROVEMENT

2.1.1 The framework is based on the following principles as detailed in Working Together

- a culture of continuous **learning and improvement** across the organisations that work together to safeguard and promote the welfare of children, identify opportunities to draw on what works and promote good practice;
- the approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined;
- reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed;
- the views of families, including children, should be sought. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively;

- final reports of serious case reviews will be published, including the LSCB's response to the review findings, in order to achieve transparency. The only barrier to publishing a Serious Case Review (SCR) is when to do so could have a detrimental impact on the principal of the review or other surviving relatives who may be identifiable by the nature of the case. The impact of SCRs and other reviews on improving services to children and families and on reducing the incidence of death or serious harm to children must also be described in the LSCB annual report.

AIMS AND OBJECTIVES

3.1 Reviews are not ends in themselves, rather a means of identifying improvements which are required and to consolidate good practice. Learning from reviews should be translated into actions that will ensure sustained improvements and the prevention of death, serious injury or harm to children.

3.2 Adherence to this framework will:

- Ensure that the LSCB fulfils its statutory obligations
- Ensure that the workforce is suitably skilled
- Assist all partner agencies understand and commit to the principles of continuous learning through active participation
- Ensure that training and development opportunities are quality assured and that the impact is evaluated.
- Ensure that lessons to be learned and good practice are clearly communicated, relevant and accessible and lead to better outcomes for children and young people.

METHODS OF LEARNING

4.1 Reviews are not ends in themselves, rather a means of identifying the improvements which are required and to consolidate good practice. Learning from reviews should be translated into actions that can be embedded into practice to bring about sustainable improvements and minimise the incidence of death, serious injury or harm to children.

Type of Review / Audit	Local LIF	Lead Sub-Group	Learning Methodology
Serious Case Review (Statutory) (Case considered by an **SCR Criteria Panel** and **LSCB Chair** to meet SCR criteria)	SCR	Audit and Case Review Group (ACRG)	SCR Panel (Independent Chair and Author) following WT 2015 guidance
Serious Case Review (non-statutory) (Case does not meet SCR criteria but the LSCB Chair wants to conduct an 'SCR'.	To be decided by the LSCB Chair.	Audit and Case Review Group	*Process as for a statutory SCR or using one of the case review tools below.*
Child Death Review (Statutory review of all child deaths (except planned terminations and still births). Any deaths where concerns exist about inter-agency working must be referred by CDOP to ACRG for consideration as an SCR (statutory).	Child Death Review	Cheshire CDOP	CDOP tools and associated guidance
Case Review of a serious incident (i.e. one notifiable to Ofsted due to a child suffering serious harm) which falls below the threshold for an SCR.	**Practice Learning Reviews** (PLR) or **Cases of Special Interest** (CSI) **Deep Dive audit**	Audit and Review Group	• SCIE Systems Model • Root Cause Analysis •
Case Review of a serious incident which falls below the threshold for an SCR	Deep Dive audits and Single agency serious incident reviews.	Audit and Review Group	Terms of reference and methodology to be agreed by ACRG.
LSCB Multi-Agency Audits (across the continuum of need including Early Help)	- Quarterly Audits - Themed Audits	Audit and Case Review Group (ACRG)	Audit tools Focus groups TAF audits
Single Agency Audits	n/a	Agencies to	Single Agency Audit

		share with ACRG	tools/TAF audit tools
Section 11 Audits Self – assessment tool for partners to self-evaluate their own policies, procedures and activities in relation to Section 11, Children Act 2004.	Sec 11 Audit	Quality Assurance Sub-Group	Section 11 Audit tool Annual programme of audit/review
Section 175/157 Schools' audit Section 175 of the Education Act 2002 places a statutory duty on Local Authorities, Governing bodies of schools and Further education settings to safeguard and promote the welfare of children. Section 157 of the same act places the duty on independent schools.	Sec 175/157 tool	Quality Assurance Sub-Group	Section 175/175 Audit tool Annual programme of audit/review
Frontline Board Member visits Board members undertake annual visits to partner agencies. The focus of these visits will be guided to learning emerging from the LiF	Frontline Visits Questionnaire	Quality Assurance Sub-Group	Frontline visit tool

Serious Case Reviews

4.2 Regulation 5 (1) (e) and (2) sets out an LSCB's function in relation to serious case reviews namely;

> "5 (1) (e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.
>
> (2) For the purpose of paragraph (1)(e) a serious case is one where:
>
> (a) abuse or neglect of a child is known or suspected; and
> (b) either – (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their board partners or other relevant persons have worked together to safeguard a child".

4.3 Working Together, 2015 states that:

> "Cases which meet one of these criteria (i.e. regulation 5(2) (a) or (b)(i) or 5 (2)(a) and (b)(ii) above) **must always** trigger an SCR. In addition, even if one of these criteria are not met an SCR **should** always be carried out when a child dies in custody, in police custody, on remand or following sentencing, in a Young Offender Institution, in a secure training centre or a secure children's

home, or where the child was detained under the Mental Capacity Act 2005. Regulation 5(2)(b)(i) includes cases where a child died by suspected suicide.

Where a cases is being considered under regulation 5(2)(b)(ii), unless it is clear that there are no concerns about inter-agency working, the LSCB **must** commission an SCR. The final decision on whether to conduct an SCR rests with the LSCB Chair. If an SCR is not required because the criteria in regulation 5(2) are not met, the LSCB may still decide to commission an SCR or they may choose to commission an alternative form of case review"

4.4 The approach required under Working Together 2015 when conducting an SCR states that it:

- recognises the complex circumstances in which professional work together to safeguard children;
- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- makes use of relevant research and case evidence to inform the findings.

4.5 Working Together, 2015 also states that LSCBs may use any learning model which is consistent with the principles in the guidance, including the systems methodology recommended by Professor Munro. However, it does not specify that this model must be used. Where it has been decided to undertake a SCR, Cheshire West and Chester LSCB will make a decision about which model to commission, dependent on the circumstances of the case.

4.6 Models for consideration when undertaking a Serious Case Review

1) SCIE 'Learning Together'

- Identifies the 'key practice episodes and contributory factors'
- Extensive engagement of members of staff involved through a review team and case group.
- The case is used as a window on the system to identify underlying strengths and weaknesses.
- Focuses on the areas considered to be 'most significant'
- There are no terms of reference; instead a series of research questions.
- No individual management reviews, given the emphasis on "learning together".
- Findings are presented in the SCR report to the LSCB for consideration and translation into a programme of further work.

2) Root Cause Analysis (RCA)

- A systems approach developed and widely used in health.
- Looks at a range of factors that have contributed to an incident
- Engagement with staff is paramount
- There is flexibility but also limitations for its use in a multi-agency environment.

3) **SILP Review: Significant Incident Learning Process**
    - Terms of reference and process agreed
    - Material gathered from individual agencies: could be a management report, chronology or a list of key events.
    - Learning event to discuss the case: material prepared and shared amongst front line staff and review team
    - Draft overview report
    - Discussion of emerging findings
    - Overview report
    - Recall day to discuss the implementation of the learning.

Non-Statutory Reviews (Practice Learning Reviews PLRs)

4.7 Cheshire West and Chester LSCB will consider conducting, where appropriate:

- A review of a critical incident which falls below the threshold for a SCR; and
- A review or audit of practice in one or more agencies.

4.8 These reviews will be conducted either by a single agency or by a number of agencies working together depending on the circumstances of the case and the nature of the review. The principles for conducting such reviews will be compliant with those set down in Working Together 2015.

4.9 The methods by which the LSCB will conduct a review will vary dependant on the circumstances of the case, but can include:

- A review of 'near misses' and cases not meeting the statutory requirements for a SCR
- Multi-agency audits of cases illustrating themes that are considered to be of strategic importance
- File audits (multi-agency or single agency)

Some forms of review are routine, e.g. multi-agency audits and Sec 11, whilst others will be triggered by specific concerns, resulting in a referral to the Audit and Case Review sub-group. In order to make a referral please follow the guidance on the LSCB website Making a referral for a Case Review.

4.10 Cheshire West and Chester LSCB have an established review team (which is largely drawn from the Audit and Case Review Sub-Group (ACR) to decide on the method required for undertaking a review. The core members of the Review Team include:

- Chair of the ACR sub-group
- Business Manager, LSCB
- Senior Manager, Safeguarding and Quality Assurance
- Senior Manager, Children's Social Care
- Senior Manager, Cheshire Constabulary
- Senior Manager, Safeguarding Children in Education
- Senior Manager, Youth Offending Service

- Senior Manager, Integrated Early Support services
- Senior Manager Specialist Support Services
- Designated Doctor Safeguarding Children, NHS West Cheshire and NHS Vale Royal Clinical Commissioning Groups
- Designated Nurse Safeguarding Children, NHS West Cheshire and NHS Vale Royal Clinical Commissioning Group
- Any additional professionals deemed appropriate to be a member of the review team.

CHILD DEATH REVIEW

5.1 All Child Death Reviews will be conducted in compliance with the procedure set down in Chapter 5, Working Together 2015.

5.2 Cheshire West and Chester LSCB is a member of the Pan Cheshire Child Death Overview Panel sub-group which has responsibility for:

a) collecting and analysing information about each death with a view to identifying –

(i) any case giving rise to the need for a review mentioned in regulation 5(1)(e) above;
(ii) any matters of concern affecting the safety and welfare of children in the area of the authority;
(iii) any wider public health or safety concerns arising from a particular death or from a pattern of deaths in the area; and

b) putting in place procedures for ensuring that there is a coordinated response by the author, their Board partners and other relevant persons to an unexpected death.

5.3 The Pan Cheshire Child Death Overview Panel conducts comprehensive reviews of the circumstances surrounding child deaths. Learning from these reviews is disseminated through their annual report which identifies themes, trends and learning.

DISSEMINATING & EMBEDDING LEARNING

6.1 Disseminating and embedding good practice, what works well and learning from when things go wrong is an important part of a continuous culture of learning and improvement. Consideration of what this might look like is key; an over reliance on action plans can provide an artificial assurance that lessons are being learned and, whilst there is a place for these, other ways to take forward recommendations need

to be developed (for example bite sized briefings, one minute guides, one page summaries).

6.2 Integral to this is the sharing of information across the multi-agency workforce to ensure transparency, accountability and consistent improvement in practice. In addition to the statutory requirements Cheshire West and Chester LSCB will use existing mechanisms and look to develop further opportunities to share learning. Sharing of learning already takes place through:

- LSCB Annual Report
- LSCB Bulletins
- LSCB website
- LSCB Multi-agency Training
- Schools' Safeguarding Leads Networks
- Conferences
- Bite-Sized Briefings
- Development of policy and protocol

6.3 Embedding learning can also take place through:

- Reflective practice and supervision
- Collaborative joint working arrangements

MEASURING IMPACT & OUTCOMES

7.1 To evidence that a child's life and outcomes have improved as a direct result of agency intervention is a challenge due to the multi-faceted nature of the social, environmental and organic issues that influence family functioning. Therefore Cheshire West and Chester LSCB recognise the need to use a range of information to seek assurance that learning has been translated into improvements in practice and outcomes. The information we use to triangulate learning includes, but is not limited to:

- Performance Information Reports e.g. can we identify a positive trajectory of change via performance measures; is there evidence that training has had a positive impact on targeted areas of practice?
- Audit reports e.g. is there an end to recurring themes in PLRs/SCR?
- Learning and Development Report – this includes pre & post evaluation of learning from events; learner's self-reflection; satisfaction rating of quality of learning experience.

7.2 The three key sub-groups that will identify and co-ordinate the information and emerging issues on behalf of the Board are:

Audit & Case Review Sub-Group (ACR)

7.3 The ACR sub-group receives updates and oversees the progress of SCRs and PLRs. It monitors the action plans arising from the case reviews and ensures that they are completed in a timely fashion. The sub-group also co-ordinates activity of the multi-agency audits and receives the associated reports and action plans arising from them.

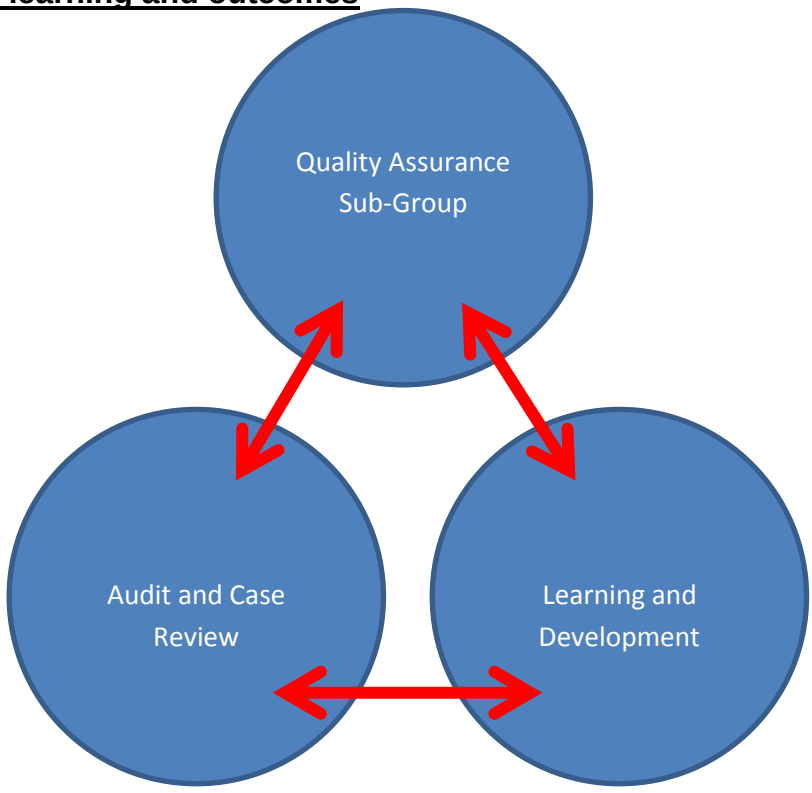
Learning & Development Sub-Group (L&D)

7.4 The L&D sub-group ensures that learning is disseminated to the workforce through a variety of sources and when required, a coordinated multi-agency training programme is provided to equip practitioners with the necessary skills, knowledge and values required to deliver high quality safeguarding services to children and young people.

Quality Assurance Sub-Group (QA sub-group)

7.5 The QA sub-group scrutinises performance information and will track key areas of practice to monitor progression against action plans arising from the ACR and evidence impact on practice. The QA sub-group will report emerging issues to the ACR to inform the commission of multi-agency themed audits, in addition to triangulating learning from audits and case reviews against performance measures within the LSCB multi-agency dataset.

Triangulating the learning and outcomes



LSCB Local Learning and Improvement Framework 2013 -2015 Summary of Learning

Source of Learning	Learning and Improvement Summary	Recommendations or Actions
SCR (Local)	Since 2009 there have been no SCRs in Cheshire West and Chester. Two reviews are currently ongoing.	
Multi-Agency Audits ***Multi-Agency Risk Assessment Conference (MARAC) Audit Q1 2014***	• There were low numbers of referrals to the Voluntary Domestic Violence Programme and those referred did not sustain the programme but both failed to attend. • CSE was a feature identified in a small number of cases highlighting the vulnerability of domestic abuse victims (particularly amongst young people) and the challenges for practitioners to distinguish between the different forms of abuse. In both of these cases they were recognised and responded to appropriately. • There was evidence of good multi-agency support for the MARAC with all actions being completed by agencies. • In some cases key agencies were not always invited to the MARAC or failed to attend/submit written reports. • All cases that were considered to have elements of excellent practice were underpinned by strong multi-agency working characterised by regular information sharing and a good understanding of each agencies roles and responsibilities. • There was no record of MARAC on the child's health records. Health colleagues requested clarity regarding information sharing and how to store	• Greater publicity of the Voluntary Perpetrator Programme and referral criteria is required. • Health Services should ensure that they keep a secure record of MARAC meetings to ensure risk to victims can be identified.

	MARAC information which has now been provided.	
Multi-Agency Audit of CSE Q2 2014	• Only a small proportion of the cohort were known to more than one agency. This highlights the need for greater multi-agency communication and the need to ensure that appropriate supports are available to those young people. • There was some inconsistency in the understanding of risk levels and language in some cases. Some cases also highlighted that CSE and Interfamilial Sexual Abuse cases were on occasion not differentiated between. • There was some inconsistency of approach to flagging cases identified. The approach agreed is that all cases to be flagged will be agreed by and communicated from the CSE Operational Group. • Very few young men were identified within the audit.	• Identified risk to children and young people should be communicated to those professionals who are in a position to offer support. • Practitioners are encouraged to familiarise themselves with the CSE pathway and referral forms. • Learning and Development to strengthen the message that boys are also at risk of CSE.
Multi-Agency Audit of Neglect Q3 2014	• Not all professionals have access to a risk assessment tool that assists them in evidencing the need to escalate the case or reflect that the level of risk can be managed at existing level. • In a number of cases a tool was used by professionals however it is sometimes unclear what impact the completion of the tool had on the outcomes for the child. • Agencies still appear to be incident led and it is the incident that accelerates the intervention rather than the impact of long standing neglect. This would suggest that professionals still find it easier to quantify risk at a specific point in time. • Management of neglect at Child in Need requires further consideration. There was an indication that agencies do not always engage with the process and priority is not given to attendance at Child in Need meetings.	• LSCB should promote the consistent use of assessment tools. • Assessment tools should be used by practitioners to review risk and evidence the impact of interventions. • Participation in the CiN process needs to be strengthened to avoid drift. • The LSCB should focus on looking at cases stepping down from statutory services to services at level 2 on the continuum.

Multi-Agency Audit of Self-Harm Q4 2014	• The Child Protection process was seen as effective and robust. • There is evidence that agencies understand the 'step up - step down' process but this cohort of cases highlighted some issues about the smooth transition from Children in Need (CiN) to Team around the Family (TaF). • The process for managing young people in the hospital is robust. However following discharge, there is currently no follow-up process in place or checks made by hospital staff. • Unless the child is known to Services the pathway doesn't allow for information to be shared without consent. This can result in children developing a significant history of self-harm and agencies, such as school being unaware. • Where children accept services and meet the criteria for CAMHS services at Level 3 the Therapeutic Support is effective and has a measurable impact.	• The Self-Harm pathways should be reviewed to ensure all relevant services are involved in offering a holistic support package to the child or young person.
Multi-Agency Audit of Children with Addition Needs (Q1 2015)	• When a child is at the right level on continuum of need, cases are working well. • When cases have complex needs, assessments are holistic and have high levels of multi-agency working. However, in one case only, there was some concern the family's needs were focussed on more than focussing on the needs of the child, but this wasn't a common theme through the cases. • When a child is at Child in Need (Section 17) without family consent/engagement in the process drift can occur. • Positive outcomes where particularly evident in cases where the group of professionals is stable over a longer period of time. • Children who are looked after with complex additional needs, had effective multi-agency planning in place. • Assessment in relation to risk was occasionally weighted more towards the family needs than those of the child.	• When a case is transferred in from other local authorities, practitioners should ensure they receive all relevant information available from the originating authority. • Practitioners should ensure cases are stepped down from statutory services. The LSCB should focus on looking at cases stepping down from statutory services to services at level 2 on the continuum.

PLRs	A thematic Review of PLRs across 2013-15 has found the following in relation to **Assessment of Risk & Need** **Start again syndrome** can occur when referrals and/or interventions are seen as separate episodes; or when there is insufficient consideration of historical events and its potential impact on the current situation, e.g. historic drug use not being considered when the most recent concern was domestic abuse, failure to use chronologies to review historic information. **Assessment tools** such as the pre-birth assessment, home conditions and graded care profile could be better understood and used more consistently to elicit early help, record concerns and measure changes. **Over Optimism** resulted in a lack of rigour in undertaking assessments and focusing on the needs of the child, e.g. Mother's status as a victim in her own right, and approach to agencies of "wanting to make a fresh start" detracted practitioners away from the emerging risks in relation to mother's drug misuse. As a consequence mother's accounts were accepted uncritically. **Sources of Information** were not always given appropriate significance. Neighbours can have very pertinent information from observation of the unguarded care of children in their community. The Ofsted report of serious case reviews (2011) highlights the fact that "often agencies have to rely on members of the public as their 'eyes and ears', but we found in two PLRs that such accounts were not perceived by professionals as "believable". **Information sharing** was not always consistent, leading to "mountains of information" being available to some agencies working with the family but not others.	**Key Messages for Managers** • Frequent changes in workers without adequate handovers can contribute to the Start Again Syndrome. • Ensure that practitioners are trained and equipped to use all available risk assessment tools and that these inform referrals for early help and child protection services. • If practitioners raise concern about the outcome of a referral, satisfy yourself that sufficient information has been provided to CART/ESAT. If you share their concern ensure you escalate the case. **Key Messages for Practitioners** • Take a forensic approach to assessment: at the outset consider all information regardless of the source. • Ensure that all children are considered within an assessment regardless of how well they might appear to be doing. • If you are concerned at the outcome of a referral for early help or protection act promptly to escalate these concerns to your Manager. **Key Messages for multi-agency practice** • Ensure that all partners working with the child and family have contributed to the risk assessment. • Remember, if you are not satisfied with the outcome of an assessment it is in everyone's interest to challenge partner's to ensure the best outcomes for the child.

	Parenting Capacity was often judged to be poor without any formal parenting assessment being conducted to support that professional judgement. **Reviews of assessment** must be regularly undertaken to evidence that the desired impact of intervention is being realised for the child. **Neglect and emotional abuse** are one and the same in the mind set of some professionals. In two Neglect cases this resulted in the clear issues of emotional abuse being obscured by responses to neglect that were focused on seeking visible improvements. A thematic Review of PLRs across 2013-15 has found the following in relation to the **child's lived experience**, namely: • **Parent focused interventions** as a result of a tendency for adult needs to be understood, while the child's needs were not being adequately identified and articulated. • **Lack of professional challenge** to the accounts provided by Parent's. • **Gaps in recording** led to lack of clarity as to whether the child had been seen. • **Failures in recognising what life is like for the child** • **Absence of the voice of the child** in records to demonstrate that it had influenced the response of the professional.	**Key Messages for Managers** • Encourage practitioners to reflect on what life is like for the child e.g. can the practitioner talk about the day in a life of the child. • Look for evidence of professional challenge in discussions and recording – with both parents / carers and with other professionals. • Ensure plans are child focused. • Check that the child's lived experience is clearly recorded. **Key Messages for Practitioners** • Keep children at the centre of what you are doing – listen, and hear what they are saying. • Recognise that a child's needs are not always the parents' highest priority and some parents may knowingly seek to distract practitioners away from the needs of the child. • Record the voice of the child in your records. • Demonstrate that the child's voice has influenced your response. **Key Messages for multi-agency practice** • Does your perception of the child's experience fit with other professional's perspectives? Ask you colleagues for their views. **Key Messages for Managers** • Adopt a reflective practice approach to supervision; ask practitioners "whatever explanation could there be?"

	A thematic Review of PLRs across 2013-15 has found the following in relation to **risk & need**, namely: • **Cases being managed at the wrong level** e.g. TAF provided a useful process by which to engage the family and establish professional relationships with them at the outset but lost impact over time, primarily because the family's needs and complexities required a higher level response. • **The escalation policy** was not used to challenge decision making in the vast majority of PLRs conducted. • **Role of the lead professional is crucial** but in some cases (at TaF level) it was not always clearly identified or they lacked sufficient skill • **Reflective Supervision** should be promoted to encourage professionals to develop professional curiosity. In cases were reflective supervision had been utilised there was a marked difference in the risk assessment and management of the case by the agency involved.	• If a practitioner raises a concern with you about professional disagreement e.g. management at the wrong level, contact your respective counterpart and challenge the decision. If no resolution can be achieved follow the LSCB Resolution and Escalation Pathway. Look for evidence of professional challenge in discussions and recording – with both parents / carers and with other professionals. **Key Messages for Practitioner's** • Access TaF training and ensure you feel properly equipped to contribute to, or lead a TaF. For advice and support contact the TaF Advisors. • If you are uncomfortable about a decision that has been made in a case, trust your instinct and report your concern. If resolution cannot be achieve tell a Manager. This is the Resolution and Escalation Pathway of the LSCB. **Key Messages for Multi-Agency Practitioner's** • Safeguarding is everyone's responsibility, but not someone else's. Get involved and stay involved until you are satisfied that risk has been reduced and outcomes for the child are improved.
Child Death OP	• ***Safe sleeping-*** One key area that the CDOP identified from their considerations in 2013/14 was the number of deaths where unsafe sleeping positions or "co-sleeping" had been a modifiable factor. • **Smoking in pregnancy**	• Safe Sleeping Guidance and training should be available to professionals

	The CDOP identified in 2013/14 that there were a number of cases where the mother had smoked during pregnancy. Smoking in pregnancy can lead to a range of health issues for newborns as well as premature births and underweight babies.	
Frontline Visits	• Staff asked for further input on Continuum of Need (Threshold) training and Mental Health Awareness. This has been passed to the Learning and Development sub-group for action. The LSCB Conference for 2015 also has a significant focus on the emotional wellbeing of adolescents. • Some agencies were able to articulate clearly the process for receiving information from local and national reviews, but not all could provide concrete examples to demonstrate how learning had changed practice. This particularly applies to Probation colleagues who were unaware of local practice learning reviews, and less familiar with National Serious Case reviews. • The apparent gap for any practitioner who is escalating concerns is making a record of that escalation and following up the response. • There was evidence that some frontline staff had a greater practical knowledge of the LSCB than their Managers, whilst Managers were able to articulate the strategic role of the Board.	• Board Members are encouraged to share the Introduction to the LSCB booklet with staff and seek assurance that this has been discussed in supervision. • Training on Mental Health Awareness and Continuum of Need to be provided. • Agencies are encouraged to send staff to the PLR/SCR briefing events. • The consistent use of the Graded Care Profile must be promoted within all agencies when there are concerns about potential neglectful parenting.