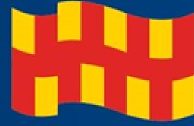

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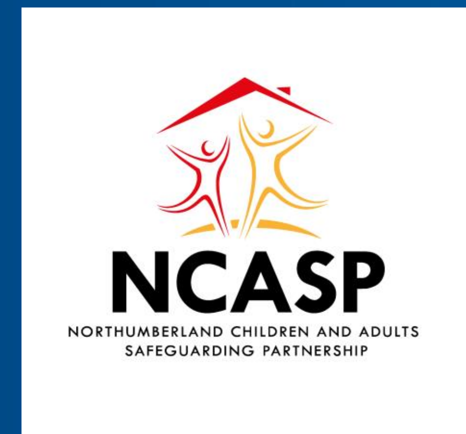

Northumberland Learning Review Toolkit

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Introduction to Learning Review Toolkit

- This toolkit was created to support those who are leading on **any** type of case review in Northumberland
- The toolkit was designed to be used as a reference tool and not a checklist. Different sections will be applicable during various stages of the review
- If at any point of the review there is any information shared that identifies a child or adult is at risk then immediate appropriate action should be taken i.e. contact the police or raise a safeguarding concern
- The final section provides links to further practice resources and supporting information / templates
- The toolkit review stages have been mapped against the national and regional SAR Quality Markers
- Please remember that support is available for Lead Reviewers

Common Learning Review Challenges

- Understanding the purpose of the Review
- Timescales and Resources
- Work capacity and competing demands
- Support for Lead Reviewer
- Senior Management team oversight and accountability
- Clarity of Terms of Reference
- Understanding wider impact of delay – on person and / or family, professionals, statutory timescales
- There is a requirement for agreement and sign-off at each stage of the review
- Quality of information – quantity, detail, structure, content, order
- Analysing information
- Focus is on production of report, rather than the actions and sharing learning
- Setting SMART and achievable recommendations
- Unconscious bias
- Different IT systems
- Understanding terminology

Types of Learning Review (1)

Safeguarding Adults Review (SAR) (Safeguarding Adults Board)	Statutory, multi-agency review where an adult (aged over 18) with care and support needs has died or experienced serious abuse/neglect and there is reasonable cause for concern about how the Safeguarding Adults Board members, or others worked together to safeguard the adult.
Domestic Homicide Review (DHR) (Community Safety Partnership)	Statutory, multi-agency review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse, or neglect by a person to whom they were related or with whom they were, or had been, in an intimate personal relationship, or a member of the same household as themselves
Child Safeguarding Practice Review (CSPR) (Safeguarding Children Partnership)	Statutory, multi-agency reviews where abuse of a child is known or suspected, and the child has died or been seriously harmed (referred to as a serious child safeguarding case). A multi-agency rapid review will be undertaken initially to determine whether a Child Safeguarding Practice Review is required.
MAPPA Serious Case Review (MAPPA Strategic Board)	Undertaken when an offender subject to MAPPA commits a Serious Further Offence (SFO). The purpose is to examine whether the MAPP arrangements were effectively applied and whether agencies worked together to do all they reasonably could to effectively manage the risk of further offending in the community.

Types of Learning Review (2)

LeDeR Reviews (Learning from lives and deaths – people with a learning disability and autistic people) (Integrated Care Board**)**	LeDeR aims to improve care, reduce health inequalities and prevent premature mortality of people with a learning disability and autistic people by reviewing information about the health and social care support people received. Everyone with a learning disability aged four and above who dies and every adult (aged 18 and over) with a diagnosis of autism is eligible for a LeDeR review.
Coroner's Inquest (Coroner's Office)	A coroner must hold an inquest if: the cause of death is still unknown (following a post-mortem); the person might have died a violent or unnatural death; the person might have died in prison or police custody An Inquest is an investigation into a death, designed to find out who the deceased was, and where, when, and how.
Case Review (Can be requested from anywhere)	A case review (single or multi-agency) may be required in a range of circumstances e.g.: - The SAB may wish to determine if a SAR referral is required - To respond to a complaint - Coroner's request

Types of Methodologies (1)

Traditional SAR model	Well-known and long-standing approach to undertaking reviews. It involves the agencies involved with the case completing chronologies and/or Individual Management Reviews (IMRs). Agency authors need to research case files and speak to the staff involved and produce a report analysing their involvement.
SCIE Rapid Review model	This is a SCIE developed model which undertakes SARs in rapid time. A SAR In Rapid Time aims to have a turnaround time of 15 working days from set-up meeting, held after the decision has been made to progress with a review.
Appreciative Inquiry	Appreciative Inquiry approach asks generative open questions about what worked well, alongside what might and should be different in the future. The approach recognises that in order for people to be able to think, reflect, learn and change; participants need to feel supported, respected and valued. Appreciative Inquiry tries to place more emphasis on learning from good practice through “conversations”. Usually, the case is reviewed at one event involving the practitioners that were involved with the case.
Significant Incident Learning Process (SILP)	SILP analyses significant events and deals not only with what happened but why it happened. SILP approach is rooted in systems methodology, and can identify what affected the practitioner’s actions and decision making at the time and what needs to change. SILP reviews see equal value in learning from good practice, and families and significant others are offered opportunities to engage with the reviews.

Types of Methodologies(2)

Practitioner workshop / Learning event	A Practitioner Workshop/Learning Event is a good way of hearing from the practitioners about their involvement. They are usually led by the SAR author and enables the reviewer to understand in greater depth whether there are any lessons that can be learnt to improve practice in the future and it also enables good practice to be identified and shared. Research in Practice have guidance on Developing Effective SAR Learning Events.
Learning Together Review	Learning Together reviews are conducted by a multi-agency 'Review Team' which is led by two Lead Reviewers (accredited by SCIE). This systems approach explicitly focuses on a deeper understanding of why professionals have acted in the way they have, so that any resulting changes are grounded in practice realities.
Multi-agency combined chronology	Developing a combined chronology of events is useful way of achieving an overview of case and areas for improvement or development. This enables agencies to identify gaps in communication, shared decision making and risk assessment, and make recommendations for change.

Overview of the 9 Review Stages

1. Accountability and Support
2. Terms of Reference
3. Evidence Gathering / Chronologies
4. Involving the Person and / or family or their advocate where appropriate
5. Co-production with workforce and stakeholders
6. Analysis, Findings and Recommendations
7. Learning Review Final Report
8. Action Planning and Review
9. Sharing Learning

1. Accountability and Support

Quality Statement: There are clear governance arrangements agreed from the outset, and the Reviewer is fully supported to undertake a quality review within the required timescales.

Accountability

- **Senior Management is accountable** for all aspects of the reviews and should be kept fully informed throughout the process.
- **Senior Leaders need to be informed** of any issues in relation to key staff, admin support or Reviewer capacity, that may impact on quality and timings of the Learning Review.
- Reviewers should establish a process to **allow challenge** to the information and analysis of the review, so that findings and recommendations can be fully considered before the report is finalised.
- **Clear governance arrangements** need to be in place from the outset, including the sign-off process and timescales.
- The SAB or other coordinating Partnership need to be **informed of any delays** and reasons for them, at the earliest opportunity.

Support

- Reviewers should be afforded **sufficient capacity**, resources and support to undertake quality reviews
- **Mentoring, support, buddying and training arrangements** should be agreed at the outset of the Review process. This would include individual feedback to the reviewer on strengths and areas for improvement
- **Access to all the relevant case notes and files**
- **Access to practitioners involved within the case**
- **Access to templates** i.e. chronology, terms of reference
- **Dedicated supervision and support** for the Learning Review
- A range of Learning Review and SAR resources are available in the **Northeast SAR library** – contact SAB Business Manager.
- As Lead Reviewer you **are responsible** for identifying any additional support that you require

2. Terms of Reference

Quality Statement: The Terms of Reference should focus upon learning and improvement across organisations and acknowledges any contributory factors specific to the review

- **Introduction**
  This should include who made the decision to undertake a learning review and why. Dates need to be included of key events, such as the date the case was allocated to the lead reviewer. Include the pseudonym name of the person, where appropriate, and explain about confidentiality.

- **Purpose of the review**
  Reinforce the review is not to apportion blame. It is about learning and improvement. Include legal frameworks if applicable.

- **Methodology**
  Identify the type of methodology to be used in the review i.e. Appreciative Inquiry

  Refer to the principles of the Care Act 2014 if appropriate i.e. Empowerment, Prevention, Proportionality, Protection, Partnership, Accountability.

  Describe how you are going to review the information – where the information is held, **which stakeholders are involved** and who will engage with them i.e. coroner / police / out of area stakeholders

- **Case Summary**
  If appropriate include a case summary and the scoping period of the case review.

- **Scoping Period and Key Episodes**
  - Identify the scoping period for the Learning Review, during which most (if not all) of the key episodes have occurred
  - If any significant events have occurred outside of the scoping period these should be referenced
  - Record any key issues and / or key episodes to be considered as part of the review.

- **Involvement of the adult; family or advocates where appropriate**
  - Identify who is involved
  - Specify the initial desired outcomes of the person, family or advocate
  - Consider pseudo names if relevant.
  - Highlight if the person has any protected characteristics and if this has impacted upon the case

- **Timescales**
  - Identify clear review timescales and key communication dates

3. Evidence Gathering / Chronologies

Quality Statement: Evidence / Chronologies should provide quality information to underpin the analysis of the case

Evidence Gathering

- **Consider and review any written evidence** relevant to the case i.e. electronic case records, paper records, minutes, previous reviews
- **Establish facts**
- Identify what **policies**, **procedures**, and **guidance** are relevant to the case
- Identify any **missing sources of information** and follow up
- Where necessary, **discuss with the police** any information relevant to criminal proceedings

Chronology

- A chronology provides an **overview** of key dates and events within the scoping period
- **Avoid any duplication and repetition** by utilising documents already completed
- Incorporate any **relevant views of the person, families or advocates** that are included within records
- Comments on the chronology should **include agency review** of the appropriateness / quality of the intervention which may assist to inform the analysis
- Emphasise the importance of agencies identifying their own themes and significant events
- **KEEP IT PROPORTIONATE AND SUCCINCT!**

4. Involving the Person and / or family or their advocate where appropriate

Quality Statement: The person, relevant family members are informed and involved, being mindful of treating them with respect. The report is informed by knowledge and experience of the person, family and relevant network regarding the period under review.

- Identify the **key family contact**
- Identify a lead officer who is **point of contact** for the learning review
- **Inform the person, relevant family members of the review at the earliest opportunity**
- Be **clear and transparent**
- Discuss the **purpose, process and parameters of the review** in the most appropriate way to promote understanding.
- **Agree a communication strategy**. Confirm with the family their preferred methods and timeliness of communication throughout the process (verbal, written)? Where possible, confirm information in writing
- **Review expectations** throughout the learning review
- **Where there are criminal proceedings, ensure a discussion has taken place with the police** (Senior Investigating Officer) **and / or Coroner** around the family involvement with the process
- **Consider how the family are to be represented in the final report** and how do they provide feedback
- **Formally acknowledge and thank the family for their involvement** within the report
- There may be circumstances when a decision is made to not involve the person and/or family members/friends or where there are no family members or friends known. **There should be clearly documented decisions around involvement / non-involvement of the person or specific representative(s)**
- At the end of the process, if the key family contact is dissatisfied with the outcome / process then they should be provided with **appropriate next steps** i.e. complaint, LGA Ombudsman

5. Co-production with workforce and stakeholders

Quality Statement: Learning Reviews should be co-produced with those practitioners, managers and partners who were involved in any decision making or interventions for the case, and those who have knowledge about the wider policies, procedures and governance arrangements.

Who do we need to collaborate with?

- Practitioners directly involved with the service user – context is key
- Managers who had oversight of the case
- Representatives from partner organisations who have been involved
- Managers responsible for any policies or procedures that were followed

Methods for involvement:

- One to one – these could be formal interviews or more informal discussions as appropriate
- Surveys – for example, to determine whether a particular procedure is routinely followed
- Focus Groups – consider dynamics and support / protection within the focus group i.e. including practitioners with senior managers may impact upon involvement / wellbeing
- Learning Events / Workshops

General points to consider:

- Who will undertake this collaboration, think about:
  - Workload
  - Confidence and ability to lead discussions / workshops / interviews
  - Is there the requirement for independence?
- What support and protection is in place for the individual(s) you are collaborating with – i.e. manager, colleague, HR, trade union representative, policy and procedures i.e. SAR Policy
- The purpose, process and parameters of the learning review should be shared prior to collaboration to promote understanding
- Agree what will be shared post collaboration i.e. key findings
- What arrangements are in place to record workforce and stakeholder collaboration

6. Analysis, Findings and Recommendations

Quality Statement: The Learning Review analysis and subsequent findings and recommendations should be transparent and rigorous. It should evaluate and explain professional practice in the case, highlight challenges, themes and learning

Analysis:

- Analysis should draw on the **full range of relevant information and evidenced gathered**, to evaluate and explain professional practice in the case
- Analysis should help explain why people did what they did, taking into account:
  - **Organisational culture**
  - **Challenges and constraints of work environment –** consider what support was available for the practitioner
  - **Multi-agency and multi-professional working**
  - **Wider system**
  - **Contextual information**
- Consider **equality, diversity and inclusion**– were there any protected characteristics or other factors that impacted upon vulnerability or practice
- Is **current, up to date research evidence / learning used** in the analysis? i.e. national SAR library, NICE guideline recommendations
- Be clear about any **methodological limitations** that may impact on the final analysis i.e. unable to speak to practitioners as they have moved jobs
- Where possible, **ask stakeholders to undertake analysis on their area of expertise**
- Avoid **hindsight bias**

Findings:

- All findings should be **derived from the analysis of evidence and research**
- Findings should **reflect causal factors**, **systems learning**, **single and multi-agency learning**
- Use a **strengths-based approach**, start with those findings that demonstrate good practice before moving onto areas for improvement
- Findings should **relate to the lived experience** of the person and / or their family

Recommendations:

- Recommendation should be **based upon the analysis and findings**
- If possible, **theme the recommendations** for ease of future action planning
- Recommendations should be **specific, realistic and achievable**

7. Learning Review Final Report

Quality Statement: The Learning Review Final Report should clearly and succinctly identify the analysis and findings while keeping the details of the person to a minimum.

General Points:

- The Learning Review final report should be as **succinct as possible** i.e. no more than approximately 20 - 30 pages
- The report is not a comprehensive description about what has happened. **The focus should be on the analysis, findings and recommendations**.
- Think about the **intended audience** for the report i.e. will the report be published online, is the Learning Review a statutory requirement?
- Consider writing a **summary report** and / or **7-minute briefing**
- Consider how you will **promote open and constructive challenge** in relation to the findings of the report
- Consider whether or not the report should be **published and / or shared** more widely than Northumberland – would the findings and recommendations resonate in other localities? If so, a clear communication plan will be required
- Use **appendices**, **foot notes** and **references**

Final Report Checklist:

- ✓ Does the report **meet the requirements of the Terms of Reference**?
- ✓ Has the person / family / staff / stakeholders had **opportunity to contribute** to the report and comment on an initial draft?
- ✓ Does the report sufficiently **protect the privacy** of the person, family members and practitioners whilst still being accessible and able to support future practice improvement?
- ✓ Is information from contributing agencies fully and **fairly represented** in the report?
- ✓ Is the **tone and choice of words appropriate** and is the report written in a way that is to the point, understandable and useful?
- ✓ **Formally acknowledge and thank the family for their involvement** within the report.

8. Action Planning and Review

Quality Statement: A robust action plan should be produced in response to the final report, detailing actions to be taken and review

Note – the Lead Reviewer role may end once the final report has been endorsed.

Action Planning

- Consider **who should be involved**, and to what extent, in drafting and approving the action plan
- **Is specialist support or facilitation needed**
- Does the proposed responses **genuinely tackle the risks** identified by the learning review?
- Action Plans should include **specific actions on sharing and building upon good practice** identified within the report
- Have any **'quick wins'** been identified – best practice would be to implement actions as soon as practicably possible – do not need to wait for the production of the final report
- Consider **learning from previous reviews** and where previous actions have not demonstrated positive impact
- **Be creative!** Think about doing things in different ways.

Review

- What arrangements are in place for **monitoring of improvement actions?**
- How will impact be **evaluated?** Think about timescales for revisiting the review. It could take a long time before impact is realised
- Have the findings been **communicated and embedded in training, policy and guidance?**

9. Sharing Learning

Quality Statement: The Case Review findings should inform effective implementation of any system changes. The impact of the findings should be evaluated to ensure they positively influence practice and improve safeguarding of adults.

Within own organisation

- Ensure **learning is identified and shared** – include both good practice and areas for improvement
- Involve **Training Leads and Senior Managers** to develop appropriate awareness raising / training with the workforce. **Think about opportunities to reflect and discuss the learning in context of own practice**
- Consider how you will **measure and evaluate impact of learning**
- Agree process to **revisit** learning if appropriate

Within other organisations

- **Communicate findings** with partner agencies to promote awareness and improvements
- Seek **assurances that recommendations have been followed** and **learning has been shared**
- If appropriate share the learning **locally**, **regionally** and where appropriate escalated **nationally**

Top Tips Checklist

- Be strengths-based – always look out for good practice
- Keep your line manager informed through supervision and regular discussion
- Identify your support contacts early in the process
- Arrange initial, mid-way and final review meeting with your support
- Agree deadline for final draft to allow senior managers time to review and submit feedback
- Ensure you have allowed time for reviewing edits and making any necessary changes
- Seize opportunity for early learning and improvement actions – don't need to wait for final report
- Maintain contact with the person and / or their family or representative as agreed from the outset i.e. monthly catch up
- Be guided by the templates
- At recommendation stage, start thinking about how these could be translated into an action plan

Practice RESOURCES

National

- SCIE Safeguarding Adult Reviews in Rapid Time
- SCIE Learning Together Reviews
- SILP
- National SAR Quality Markers (SCIE)
- National SAR Library
- Writing Chronologies Practice Guidance (CC Inform)
- Research in Practice – Developing effective SAR learning events

Local

- Learning Review Toolkit (including online webinar showcasing the Learning Review Toolkit)
- Northumberland SARs / DHRs / Learning Reviews
  - ✓ Examples: SAR - Leanne, Mrs C - DHR, Learning Review - Harry
- Northumberland Multi-Agency Safeguarding Adult Policy and Procedures – SAR Policy
- North East SAR Quality Markers Checklist
- North of Tyne Safeguarding Adults Review Policy and Procedures 2023
- Review Templates:
  - ✓ NCASP Terms of Reference template
  - ✓ NCASP Individual Management Review (IMR) template
  - ✓ NCASP Chronology template and guidance
  - ✓ Agency report template – SILP methodology example
  - ✓ Terms of Reference template – SILP methodology example