Multi Agency
Case Review Framework

April 2015

The LSAB believes that when service users experience poor outcomes it is important that all services reflect on the quality of their services both internally and collaboratively, so that they are able to learn from their practice and that of others in order to improve local safeguarding practice. This Framework is designed to support these processes.

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1. INTRODUCTION

Southampton Local Safeguarding Adult Board (LSAB) is committed to promoting a culture which values and facilitates learning and in which the lessons learned are used to improve future practice and partnership working to safeguard adults at risk. The Southampton LSAB has developed this multi-agency Case Review Framework to support this approach. It has been developed for use by all partner agencies and local organisations which work with adults at risk across the Southampton Local Safeguarding Board area, it is based on the framework developed in the Hampshire and other 4 LSAB areas to ensure consistency for services that work across the county. The LSAB is confident that the approaches outlined in the Case Review Framework will drive improvements in the wider safeguarding system as well as in the outcomes experienced by users of services.

Overview

The Case Review Framework recognises that LSAB member agencies and organisations have their own internal governance and learning structures. This Framework therefore, seeks to complement and build on single agency arrangements by adding a multi-agency approach to enable partner agencies to work collaboratively to learn lessons from cases where there may have been multi-agency failings and to use this learning to improve future joint working. The Case Review Framework is designed to support decision making regarding the use of multi-agency review processes and outlines the pathway for commissioning reviews and the governance arrangements underpinning these arrangements.

Guiding Principles

The review and audit processes referenced in this Case Review Framework are underpinned by the following principles:

- Case Review activities should be proportionate according to the scale, significance and level of complexity of the issues and concerns highlighted.

- Adults at risk and their families should always be offered the opportunity to contribute to the learning review and receive feedback on the learning outcomes achieved.

- Professionals from the range of agencies involved in the case should be fully engaged in the learning review and be invited to contribute their perspectives.

- The central focus of any learning review will be to gain insight and understanding of how effectively agencies were working together to support and safeguarding the person at risk and to identify any actions needed to improve future practice and partnership working.

- The learning review should be fair and balanced and not used to allocate blame. It should take account of what practitioners knew or could have reasonably have been expected

to have known at the time. Consideration should also be given to the capacity of the person at risk and their views and choices at the time.

- Learning reviews are not disciplinary proceedings and should be conducted in a manner which facilitates learning and allows for reflection.

- The Care Act 2014 provides a statutory basis for undertaking the Case Review processes described in this Framework.

- This Framework recognises that there are other forms of statutory reviews (such as domestic homicide reviews, mental health homicide reviews, MAPPA reviews, children's serious case reviews, etc.) and the importance of managing the interface between these.

- Where the LSAB is satisfied that other review processes have adequately identified learning it may not be necessary to conduct a review under this Framework in order to avoid duplication of activity.

- Where necessary, an independent advocate will be arranged to support and represent an adult who is the subject of a multi-agency review.

2. LEGAL AND POLICY CONTEXT

The Care Act 2014 creates a new legal framework for Adult Safeguarding. Section 44 of the Act requires Safeguarding Adults Boards (SAB) to undertake a safeguarding adult review (SAR) in specific circumstances and places a duty on all Board members to contribute in undertaking the review, sharing information and applying the lessons learnt. The law requires Local SABs to arrange a safeguarding adult review when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the person at risk. The SAB must also arrange a safeguarding adult review when an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect.

However, the Care Act 2014 also enables SABs to carry out reviews in other cases where it feels this would be appropriate in order to promote effective learning and improvement action to prevent future deaths or serious harm occurring again. These may be cases which provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults but which may not meet criteria for a safeguarding adult review for example. This Framework highlights a number of other review processes that could be used in these circumstances.

This Case Review Framework reflects and builds on the six safeguarding principles outlined in the Government's Statement on Adult Safeguarding published May 2013. These not only

should be the basis upon which judgements are made about events and practice but also are the principles underpinning the review process itself. These principles are:

Empowerment	Presumption of person led decisions and informed consent.
Prevention	It is better to take action before harm occurs.
Proportionality	Proportionate and least intrusive responses appropriate to risks.
Protection	Support and representation for those in greatest need.
Partnership	Local solutions through services working with their communities.
Accountability	Accountability and transparency in delivering safeguarding.

3. ROLES AND RESPONSIBILITIES

The LSAB believes that when service users experience poor outcomes it is important that all services reflect on the quality of their services both internally and collaboratively, so that they are able to learn from their practice and that of others in order to improve local safeguarding practice.

Individual organisations will have their own internal governance systems and statutory or contracting requirements in respect of investigating or reviewing incidents. This Case Review Framework is not intended to duplicate or replace these but seeks to enhance and complement these arrangements. In relation to current single agency governance arrangements, the NHS is required to undertake Serious Incidents that Require Investigation Reviews (SIRIs) when specific criteria are met.

In addition to the safeguarding adult review process, the Case Review Framework also provides other tools to enable partner agencies to reflect on and learn from cases which may not meet the criteria for a safeguarding adult review but nonetheless have the potential for providing important learning with which to improve practice and partnership working.

Partner agencies and local organisations who work with adults at risk are invited by the LSAB to endorse this Framework and going forward, to embed it in their internal governance processes as well as Learning and Development policies.

The LSAB is supported by two of its Groups in the implementation, management and oversight of the Case Review Framework and the activities linked to it. The Case Review Group is responsible for determining whether or not a review should take place (and if so, the most appropriate type of review to commission). It will also oversee the review process and the development of the action plan and publication of the report. The Monitoring and Evaluation Group is responsible for monitoring the implementation of any action plans arising from reviews and for ensuring that the impact of changes on the experiences and outcomes for service users are evaluated.

As part of the Case Review Framework, LSAB will develop a programme of learning and development activities and workshops in order to improve frontline practice and partnership working.

This framework covers a range of reviews and audits aimed at reducing future risk and driving improvements. The Framework provides a mechanism to check that learning from serious case reviews, domestic homicide reviews, CQC investigations, etc. have led to changes and improvement at service delivery level. Appendix A outlines roles and responsibilities in the implementation of the Framework.

4. ACTIVITIES TO SUPPORT LEARNING FROM EXPERIENCE

A. Safeguarding Adults Reviews (previously Serious Case Reviews)
B. Multi-agency partnership reviews
C. Multi-agency reflective workshops
D. Multi-agency themed audits

Referrals for a multi-agency review

This section outlines the process for making a referral for a multi-agency review. Following a serious incident, active consideration should be made as to whether or not a referral for a multi-agency review under the Case Review Framework is necessary. To support this, organisations should consider including an appropriate trigger question to include on internal incident reporting, investigation and/or review templates.

However, it is important to note that if the nature of the incident triggers a mandatory investigation or review within the organisation concerned (e.g. SIRI), this should take place as a matter of priority. Internal governance processes and multi-agency reviews are not mutually exclusive and indeed, the multi-agency perspective may provide invaluable insights to inform internal review processes. Key questions to consider as part of internal processes include:

- Was the incident reported internally?
- Has an internal investigation been carried out?
- Has the investigation highlighted concerns about any other organisations?
- Has any information come to light indicating abuse or neglect as a contributory factor?
- Based on findings, are criteria for making a referral met?

The following considerations should be made when deciding whether to make a referral for a multi-agency review:

- The concerns must relate to a person with needs of care and support – whether or not in receipt of services.

- Abuse, neglect or acts of omission is known or strongly suspected to have contributed to the harm caused.

- There are concerns about systemic failings relating to multiple organisations and so there is potential to identify to improve multi agency practice and partnership working.

Some cases referred may overlap with other statutory review processes such as a domestic homicide review, mental health homicide review, MAPPA review or a children's serious case review. In these circumstances, the chairs of the respective review processes will formally discuss and agree how the interfaces between these should be managed and to dovetail activity as far as possible.

There may also be parallel processes in place such as a criminal investigation or coroner's inquest, which whilst not preventing a referral being made, will need to be taken account of in terms of the timing and management of any subsequent multi agency review.

The family should be informed of the concerns and that a Case Review referral is planned and so providing an opportunity for them to give their view about the referral and to discuss how they might want to be involved.

If it is felt that the circumstances of the case may benefit from a multi-agency review, the organisation's LSAB representative and/or Case Review Group representative must be briefed on the case and notified of the intention to make a referral.

To make a referral for a multi-agency review, the referral form in Appendix B should be completed and submitted to the LSAB Case Review Group via the following email address local.safeguardingboard@southampton.gcsx.gov.uk .

Each referral will be looked at the LSAB Case Review Group. Prior to the sub group meeting the Safeguarding Boards team may contact involved agencies to request completion of a scoping form and outline chronology to inform decision making about next steps. Appendix C outlines the referral pathway and timescales.

If the case meets the criteria for a safeguarding adult review, the LSAB Case Review Group will commission this and depending on the case will decide on the methodology to be used and will follow the specific 4LSAB policy guidance written for such reviews.

A safeguarding adult review is a statutory process for cases meeting specific criteria. For cases not meeting these criteria, the LSAB Case Review Group may consider commissioning another type of review. The following section provides guidance on the different types of review which may be considered.

A. Safeguarding Adult Review

The Safeguarding Adults Board is the only body that can commission a safeguarding adult review. Under section 44 of the Care Act 2014, the SAB must arrange a SAR when an adult in its area dies as a result of abuse or neglect (whether known or suspected) and there is concern that partner agencies could have worked more effectively to protect the adult. The SAB must also arrange a SAR if an adult in its area has not died, but the SAB knows or

suspects that the adult has experienced serious abuse or neglect. The adult who is the subject of any SAR need not have been in receipt of care and support services at the time.

Purpose

The purpose of a safeguarding adult review is to:

- Determine what might have done differently that could have prevented harm or death.
- Identify lessons and apply these to future cases to prevent similar harm occurring again.
- Review the effectiveness of multi-agency safeguarding arrangements and procedures.
- Inform and improve future practice and partnership working.
- Improve practice by acting on learning (developing best practice).
- Highlight any good practice identified.

Its purpose is not to hold any individual or organisation to account. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as CQC and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council.

Criteria for a safeguarding adult review

The LSAB must arrange a safeguarding adult review of a case of an adult in its area with needs of care and support (whether or not the local authority was meeting those needs) if:

1) The case involves an adult with care and support needs (whether or not the local authority was meeting those needs)

2) There is reasonable cause for concern about how the SAB, its members or organisations worked together to safeguard the adult

   AND

3) The person died (including death by suicide) and the SAB knows/suspects this resulted from abuse or neglect (whether or not it knew about this before the person died)

   OR

4) The person is still alive but the SAB knows/suspects they've experienced serious abuse/neglect, sustained potentially life threatening injury, serious sexual abuse or serious/permanent impairment of health or development.

Process

See Appendix C for details of Case Review Process.

The Case Review Group will be responsible for agreeing the methodology and format of an SAR. This may include: establishing an independently chaired Safeguarding Adult Review Panel to undertake the review and will maintain an oversight and co-ordination role throughout the process.

- The safeguarding adult review will be undertaken by people who are independent of the case under review and of the organisations whose actions are being reviewed. A reviewer role profile has been developed to ensure appropriately experienced and skilled people undertake this role.

- The SAR will reflect the six safeguarding principles outlined on page 3.

- The LSAB Case Review Group will agree terms of reference

- If the SAB requests information from an organisation or individual who is likely to have information which is relevant to SAB's functions and completion of a review, they must share what they know with the SAB as detailed within the Care Act and Statutory Guidance for conducting SAR's.

- When undertaking the SAR, consent to share personal details should be sought as a matter of good practice with the family and individuals concerned, however this will not prevent information being shared for the purposes of a SAR.

- Where necessary, an independent advocate will be arranged to support and represent an adult that survives who is the subject of a safeguarding adult review.

- Recommendations made and subsequent action plans arising from the safeguarding adult review will be monitored by the LSAB.

Reporting arrangements

The Case Review Group will provide regular updates to LSAB on the progress of the review. The safeguarding adult review will, where possible and appropriate report within six months of the SAR being established.

Once completed, the report and recommendations will be presented to the LSAB for consideration. Once the report is approved, the LSAB will produce a multi-agency action plan responding to any recommendations made.

Monitoring of the implementation of the action plan will be undertaken by the LSAB Case Review Group.

Where appropriate and subject to other parallel proceedings the LSAB will publish the report on the LSAB website. In exceptional circumstances however, this practice may vary.

Collated findings from SAR's and other forms of partnership learning and review will be included in the LSAB Annual Report.

B. Multi-Agency Partnership Reviews

A multi-agency partnership review may be commissioned by the LSAB Case Review Group where a case does not meet the criteria for a SAR. The organisations involved with the case are responsible for delivery of the review led by the Case Review Group.

Purpose

The purpose of this type of review is to focus on the multi-agency organisational learning for the specific organisations involved in a case and to undertake these on a collaborative basis between the agencies involved.

Criteria

This form of review can be used for cases falling short of SAR criteria and any of the following criteria can also be applied:

- The person was receiving services from more than one agency at the time of the incident
- The service user was under formal safeguarding procedures at the time of the incident
- Multi-agency concerns or learning has been identified
- The incident arose from or occurred during the delivery of care

Process
See Appendix C for details of Case Review Process.

The following is an example of a process that could be used in the case of a Partnership Review. The LSAB Case Review Sub Group will agree the appropriate methodology to be utilised and that is appropriate according to each case. Supportive partnership working should be maintained throughout the process that is used.

- A review team will be set up consisting of representatives of the agencies involved.
- The lead, co-ordinating agency will be agreed who will be responsible for arranging and chairing meetings as well as drafting the review report. Terms of reference will be agreed jointly at an initial scoping meeting.

- Each review team member will review their practice against expected organisational standards by interviewing staff, reviewing records and referring to organisational policies and procedures.

- The review team will share their own organisational findings with each other and will produce a report jointly agreed by agency representatives, covering both single agency and multi-agency responsibilities.

Reporting arrangements

Reporting will be via internal individual organisations usual governance arrangements.
In addition, reporting will be through LSAB Case Review Group who will include collated findings in an annual learning report to the LSAB.

C. Multi-Agency Reflective Workshops

The following is an example of a process that could be used in the case of a Partnership Review. The LSAB Case Review Sub Group will agree the appropriate methodology to be utilised and that is appropriate according to each case. A multi-agency reflective workshop may be commissioned by the LSAB Case Review Group and if so will be attended by the organisations involved.

Purpose

The purpose of this type of review is for agencies involved with an incident to meet together and share their perspectives as a self-assessment of the multi-agency safeguarding arrangements and practice and to identify improvements.

Criteria

A reflective workshop should be undertaken in the event of an adult at risk experiencing harm and where there are limited concerns about how organisations or professionals worked together but where the outcome for the adult(s) involved was poor. The issue may have come to attention due to a complaint or a concern raised. These reviews should be commissioned where it is believed there is potential learning and the possibility of improvements in the system to be made.

Process
See Appendix C for details of Case Review Process.

The workshop will involve a one off facilitated event involving practitioners and managers directly involved in the case (or in some circumstances) other representatives such as those in policy or strategic roles who may be able to contribute to the learning process and/or in

supporting implementation of learning into practice. The aim of the activity is to make a positive impact on frontline practice. The focus of the workshop will be to reflect on the adult's journey through the system to identify any opportunities for improved interface between agencies. The workshop will be facilitated by a people independent of the case or the organisations involved.

Reporting arrangements

As an outcome of the workshop a series of actions or recommendations will be agreed by the attendees. Delegates will be responsible for providing feedback on generic areas of learning and to their respective senior management teams to relevant operational teams. These will also be shared with the LSAB Case Review Group. Partner agencies' LSAB representatives should be involved in any action planning within their organisation around the recommendations highlighted (as relevant to their organisation). The agencies involved in the review will be asked to provide LSAB with an impact analysis report outlining actions taken by their organisation to improve practice and partnership working in response to the case. Thematic findings from the reviews will be collated on an annual basis and summary included in the LSAB Annual Report.

D. Multi-agency Themed Audits

Purpose

The purpose of multi-agency themed audits is to audit practice across agencies relating to a specific topics of interest. They yield qualitative information enabling the LSAB and partner agencies to test out the effectiveness of the system following changes in policy or guidance or it may be in order to understand why a particular group are more at risk or to evaluate the scale of an emerging problem area in order to seek to address it. These will be commissioned by the LSAB Monitoring and Evaluation Group but will be overseen by the LSAB. Audit activities will form part of the LSAB Annual Audit Programme.

Criteria

Multi-agency themed audits can be undertaken on any topic or themes where concerns are identified that suggest a particular group may be more at risk. Examples might include undertaking a multi-agency audit on responses to financial abuse to test out any blockages in the system or check how agencies are working together.

Process

The programme will be agreed annually by the LSAB and will be co-ordinated and managed by the LSAB Monitoring and Evaluation Group. The programme will be informed and influenced by an inter-play of five key factors:

- Issues and themes emerging from local safeguarding monitoring information
- Patterns and trends in local cases referred for Case Review
- LSAB priorities

- Response to national developments and events

The audits will normally be undertaken by a multi-agency audit team working to agreed terms of reference. A report outlining findings and recommendations will be produced and a multi-agency action plan developed to address these. The Monitoring and Evaluation Group will be responsible for monitoring implementation.

Reporting arrangements

The audit report will be shared with the LSAB and more widely with partner agencies.

5. LEARNING INTO PRACTICE

In order to improve safeguarding practice learning identified from reviews and audits of practice must be considered operationally and strategically so that changes to policy and practice can be taken forward.

Embedding Learning

Embedding learning is achieved by disseminating learning and taking actions as a response to improve practice by:

Dissemination of Learning

What	Responsibility	Reporting to LSAB
Multi-Agency Training Programme	LSAB Learning and Development Group Partner agencies Relevant organisations	LSAB Learning and Development Group
LSAB 'Learning Lessons' Workshops	LSAB Manager Learning and Development Group	LSAB Learning and Development Group
LSAB briefings and communication strategy	LSAB Manager LSAB Communication Group Partner agencies Relevant organisations	LSAB Community Engagement & Awareness Group LSAB Case Review Group
Publication and dissemination of SAR final reports	LSAB Partner agencies Relevant organisations	All agencies All agencies

Single agency training Single agency briefings and other communication strategies	All agencies All agencies	Group

Actions to Improve Practice

What	Responsibility	Reporting to LSAB
Implementation of single and multi-agency action plans from themed audits, multi-agency partnership reviews and reflective workshops	Relevant agencies	Relevant agencies via LSAB Monitoring and Evaluation Group
Monitoring of single agency action plans	LSAB Case Review Group	LSAB Chair Via Case Review Group
Monitoring of action plans from SARs	LSAB Case Review Group	LSAB Chair

Evaluating Learning

As part of its quality assurance activity LSAB evaluates the impact of lessons learnt from reviews of practice. Evaluation includes:

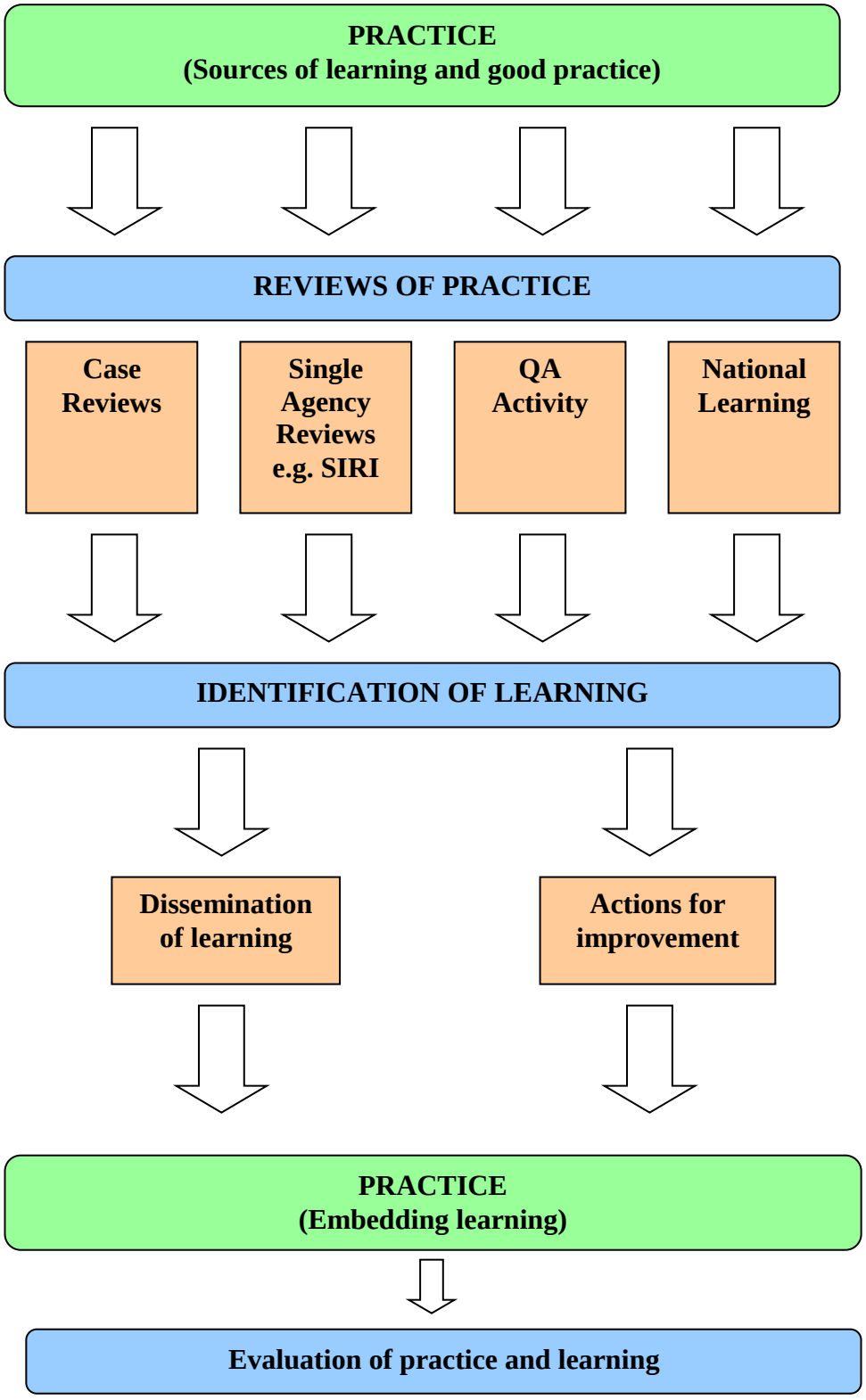
How	Who	Reporting to LSAB
Follow up single and multi-agency case audits	Partner agencies Relevant organisations	LSAB Monitoring and Evaluation Group
Reporting on multi-agency and single agency action plans	Partner agencies Relevant organisations	LSAB Case Review Group
Evaluation of training	Learning and Development course participants	LSAB Group
Surveys and questionnaires	Relevant agencies with oversight from LSAB Learning and Development Group	LSAB Group
Impact evaluation reports of the difference made on	Relevant agencies	LSAB

service users experiences and outcomes		
Annual report of LSAB to include collated findings and analysis of the range of review activities undertaken throughout the year.	LSAB Chair & Safeguarding Boards Team	LSAB Group

6. MONITORING AND REVIEW

This framework will be monitored by the LSAB Case Review Group and will be reviewed on an annual basis or sooner in response to the delivery of this framework or changes in national policy or guidance. The LSAB Case Review Group will also contribute to an annual report for LSAB to ensure collated findings and analysis of the range of review activities undertaken throughout the year.

Appendix A


PRACTICE
(Sources of learning and good practice)
REVIEWS OF PRACTICE
Case Reviews
Single Agency Reviews e.g. SIRI
QA Activity
National Learning
IDENTIFICATION OF LEARNING
Dissemination of learning
Actions for improvement
PRACTICE
(Embedding learning)
Evaluation of practice and learning

Appendix B

CASE REVIEW NOTIFICATION FORM

REQUEST FOR CONSIDERATION OF A CASE (safeguarding adult review or otherwise)

1. Details			
Adult's First Name		Surname	
Other Names Known			
Date of birth		Date of death (as appropriate)	
Ethnicity		Religion	
Address			
Previous address (if known)			

2. Referral Details	
Date of referral to LSAB	
Your name	
Your role	
Organisation	
Address	
Tel. No.	
Email	
Date of notification	
Any linked cases:	

3. Agencies known to be involved with the case (please tick)			
Adult Services			
Police			
Health Services			
Education			
GP Surgery			
Others (please specify)			

6. Case Outline
Please give a summary of the circumstances of this case *(Please continue on a separate sheet if necessary)*

7. Serious Case Review Criteria

Please explain why you feel this case should be considered for a Safeguarding Adult Review. In accordance with The Care Act 2014, a review should commence if **1** and **2** OR **3** is met.

1) **There is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult,**

2) **The adult has died, and the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).**

3) **The adult is still alive, and the SAB knows or suspects that the adult has experienced serious abuse or neglect.**

(Please continue on a separate sheet if necessary)

PLEASE RETURN THIS COMPLETED FORM TO:
Southampton LSAB: lsab@southampton.gov.uk Please password protect this document or send securely to local.safeguardingboard@southampton.gcsx.gov.uk and title your email "Confidential SAR referral".

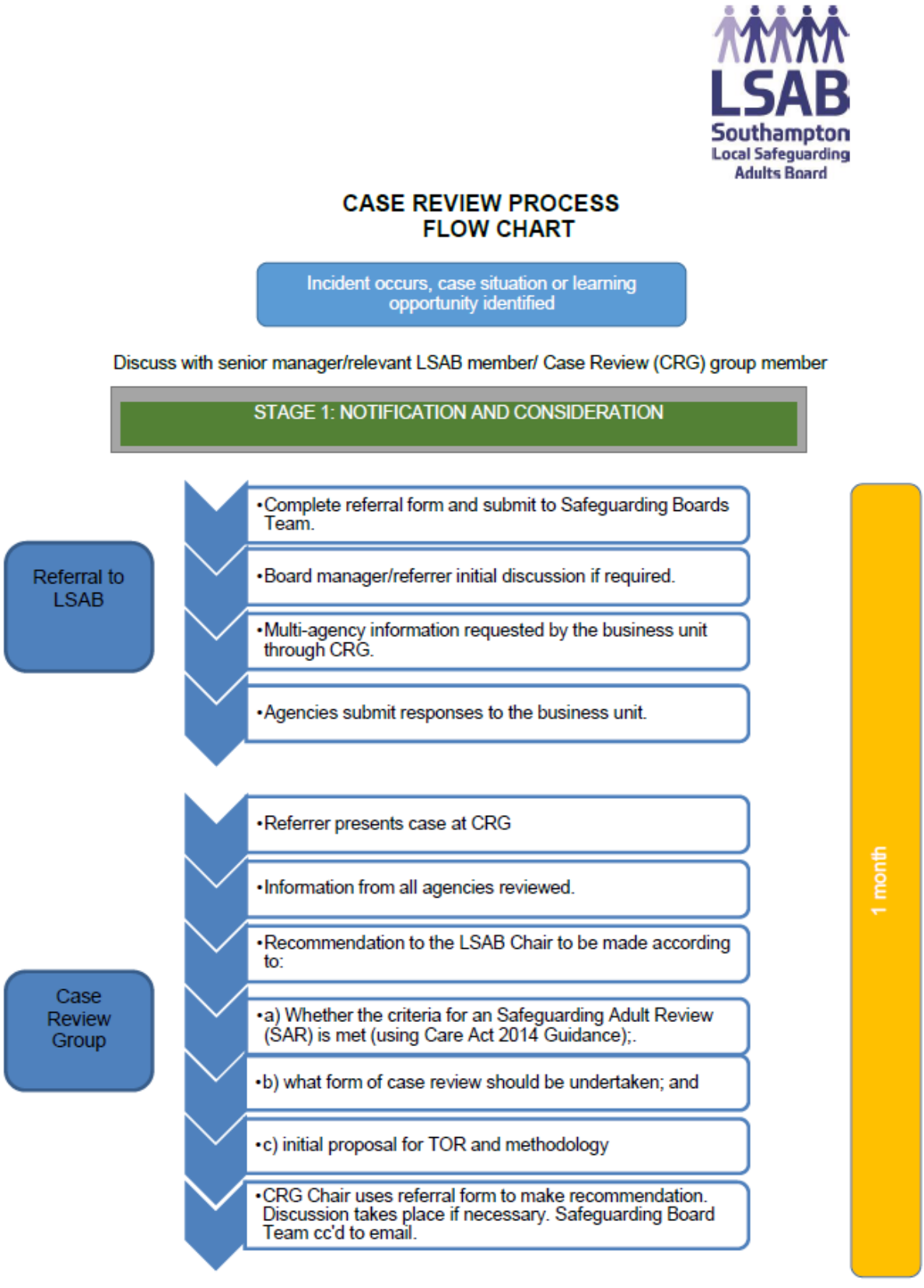
For Office Use:	
Date case discussed by LSAB CR Group	
Recommendation to be made by Case Review Group to Chair of LSAB	
This case fits the criteria within The Care Act 2014 and should be considered for a Safeguarding Adult Review.	
This case does not meet the criteria within The Care Act and should not be considered for a Safeguarding Adult Review.	
This case does not fit the criteria within The Care Act for a full Safeguarding Adult Review, however we recommend a review, detail below:	
Chair of Case Review Group: Signed……	Date……

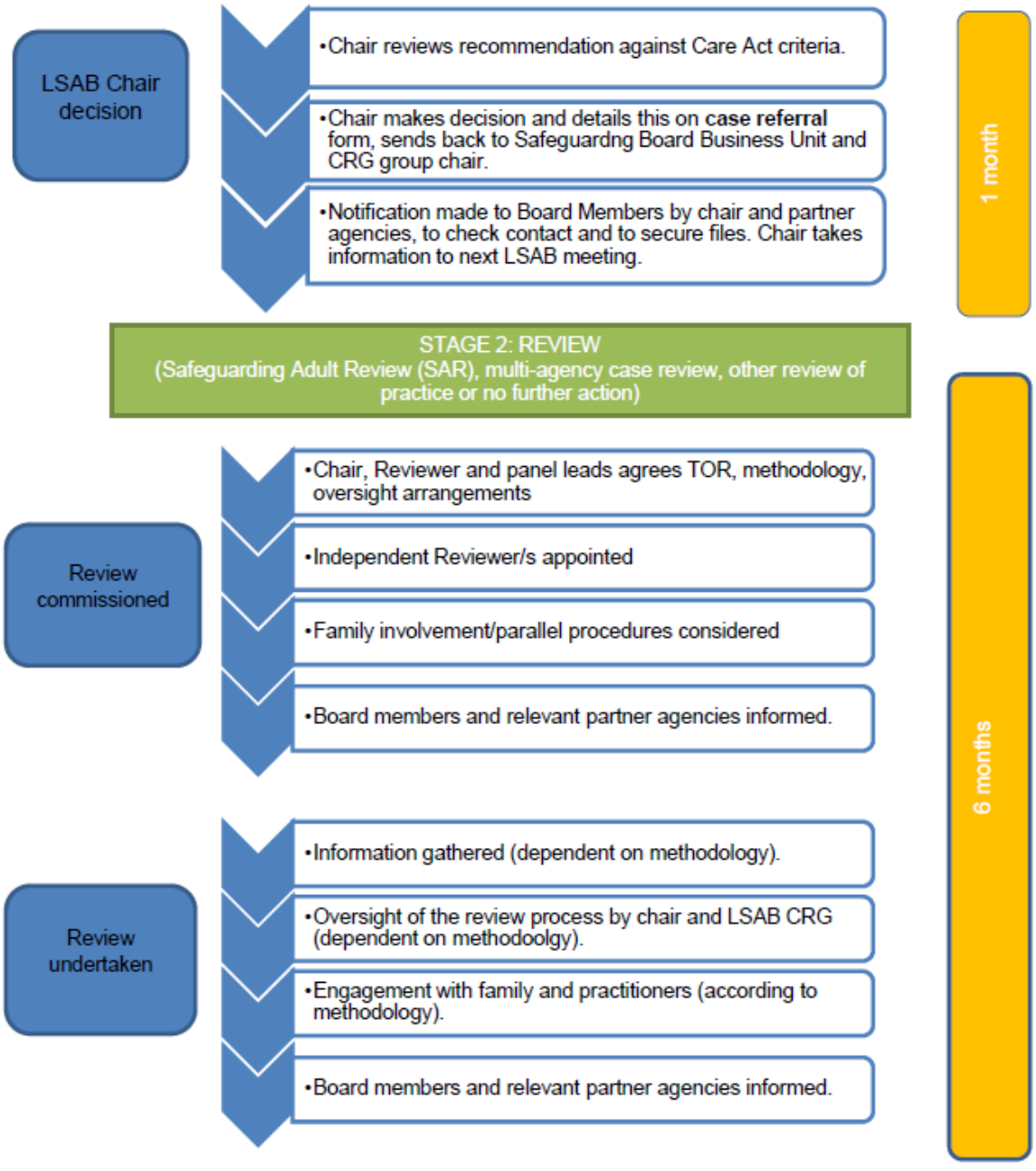
For Office Use:	
Date case reviewed by LSAB Chair	

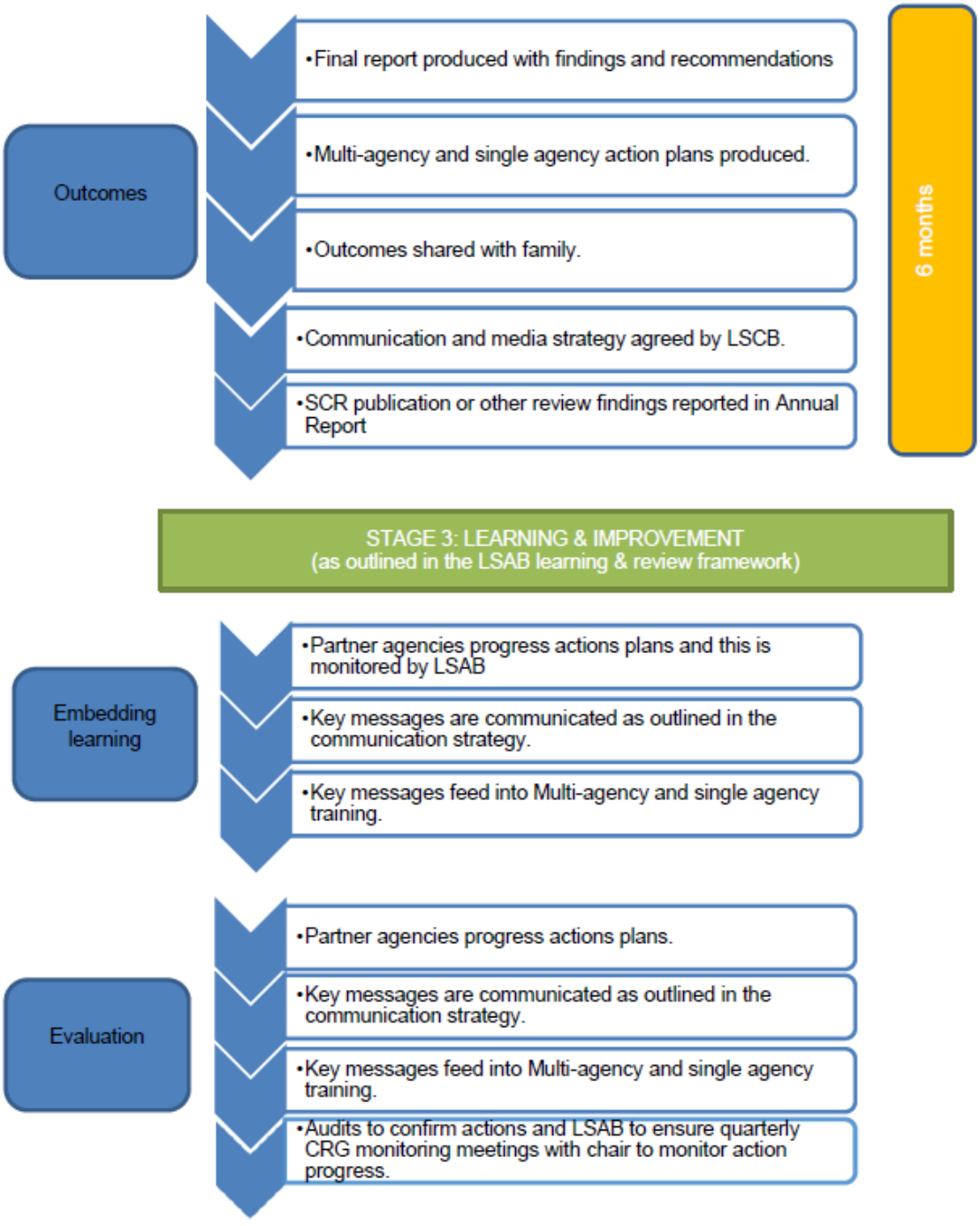
Decision by Chair of LSAB	
This case fits the criteria within The Care Act 2014 and should be considered for a Safeguarding Adult Review.	
This case does not meet the criteria within The Care Act and should not be considered for a Safeguarding Adult Review.	
This case does not fit the criteria within The Care Act for a full Safeguarding Adult Review, however we recommend a review, detail below:	
Chair LSAB:	

Signed:	Date……

Appendix C


LSAB
Southampton
Local Safeguarding
Adults Board
CASE REVIEW PROCESS
FLOW CHART
Incident occurs, case situation or learning opportunity identified
Discuss with senior manager/relevant LSAB member/ Case Review (CRG) group member
STAGE 1: NOTIFICATION AND CONSIDERATION
Referral to LSAB
•Complete referral form and submit to Safeguarding Boards Team.
•Board manager/referrer initial discussion if required.
•Multi-agency information requested by the business unit through CRG.
•Agencies submit responses to the business unit.
Case Review Group
•Referrer presents case at CRG
•Information from all agencies reviewed.
•Recommendation to the LSAB Chair to be made according to:
•a) Whether the criteria for an Safeguarding Adult Review (SAR) is met (using Care Act 2014 Guidance);.
•b) what form of case review should be undertaken; and
•c) initial proposal for TOR and methodology
•CRG Chair uses referral form to make recommendation. Discussion takes place if necessary. Safeguarding Board Team cc'd to email.
1 month


LSAB Chair decision
•Chair reviews recommendation against Care Act criteria.
•Chair makes decision and details this on **case referral** form, sends back to Safeguardng Board Business Unit and CRG group chair.
•Notification made to Board Members by chair and partner agencies, to check contact and to secure files. Chair takes information to next LSAB meeting.
1 month
STAGE 2: REVIEW
(Safeguarding Adult Review (SAR), multi-agency case review, other review of practice or no further action)
Review commissioned
•Chair, Reviewer and panel leads agrees TOR, methodology, oversight arrangements
•Independent Reviewer/s appointed
•Family involvement/parallel procedures considered
•Board members and relevant partner agencies informed.
Review undertaken
•Information gathered (dependent on methodology).
•Oversight of the review process by chair and LSAB CRG (dependent on methodoolgy).
•Engagement with family and practitioners (according to methodology).
•Board members and relevant partner agencies informed.
6 months


Outcomes
•Final report produced with findings and recommendations
•Multi-agency and single agency action plans produced.
•Outcomes shared with family.
•Communication and media strategy agreed by LSCB.
•SCR publication or other review findings reported in Annual Report
6 months
STAGE 3: LEARNING & IMPROVEMENT
(as outlined in the LSAB learning & review framework)
Embedding learning
•Partner agencies progress actions plans and this is monitored by LSAB
•Key messages are communicated as outlined in the communication strategy.
•Key messages feed into Multi-agency and single agency training.
Evaluation
•Partner agencies progress actions plans.
•Key messages are communicated as outlined in the communication strategy.
•Key messages feed into Multi-agency and single agency training.
•Audits to confirm actions and LSAB to ensure quarterly CRG monitoring meetings with chair to monitor action progress.