



# Comparing safeguarding review methodologies

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## Preface

This report is based on the evaluation of two safeguarding review methodologies employed in the delivery of serious case reviews. The work was commissioned by the Lancashire Safeguarding Board and aims to evaluate the benefits and deficits of each model with a view to implementing the Welsh methodology in future adult and child case reviews.

One of the most important but also most time-consuming and costly activities undertaken by Lancashire Safeguarding Children Boards (LSCB) and Lancashire Safeguarding Adult Boards (LSAB) is the conduct of case reviews – Serious Case Reviews (SCR) in respect of children and Safeguarding Adult Reviews (SAR) in respect of adults.

Lancashire is a large county with a big and diverse population. In line with national trends, the volume of SCRs has risen over the years but Lancashire would appear to be a statistical outlier in terms of the rate of reviews and the sheer number this results in. With the implementation of the Care Act 2014, we refreshed our systems for SARs and, as agencies became more familiar with the criteria, we began to receive an increasing number of referrals. We manage our business in a combined unit serving both Boards and the pressures resulting from referrals for reviews, both on the Boards and on agencies, was palpable.

At the same time that the Wood Review was considering SCRs nationally, we were reviewing our own procedures and methodology for both SCRs and SARs. This was driven by the need to identify learning as early as possible, manage the demand that the completion of case reviews places on all agencies, and both the financial costs and administrative resources being taken up by these activities.

Having looked at a range of methodologies in use currently, we made a decision to start to use a customised version of the Welsh Government approved methodology. We offered training to staff from member agencies in the hope that we could then draw Chairs and Reviewers from a local pool. We had a good response and have now run the course several times.

The nature of our area – a large county with 12 District Councils; 6 CCGs; 7 Hospital Community Trusts; 3 Police divisions; 3 Children's Social Care localities; and a big geographical spread – means that it is usually possible to identify trained people who have had no operational or managerial involvement to act a Chair. Our aspirations to find Reviewers proved to be unrealistic due to capacity to create space to do the work alongside the "day job" and we soon recognised that we would need to continue to recruit reviewers from outside our own workforces.

Over time, we have amended the Welsh Model in the light of our experience. At the outset, we recognised the need to evaluate the outcome of these changes and the report, which follows, presents the findings. In response, we have accepted the recommendations and made further changes. At the point when we commissioned this work there were insufficient SARs to do a comparative study so the work focussed on SCRs. We feel however that the findings are entirely applicable to both. If the opportunity arises, we would like to do further work to validate this view.

We are grateful to the researchers and the work has had positive impact in promoting change.

**Jane Booth, Chair of the Safeguarding Children and Adults Board**



# Comparing safeguarding review methodologies

An evaluation of the Traditional and Welsh review methodologies in Child and Adult Serious Case Reviews

## Introduction

In 2017, Lancashire Safeguarding Board made a decision to implement new methodologies for conducting Serious Case Reviews in Lancashire Adult and Child Serious Case Reviews. They have traditionally used a standard case review methodology (referred to as the Traditional process in this report), but have implemented the Welsh method in more recent reviews, and wanted to explore the benefits of using this new methodology. An evaluation of the two different approaches was commissioned to understand the impact of using the new methodology on the reviews produced and the cost benefit of implementing the Welsh model. This report details the findings of the review.

## Background

Local Safeguarding Children's Boards are responsible for initiating a Serious Case Review (SCR) in circumstances where there has been a death of a child or young person and abuse or neglect is known or suspected, or where there has been a serious injury and there are concerns about inter-agency working. The purpose of the Review is to:

- Establish whether there are any lessons to be learnt from the case and from the way in which local professionals and

## Key Findings



The evidence points to significant advantages of the Welsh model compared to the Traditional Model at three levels: clarity of purpose, resource (time), and economic cost.

The data triangulated (interviews content analysis and economic costs) suggests the Welsh reports are shorter in length (whilst not losing rigour and clarity); are significantly less resource intensive, and costs less to commission.

On average, the Welsh model can produce a report in a quarter of the time required for a Traditional Report and at one third of the cost.



organisations worked together to safeguard and promote the welfare of children and young people.

- Identify clearly what those lessons are, how they will be acted on, what is expected to change as a result and within what timescale; and
- As a consequence, improve inter-agency working to better safeguard and promote the welfare of children and young people.

The Care Act 2014 comes into force in April 2015 and creates a new legal framework for Adult Safeguarding. Section 44 of the Act requires local safeguarding adult boards (SAB) to arrange a safeguarding adult review (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 person at risk. It places a duty on all Board members to contribute in undertaking the review, sharing information and applying the lessons learnt.

There is no single prescribed methodology for conducting a serious case (adult) review. Traditionally the SCR or SAR has followed a process (which is described later in this report) rather than being underpinned by a model, and has consisted of a number of steps which must be followed to develop the review. However, a range of models have been utilised by different safeguarding boards across the UK, including:

**SCIE Learning Together (LT):** developed during the Working Together consultation period. This method incorporates context into the case and includes practitioner contributions

**Root Cause Analysis (RCA):** Aims to use systematic analysis to explore beyond individual involvement in a case, and understand the underlying causes and environmental context to establish how this has caused the incident to take place.

**Significant Incident Learning Process (SILP):** Uses a broad range of views on the case from families, frontline practitioners and managers. Includes review of agency reports and a 'learning event' and 'recall session'.

**Appreciative Enquiry (AI):** This method seeks to create a safe, supportive environment, whereby the positive aspects of a case are reviewed and the failures explored with a view to moving forward and finding solutions for future cases.

**The Welsh Model:** This involves several interrelated aspects including a multi-professional learning event to understand the events of the case, and the use of case practice. A review also includes a timeline of the events, which can either be a concise or extended review depending on the circumstances of the case.



The focus of this evaluation is a comparison of the Traditional case review process and the use of the Welsh model to carry out a review, and the impact this has on the outcomes.

### Methodology

This evaluation used a three-stage approach to gather a range of data regarding the use of the Traditional process and the Welsh methodology for conducting safeguarding reviews. This approach comprised:

**Strand 1:** Face-to-face interviews / telephone interviews with staff members who have been involved in delivering serious case reviews using both the Traditional and Welsh models.

**Strand 2:** Content analysis of the final review documents produced with three Traditional process SCRs and three Welsh model SCRs.

**Strand 3:** Development and administration of an online survey using Bristol Online Survey (BOS) software to gather data on the time and cost associated with producing the Traditional process reviews and the Welsh model reviews.

Data from these three strands has been used to build a picture of the differences and similarities of the two methodologies.

#### Strand 1: Interviews

Interviews were conducted with nine members of staff who have been involved in both Traditional and Welsh methodology serious case reviews. These interviews were either conducted face-to-face or via telephone, depending on availability and location of the interviewee. Interviews were recorded and transcribed before thematic analysis was utilised to draw out the main themes from the data.

Interviewees were asked about their experiences of using the different methodologies, focused around three main aspects: Structure of the review, Governance and the Outcomes / Outputs of the review.

#### Strand 2: Content Analysis

Documents relating to six serious case reviews were gathered, three of the reviews were based on the Traditional process and three were based on the Welsh model. These documents were read and analysed in terms of structure, length and content.



### Strand 3: Online survey using BOS software

A questionnaire was developed using BOS, to establish the amount of time being spent on different aspects of the serious case review, using the Traditional process and the Welsh method. Participants were asked how long they spent completing five aspects of the review process: the IMR, the chronology, reviewing files, making phone calls and attending meetings. They were also asked if anyone else in their organisation had worked on the case and how much time they had spent overall on the case. Details were requested of salaries for the participant and for other members of staff involved in the review. This information allows for a cost analysis of the two processes to be completed, and enables a comparison of the time / cost of the two methods. The questionnaire was sent to sixty members of staff who had worked on at least one of the six case reviews identified in this evaluation.

## Findings

### Strand 1: The Interviews

The findings are presented under the three main themes explored in the interviews: The structure of the review, Governance of the process and the Outcomes / outputs of the review.

#### Structure of the review

##### *Traditional process*

Participants were asked to describe the Traditional process used for conducting SCR/SARs, and explain how this worked in practice.

On commissioning of the review, individual agencies are contacted to provide information and asked to complete an Individual Management Review (IMR) for their agency. An author is appointed to conduct the IMR, and this person should be a senior manager who has the relevant competencies to undertake the review, but who has not been directly involved in the case under review, e.g. from outside the team or locality involved in the case. Staff who have been involved in the case are purposefully excluded from the process, to ensure independence.

The IMR incorporates the chronology, which is predominantly a paper based exercise drawing together all the case documentation into a narrative record of events. As one participant stated

*“It’s a database dump of case involvement – no discussion”*

*Participant A*

The chronology was considered labour intensive, often lacking a tight focus. It was not unusual for an agency to be asked to complete a chronology covering the whole life of a person,



subsequently finding that only part of it had been included in the final review report. This was judged a waste of time and resources, and was frustrating to those who had completed the work. Further, although agencies were asked to produce all their documentation regarding a case, the interpretation of this varied widely amongst agencies, for example some would document the minutia of the case, which was considered excessive, e.g. called Person A on 21/10/2015, no answer, or went to lunch at 12.15-12.45. This situation partly arose because there was a lack of clarity around the period to be included in the chronology, but also as a result of the ethos surrounding the Traditional process, which was viewed as a 'deficit model'. Agencies felt the process was designed to apportion blame, and this tendency could lead them to include excessive details trying to 'cover their back' or deflect blame to another agency involved in the case.

The purpose of the review was to identify gaps in practice or poor practice and make recommendations to rectify this based on the findings. There was no emphasis on exploring good practice, or how this might be rolled out to other agencies.

*“More on identifying gaps, but you would never talk about good practice”*

*Participant D*

On completion of the IMRs from all agencies, the information was reviewed and integrated into an overview report to be discussed by senior managers at group meetings. This cumulative document was often an enormous and complex piece of work, described by one participant as a 'Bayeux Tapestry' of information, which could quickly become unwieldy. The independent author then takes on the task of extracting the key themes and recommendations associated with the case to produce the final overview report.

There was a recognition that Traditional SCRs followed a process, rather than being based on an underlying model, and this could lead to a lack of consistency in the review report.

*“Lots of minutiae and every author does it slightly differently, and you never know which methodology they're using. It doesn't have a method, it's just a process”*

*Participant B*

The review report could often reach 100-200 pages long, and although it was recommended that its production be completed in under 6 months, the reality was often closer to 12-18 months.

### *The Welsh Model*

By comparison, the Welsh Model was considered a much more inclusive model, with significant practitioner input and a learning culture. As with the Traditional process, an independent author



was employed to write the overview report, however as discussed later in this report, the author worked in a more structured but inclusive manner to report the findings of the review.

Individual agencies were asked to complete a timeline of the key incidents and learning around a case, rather than a chronology. This was more focussed on significant events, which affected the case vis-à-vis a chronology, which often includes a lot of extraneous information. The timelines are tightly focused on the period being reviewed, usually either twelve months (concise timeline) or twenty-four months (extended timeline) and are usually much shorter than chronologies. This focus makes the process of constructing the timeline less time and resource intensive, and therefore less costly.

*“They are very succinct; they’re very relevant, very proportionate”*

*Participant C*

There were some initial concerns that the more concise timelines would lead to information being missed from the review, but these issues have not materialised, and there is always an opportunity to go back and ask for more information or clarity on the content of the timeline if necessary.

*“It’s not anywhere close to the level of work that was required in and IMR, and I’ve seen that we’re still able to highlight the significant events and pull out the analysis as much as we were with the Traditional IMR”*

*Participant F*

Nevertheless, some participants still felt there was a need for a chronology to be included in a review in order to set the parameters for the review author, and had adapted the Welsh model to incorporate a short chronology.

*“Without any sort of chronology it was difficult to set the parameters for the reviewers....we fairly quickly found if you stuck with the Welsh model template you didn’t really get the story of the case. We’ve let the authors of the report write in a more flowing and flexible fashion, and it evolved over time.”*

*Participant A*

A standard template is used to capture the key incidents, and also good practice, identification of gaps, and anything that is not expected practice. At this stage, individual agencies are already undertaking some analysis to pull out the key learnings and practice, before collation of the individual timelines into one document moving forward.

Once individual agencies have completed their timelines, these are collated into an overall timeline of the case, highlighting important and impactful events across agencies. The focus of





this is to identify gaps in practice, but also to highlight good practice and explore instances where practice has worked well and had a positive impact. Staff were subsequently invited to attend a practitioner event, whereby they could discuss their involvement in the case, and offer explanations to some of the actions (which previously would not have been explored in the Traditional process). This enabled staff to explain the context in which their actions and decisions were made, and provide additional insight into the timeline. The practitioner event was considered to be a very positive aspect of the Welsh model, and one where there was an openness to learn and move forward. Interviewees reported that was a high degree of support from the safeguarding team, and other agencies, at these events, however there was also a high level of challenge:

*“So one of main things is high support, high challenge, so we will compete those chronology or time lines in the first instance, alongside somebody from the network, and constantly we’re challenging.”*

*Participant C*

The practitioner event brought together frontline staff from across agencies, and predominantly included practitioners rather than managers, contrasting with the meetings held as part of the Traditional review process. The greater involvement by practitioners in the case review was felt to increase staff ownership of the process, and enable a better understanding of the events and outcomes of the case, for example

*“Someone might say “I just felt there was something wrong about that and that’s why I took the approach I did” or “I wish I’d known more about this at the time, but now I can clearly see that something had been done about it” you know that kind of thing”*

*Participant D*

The event also helped to build a rich picture of the case and the actions taken by agencies, rather like piecing together a jigsaw

*“It was like a story, but not the case’s story, it was the agencies’ story”*

*Participant D*

Subsequent to the practitioner event, an overview report was collated by the independent author, with input from the staff utilising a more collaborative approach. The report was usually much shorter than that produced via the Traditional process, often only 8-12 pages and ideally less than 30 pages. It was written using a thematic approach rather than storytelling, and the emphasis was on swift publication within 6-8 months, making timely delivery a key aspect of this model.



Panel meetings would take place before and after the practitioners event and the panel members, usually reasonably senior managers who could speak on behalf of their agency, would discuss the report and recommendations before they were presented to the board.

## Governance

### *Traditional process*

In the Traditional process, the independent author of the review was very much considered the owner of the review, and took the decision as to how the report was presented and what was included in the report. Authors were selected from a small pool of people who were deemed suitable for the role, and these often had a Domestic Homicide Review (DHR) background or were practitioners in the area of forensics. This resulted in a narrow range of background experience and expertise of the people employed as independent authors. There was customarily no official contract in place, or only a one-page contract with the author, and the charges made for authoring the review were made on a daily basis, ranging between £500 and £750 per day. Whilst there was guidance on the timelines for delivery of the report (to be within 6 months), this was often exceeded due to delays, either under or beyond the author's control, and could lead to a spiralling of costs.

*“The IMR can drift and report format is lengthy. In the Welsh model you can set out your meetings and the dates and relevant panel dates”*

*Participant B*

Agencies involved in the review process often felt detached from the process, and agency staff who had been involved in the case were completely excluded from constructing the IMR, as one interviewee stated:

*“The only thing that would make you know you know that your case was subject to a serious case review was someone would seize and seal your file and then you wouldn't hear anything else until it was published”*

*Participant A*

However, one area that was felt to be more robust in the Traditional process compared to the Welsh model, was that of IMR and chronology sign off. These were always sighted and signed off by senior managers, e.g. directors or assistant directors, who then had an overview of the process. The Welsh model does not stipulate sign-off of the timelines, and although it was believed most agencies would review their timelines with their own senior management before submitting them, this was an assumption. Some participants stated they were not happy with



this situation, and one explained they had put an extra step in place whereby senior management was included in the process before sign-off of their documents.

Another influential aspect of the Traditional reviews was the involvement of Ofsted in the process for child reviews. This had a pronounced impact on what was included in the review, and one participant explained

*“The old process was very much driven by Ofsted...the reports were graded, if you remember they were rated by Ofsted so the stakes were higher”*

*Participant E*

This resulted in a one-size fits all approach to ensure that all aspects possibly affecting the Ofsted grade were included, but was considered a tick box exercise with no proportionality to the actual case.

Recommendations from Traditional reviews were often numerous, with sometimes more than thirty recommendations included in the report. These were single agency and multiagency recommendations, and due to the large size of Traditional review reports, they were often the first (and sometimes only) section to be read. However, there were no action plans attached to the recommendations, and it was the role of the board and agencies to put in place plans to achieve these recommendations. Some of the report recommendations were considered unachievable by local partners, e.g. ones that stated national legislation needed changing, and this caused frustration, and disengagement with the outcomes.

### *The Welsh Model*

The Welsh model also uses an independent author to collate and write the final review report, however these authors were selected from a much larger pool of potential authors with a wider range of experience and background. This was considered a positive move, and the wider range of viewpoints was welcomed. As with the Traditional process, there was a need to balance the independence of the author with the breadth and depth of their experience in a particular area. Initially there were concerns that the number of authors who were familiar with the Welsh model was limited since only authors trained in the Welsh model were employed. However, as the number of potential authors attending the training has grown and more people have become aware the model and its implementation, so this pool had expanded considerably

The review process is now put out to tender, and authors bidding to conduct a Welsh review undergo a more rigorous ‘semi-interview’ process to discuss their background and expertise. If selected potential authors are also subject to much more rigorous contracts; these contracts

## Comparing safeguarding review methodologies



include performance measures, stipulations around not outsourcing the work and include a cost ceiling to avoid spiralling costs. They are also managed on a monthly basis, unlike in the Traditional process where and author could be seen at the outset of the review and again at the conclusion of the process. This allows the identification of any issues, or rectification if the review is moving off track, and enables faster resolution of any problems that might arise.

Training for agency staff completing timelines was also considered important. Agencies were asked to nominate someone from their organisation to complete their timelines, and this would depend on the agency and the timeframe. However, training in the Welsh method is offered to the nominated people in the agencies to ensure that they understand the process and are able to complete the timeline to a high standard.

Participants highlighted the importance of the practitioner event in the Welsh model, but also touched on the issue of who should attend the event. It was considered imperative that the practitioners attending from agencies had a comprehensive understanding of the case, and their agency's involvement, and that they were consistent in their attendance at the events.

*“If they don't send the same person, they don't understand the process of the case and don't have continuity.”*

*Participant A*

Further, this person must be able to report back on the proceedings of the practitioner event, where relevant, otherwise

*“There is a risk of the learning being limited to those who are at the event”*

*Participant A*

Participants were asked about the processes in place if there were disagreements or conflicts between practitioners. Mostly this situation was worked through at the practitioner event until agreement or a majority consensus reached, although sometimes one agency would ask another for more information before proceeding.

*“That is why it is important to have consistency. We had one agency who did not agree, but they weren't even there....if there's disagreement we let them go back to it, but in the end we go for a majority decision and note who wants what.”*

*Participant A*

In the event that no agreement could be made, there was an escalation process or professional disagreement policy, which could be implemented to take the issue forward if needed.



The area of potential conflict between practitioner involvement in the review, and criminal proceedings / disciplinary action that may need to be undertaken was also discussed. It was acknowledged that this was a 'difficult' area, and there was a need to ensure professional accountability.

*“But that professional accountability is there regardless of whether you’re doing a serious case review or not”*

*Participant E*

None of the interviewees had actually been faced with this issue to date. However, if the situation arose this would be addressed, in a separate and entirely independent process to the case review, and that would be made clear to practitioners involved.

*“You would have to be very clear about the distinction between issues that you’re dealing with under management capability disciplinary and a serious case review which is the learning process”*

*Participant E*

However, participants also recognised the need to support practitioners involved in such a process

*“You know you’re doing that [supporting] even if there was a capability issue. I don’t think you can underestimate the impact that a child death or a serious injury has on a staff member, you know regardless of whether there were issues in relation to their practice.....and supporting people through attending something like the practitioner event....you’d still want their contribution.”*

*Participant E*

It was suggested that in other areas, which had moved to the Welsh model, there was some friction with local coroners who expected to use the findings of the SCR review in their own process and found the Welsh review did not provide the level of detail they required. One participant agreed there had been some friction with the coroner over the content of a review

*“When you take it to the coroner and the coroner is saying, “This doesn’t look like I expect it to look, it doesn’t tell me who did what or when, and I’m going to have to call these people as witnesses if the SCR doesn’t give that information.” And I have to ring her to tell her that wasn’t the job of the SCR, and she is very unhappy.”*

*Participant A*

However, none of the other participants in the interviews had found this to be an issue, and in fact were disconcerted that this had been a problem in other areas.



*“Actually it feels a bit uncomfortable with the coroner dictating the model. The coronial process should be a completely independent process to an SCR or SAR”*

*“Certainly our coroners are aware of our model and are quite happy with it”*

*Participant G*

One area of disparity amongst the interviewees was whether actions identified in the review process were being implemented to change practice more quickly using the Traditional process or the Welsh method. Some interviewees felt that agencies were delaying implementing changes under the Welsh model until the review was published, and therefore although the overall review took longer using the Traditional process, implementation of changes in individual agencies was faster.

*“I’m not sure in every case we are instigating actions in parallel.....Sometimes were waiting for the review to be completed to then look at it to see how it applies to organisation”*

*Participant C*

Conversely, other participants felt the Welsh review was timelier in delivering change.

*“I don’t know that I’d agree with that. I think a lot of the time previously was focussed on producing that report and getting your IMR, whereas now you do think earlier on in the process what you need to change, and you do your rapid learning....so if there’s bit that an organisation needs to look at immediately, you do that”*

*Participant E*

*“Sometimes with the [Traditional process] by the time the recommendations came out they were already out of date because there had been changes to national policy or things like that”*

*Participant B*

*“I think the new methodologies have more potential to be effective, as long as we get agencies involved in self-criticism along the way and not just waiting to be told what to do. They are more focused, more timely, they have engaged with practitioners, and they’re really about now. Whereas the old ones were so old when we got them everyone had moved on and lost interest really.”*

*Participant A*

There was however consensus that across both methodologies formulating SMART recommendations and producing impactful action plans and outcomes from the review was an area of weakness. It was not always clear how recommendations could be turned into the achievable actions needed to change practice positively. However, the Welsh methodology implements a more systematic approach to recommendations, whereby the report might state



*“This is the recommendation and this is the outcome we are wanting to see”*

*Participant D*

Recommendations from the Welsh review focused on multiagency outcomes and it was suggested that implementation of these should be undertaken thematically at a strategic level, with the individual agencies implementing the operational processes which may have been identified throughout the review. However, one interviewee felt they were missing opportunities to pick up single agency learning

*“If there was anything missing it was added in the SCR, but now we’re only looking at multiagency messages, and I’m not happy with that. I want to know what the agencies are doing about their own practice and not just what we’re doing as a board...Often what’s gone wrong on a multiagency basis is in the context of poor preliminary practice in the single agency”*

*Participant A*

And

*“It leaves me feeling that if we’re not careful we let agencies off the hook both in terms of looking at their own practice and taking a view about the quality of it.”*

*Participant A*

Further to this, and pertinent to both methodologies, is the concern that some sub-groups do not recognise their governance and accountability function strongly enough. They see themselves as a functional group tasked to make sure the review is completed, is of a good quality and then ensuring the learning outcomes and action plans are put in place. The interviewee stated regarding the ethos of these groups:

*“This is what we have to do, so let’s get it done. In terms of governance I don’t think this is strong enough when it comes to something like a case review subcommittee...I don’t think they see it in terms of holding themselves to account”*

*Participant A*

In both methodologies, reviews can be subject to delays due to coroner’s reports and court proceedings; although participants worked to build close relationships with other parties involved in a case and usually were able to work around any delays. However, some had experienced inconsistencies when working with other parties, e.g. CPS or senior investigating officers as to what they were willing to allow as parallel processes.

*“Rarely has anyone involved been a witness to the facts, so corruption of evidence is unlikely, but some investigating officers won’t take the risk and in these situations delays can occur.”*

*Participant D*



## Outputs / Outcomes

### *Traditional process*

Reports produced using the Traditional process are often lengthy and considered by some to be inaccessible. As previously highlighted, due to the independent author's ownership of the document there can be a wide variety of styles and content in the final report. This was seen in the review documentation received pertaining to the six case studies, where there was little clarity regarding the structure or content of some of the reports and finding particular data was not easy.

Interviewees consistently stated that the reports were too long, and that it was difficult to read the whole document without losing focus. Reports included so much information that it was sometimes impossible to see the 'wood for the trees'. In spite of the fact that the rigorous approach to gathering the data resulted in large amounts of information and very detailed output, some felt that the output still didn't get to the heart of the problem as it only included recorded practice, lacking in any contextual information.

Further to this, huge amounts of personal information could be included in an overview report, much of which had to be redacted before the report was made public. There was a fear that those involved in the case and their offences would be identifiable if the information was not removed, and this could result in a breach of the law. Therefore, large parts of reports were sometimes deleted before publication, making the published report more ineffectual.

An additional frustration was the recommendations produced, which were often numerous, sometimes between 20-30. These included single agency and multi-agency recommendations, however they were rarely SMART (Specific, Measurable, Achievable, Realistic, Time-based) and some were very general, unrealistic and not easy to implement, especially at a local level e.g. changing national legislation, and. The reports offered no action plan attached to these recommendations:

*“Reports weren't thinking in terms of how are you going to implement the recommendation you're making, or being very clear about what the recommendation was, so they weren't clear what the requirement was”*

*Participant D*

It was only after the report had been presented to the board that they would then take on the responsibility of developing action plans. These were then passed back to the agency or agencies to implement the plans and best decide how they would make the required changes.





The action plans were extensive, but not always strategic, and they were not monitored or RAG (red, amber, green) rated to assess impact or record improvements.

*“Agencies would take them away and had this mad frenzy to try and get as much done, or produce as much evidence as they could”*

*Participant D*

### *The Welsh Model*

The outputs from the Welsh model SCR/SARs were much shorter, and more succinct. The report was supplemented by a short 1-2 page learning brief which was a summary of the key findings and these were published online. A learning brief was always produced for practitioners, and sometimes an additional learning brief for senior managers if it was relevant.

The brevity of the reports enabled them to be more universally accessible, and interviewees considered there was a greater likelihood they would be read in full. A further benefit was that some interviewees felt the shorter reports gave more prominence to the ‘family’s voice’. Both methods recognised the importance of engaging with the family and including their views or ‘voice’ in the report wherever possible, however, it was felt to be more prominent in the shorter report as there was less other information or ‘noise’ to swamp it.

Initially the brevity had caused some consternation as to how the shorter reports would be effective and how they would be viewed outside the safeguarding team:

*“I have to confess the initial reaction was, these can’t be good enough because they’re so short”*

*Participant E*

*“.....someone has just died and this is all we are getting”.*

*Participant D*

The length of the Traditional process report was seen as a ‘safety blanket’, which assured readers all relevant areas had been covered thoroughly.

*“I don’t know why, I think it was a cultural thing for us”*

*Participant E*

Nevertheless, as more people have become aware of and familiar with the Welsh model this has become less of a concern, as they have been reassured that all the relevant information is still included. Further, when visiting the family involved in the case

*“It’s much easier to talk through a ten page report that they understand, they can read themselves, rather than going with a massive lengthy tome of a document.....my test*



*is, anybody who doesn't know anything about that case should be able to pick up the report, read it and understand the case completely"*

*Participant E*

The reports from the Welsh model have far fewer recommendations than those of the Traditional process, however they do also include outcomes. The recommendations themselves are more realistic and 'SMARTer', although they do focus mainly on cross-agency actions, as opposed to single agency actions. This was viewed as a potential negative of the Welsh model, as some interviewees were concerned that if there were individual agency recommendations these were not necessarily captured in the report. Single agencies were expected to address issues for their own agency without recourse to the board, and some felt that made monitoring outcomes more difficult, and expressed concern there was an interlinking between individual agency failings and wider inter-agency failings, which could be missed.

*"Sometimes a problem at interagency level has its roots in an individual agency, and if we do not include single agency recommendations in the report we risk losing the opportunity to change underlying factors which could have an impact on interagency working."*

*Participant G*

There was a recognition also with both the Traditional and Welsh models that action planning and making changes based on recommendations needed to get better.

*"We've done these reports and so what, yeah it's great but what do we do as a result and how can we measure that"*

*Participant E*

One participant suggested it might be preferable if the reports produced findings rather than outcomes

*"If we're told this is a finding then we can think what do we need to do to change that situation? Whereas what you get is a recommendation, e.g. the board should develop a protocol regarding concealed pregnancy. So you do, you write a protocol"*

*Participant A*

Another agreed that the specific recommendations could result in a tick box exercise, whereby all the recommendations are completed and have a green RAG rating on the spread-sheet, but practice has not actually shifted, and the outcomes have not been met. To rectify this situation they are exploring how the quality audit team can work with the safeguarding team to ensure outcomes are achieved.



*“So if the recommendation is to change how we do routine enquiries, then that becomes a multiagency quality audit which would be re-visited in 12 months’ time. So we can actually see if any of the general learning points had any impact on practice.....So every action that comes out, every agency will try to do that and then we come back to the multi-agency view on has this had the desired outcome? It cuts out the middle man of hundreds of little action plans and trying to chase whether they’re red, amber or green”*

*Participant H*

Further, early stage plans are being developed for members of the safeguarding team to visit organisations, with a view to better understanding the changes they have made and the effect on staff. Another participant also recognised the need to

*“Deal with themes strategically rather than operationally.....and need to look wider to see who is best to take forward themes and implement them, for example Public Health”*

*Participant I*

The communication strategy from both models was tailored depending on the review. However, there seems to be greater strategic consideration of the communication strategy with the Welsh model, although it was unclear whether this was due to the model or the current climate around the media. It was suggested that the Traditional process gave the press numerous salacious details, which could be misinterpreted or sensationalised. With the more recent reviews, greater thought is given to the communication and media strategy at the outset of the review, and there is a focus on preparedness. It was felt the media may be more likely to read the shorter Welsh reviews

*“The press like it for obvious reasons [shorter and more user friendly], which is sometimes a disadvantage because they’ll actually read it”*

Therefore, a more proactive strategy was required, with all agencies aligning their communication strategy to give a single story. In addition, there is more in the way of education around some of the issues identified in recent reviews, e.g. campaigns around concealed pregnancy or co-sleeping.

## Conclusions

The interviews highlighted that the Welsh model was felt to be much less resource intensive, with shorter timescales, more accessible outputs and outputs that are more actionable.

The Welsh model was becoming more accepted as people gained awareness of the methodology, however training was considered important to raise the profile and ensure all staff understood the ethos and practice used in Welsh reviews.



Some participants felt there was a need for a short chronology to establish the context and focus of a review, however none believed this needed to be as long or detailed as that found in Traditional methods of SCR reviews. The Welsh model has sufficient flexibility for this adaptation to be incorporated if it was considered beneficial in a particular review.

The practitioner event was well received and appreciated for the inclusivity, support and co-production it enabled. It was noted that there needed to be a consistency / continuity of attendees at practitioner events to ensure the complex picture of a case was understood.

The structure of the Welsh model has removed the need for senior managers to sign off reviews before they go to the board; some staff felt uncomfortable with this process. However, some had adapted the methodology to include senior staff sign off and ensure there was a greater oversight of the review before it was completed,

The outcomes from the Welsh reviews were considered an improvement on those from Traditional reviews, as they were 'SMARTer' and less numerous. However some concerns were raised that single agency actions were no longer included in the review, which focussed on multiagency recommendations, and these still needed to be noted and actions reported. Further, there was still work to be done in monitoring outcomes and ensuring practice changed as a result of the recommendations, both single and multiagency outcomes, and it was felt that neither model had, as yet, successfully achieved this.

Overall, the Welsh model was well received as an evolving work in progress, with on-going adaptations and flexibility key to its success.



## Strand 2: Content Analysis of Documents

The six case review reports / learning briefs were analysed in terms of their length and content

Case	Report length (pages)	Average (pages)	Report word count	Average (word count)
Child N (Traditional)	66	53.3	36,478	23167
Child O (Traditional)	57		19,746	
Child G (Traditional)	37		13,276	
Child LA (Welsh)	25	29.6	13,622	11253
Child LC (Welsh)	14		5,109	
Child LE (Welsh)	50		15,028	

Table 1: Case documentation

Case	Readability score <sup>1</sup>	Grade level <sup>2</sup>
Child N (Traditional)	38.7	13.3
Child O (Traditional)	41.9	13.0
Child G (Traditional)	37.6	13.3
Child LA (Welsh)	39.1	14.0
Child LC (Welsh)	47.1	11.7
Child LE (Welsh)	46.3	11.6

Table 2: Ease of reading scores

<sup>1</sup> Readability score is taken from Word reading statistics: Flesch Reading Ease test.

This test rates text on a 100-point scale. The higher the score, the easier it is to understand the document. For most standard files, you want the score to be between 60 and 70.

<sup>2</sup> Grade level is taken from the Word reading statistics: Flesch-Kincaid Grade Level test

This test rates text on a U.S. school grade level. For example, a score of 8 means that an eighth grader can understand the document. For most documents, aim for a score of approximately 7 to 8.



### Strengths and weaknesses of the reports

The content analysis is structured addressing overall aspects of the reports and then focussing on the information in the introduction, main body and report conclusions

#### *Overall report*

All except one report, had a front cover; this was effective in promoting uniformity of the reports and supporting confidentiality of contents.

Reports produced from reviews utilising the Traditional method were generally longer, and had a higher average word count than those from the Welsh model reviews, see table 1. Whilst the length of the report clearly articulated a considerable amount and depth of information, it could be argued that some of this detail was extraneous to the outcomes and recommendations of the review. The Welsh review reports were concise and focussed, and the absence of detail did not detract from the outcomes and/or recommendations.

Review LE and LC had a higher readability score (meaning they are easier to read) and also a lower grade score (which means they are easier to understand), see table 2. This suggests they would be acceptable to a wider [lay] audience than just health and social care professionals.

There was no standardisation of the font size and type, or page layout and margins in any of the reports.

#### *Introduction*

Five of the six reviews included an introduction, which was useful for placing the case in context. There was a lack of consistency in the length and content of the introduction; however, the shorter introductions in the Welsh model reviews were able to convey the same message in a more concise manner.

#### *Main body of report*

With reference to the main body of the reports, neither model adopted a consistent approach, consequently the final reports strongly reflected individual author style and preference. The Traditional method reports were extensive and wide ranging and narrated all events in the case (some events perhaps not entirely relevant to the significant issues), whereas the Welsh reports by virtue of the practitioner events focussed strongly on the significant elements of a case.

In both models, whilst similar information was contained therein, there was no systematic approach to the overall format and content of each section. This made navigation through the document more complex and time consuming. There is the potential for the stylistic elements to detract from the content of the report.



The Welsh model reports benefitted from the use of practitioner events in a number of ways:

- Identified which events were critical in the context of the SCR
- Promoted co-production and multi-professional learning
- Enhances critical analysis and reflexivity as a result of learning in action and on action
- Scaffolds the overall rigour of the report by the nature of co-production
- Enriches individual reflection and professional development needs

### *Report conclusions*

There is an absence of systematic approaches, and a wide variation in the presentation of the conclusions and recommendations.

In the recommendations, there are a mix of recommendations, statements, and observations, and there is a deficiency of 'SMART', actionable and achievable (no set time windows) recommendations. The occasional recommendation, whilst laudable, would appear unlikely to be achievable (the recommendation to make a formal request to government, which could have recommended a formal request to the responsible government agency, i.e. Ofsted which is more likely to be achievable).

Unrealistic recommendations are noted, for example a recommendation to amend legislation.

### Recommendations – to be included.

- One instance of good practice noted was the inclusion in one report of a chair's foreword, from the report for Child O, and this was an effective way of producing a summary of the report; this should be good practice in all reports;
- Standardised template or guidance on setting out document layout, for example specific headings, sections, font, anonymisation, etc.;
- Guidance on what should be included in each of the sections;
- Inclusion of a contents page with relevant headings, e.g. as laid out in the report for Child O;
- Nomenclature to be included in appendix, or as a short section in the introduction, e.g. who is involved in the case;
- Glossary of terms and acronyms;
- Consistent use of tense when writing;
- Incorporate a 'statement of independence from the case' to be signed by the reviewer, e.g. as included in the report for Child LA



## *Conclusion*

Although in general the Welsh model review reports are shorter and more succinct, the clarity of the analysis and explanation of the case, it is suggested, is not weaker. Indeed it is suggested that the absence of unnecessary detail allows the reader to focus on the essential and important factors relevant to the review.





### Strand 3:

The BOS survey was developed and sent to members of staff who were involved in at least one of the six cases identified above. We received responses from 24 participants in the survey; however, some people were involved in more than one case, therefore we calculated the response rate using the expected ‘sets of data’ regarding time and costs. From a maximum of 61 sets of data (figure provided by the funders of this evaluation), we received 37 responses, giving an overall response rate of 60.66%. Breaking this down into the response rate for each of the six cases, we looked at the number of people who worked on the case (figures supplied by funder) and the number who responded to the survey.

Case	No. respondents of survey	in	No. of people involved in case	Response rate for this case (%)
Child N	7		14	50
Child O	5		10	50
Child G	9		14	64.3
Child LA	5		7	71.4
Child LC	4		9	44.4
Child LE	7		7	100
<b>Overall response rate</b>	<b>37</b>		<b>61</b>	<b>60.7</b>

Table 3: Response rate for survey and individual cases

Data collected from the survey was entered into MS Excel for analysis and calculation. Information was collected on the number of hours the respondent spent and the cost of their time for each review they undertook. Additionally they reported the number of hours spent and costs of other people in their organisation who had taken part in the case review. Where there was missing data in the original data set, e.g. a respondent had stated they spent 10hrs in meetings, but had not given their salary costing for this, we used an average of the total data provided for that case to substitute in the missing data.

### Time spent conducting review

The time spent on each case is shown in table 4 for both respondents and other staff involved in the review. The average number of hours each person (combined respondent and additional) spent on the Traditional method reviews was 60.72 hours versus 17.55 hours on the Welsh model reviews: this was a reduction of **71.1%**. When looking at the average total hours by

## Comparing safeguarding review methodologies



method the Welsh model also produced a reduction in average hours of **74.5%** (from 663.67 hours with the Traditional method to 169.48 hours with the Welsh model).

	Traditional method			Welsh model		
	Child N	Child O	Child G	Child LA	Child LE	Child LC
<b>Total hours Respondent</b>	452.50	147.00	470.00	166.88	76.00	180.50
<b>Total hours Additional</b>	344.00	199.50	378.00	41.88	12.00	31.17
<b>Total hours</b>	796.50	346.50	848.00	208.76	88.00	211.67
<b>Average hours per person</b>	79.65	49.50	53.00	20.88	10.60	21.17
<b>Average hrs /person by method</b>	60.72			17.55		
<b>Average total hrs by method</b>	<b><u>663.67</u></b>			<b><u>169.48</u></b> <b>(This figure is 25.5% of the Traditional Model Average hours)</b>		

Table 4: Number of hours on case

### Hourly cost of conducting a review

We analysed the hourly cost of conducting each review and compared the average hourly rate for each of the methods, see table 5 below. This showed that the average hourly rate for conducting a Traditional method review was **38.16%** more than when conducting a review using the Welsh model. Is this due to a different reviewers; we hypothesize that the Traditional review authors may be middle/senior managers, whilst in the Welsh reviews staff may be practitioners on a lower salary?

	Traditional method			Welsh model		
	Child N	Child O	Child G	Child LA	Child LE	Child LC
<b>Total cost respondents</b>	<b>£14,184.02</b>	<b>£6,615.00</b>	<b>£22,343.00</b>	<b>£4,625.80</b>	<b>£1,866.46</b>	<b>£4,475.55</b>
<b>Total cost others</b>	£10,089.98	£8,977.50	£20,703.00	£1,337.37	£284.00	£772.93
<b>Average hourly rate</b>	£31.87	£45.00	£54.67	£31.93	£24.60	£24.80
<b>Average hourly rate by method</b>	<b><u>£43.84</u></b>			<b><u>£27.11</u></b> <b>(This figure is 61.8% less than the Traditional Model Average /hr)</b>		

Table 5: Hourly costs for case



### Total cost of completing review

Using the figures from the time and hourly cost for each case, we were able to calculate the overall cost of completing each review. These figures are shown in table 6, which includes the cost for each case, together with the total cost for the three reviews in each method, and the average cost for a review using each of the methods. Additional information on the cost of the reviewer and venue / food costs was provided by the funder of the evaluation, and included in the calculations for the cost analysis.

The total cost for completing the three Traditional method reviews was £209,497.65 compared to £41,329.73 for the Welsh model, giving an overall reduction of **80.27%**. We included a confidence interval<sup>3</sup> of 80% to account for outliers in the data, and this showed that even using the lower confidence limit for the average cost of the Traditional method (£55,866.12) versus the upper confidence limit of the average cost of the Welsh model (£16,531.90) gave a cost reduction of **70.41%**.

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<sup>3</sup> A confidence interval indicates the level of uncertainty around the measure of effect (precision of the effect estimate). Confidence intervals are used because a study recruits only a small sample of the overall population so by having an upper and lower confidence limit we can infer that the true population (in our case the cost) effect lies between these two points.

## Comparing safeguarding review methodologies



	Traditional method			Welsh model		
	Child N	Child O	Child G	Child LA	Child LE	Child LC
<b>Total cost (of responding team)</b>	£24,274.00 (7 of 14)	£15,592.50 (5 of 10)	£43,046.00 (9 of 14)	£5,963.17 (5 of 7)	£2,150.46 (4 of 9)	£5,248.48 (7 of 7)
<b>Total cost (of full team)</b>	£48,548.01 (14 of 14)	£31,185.00 (10 of 10)	£66,960.44 (14 of 14)	£8,348.44 (7 of 7)	£4,838.535 (9 of 9)	£5,248.48 (7 of 7)
<b>Reviewer cost</b>	£35,757.40	£13,737.28	£12,639.37	£8,809.50	£8,300.00	£5,454.28
<b>Venue / food cost</b>	£670.45	£0.00	£0.00	£106.25	£106.25	£118.00
<b>Final total for case</b>	<b>£84,975.86</b>	<b>£44,922.28</b>	<b>£79,599.81</b>	<b>£17,264.19</b>	<b>£13,244.79</b>	<b>£10,820.76</b>
<b>Total of model</b>	<b>£209,497.95</b>			<b>£41,329.73</b>		
<b>80% confidence interval</b>	£167,598.36 - £251,397.54			£33,063.78 - £49,595.68		
<b><u>Average</u></b>	<b><u>£69,832.65</u></b>			<b><u>£13,776.58</u></b> <b>(This figure is 80.27% less than the Traditional Cost)</b>		
<b>80% confidence interval</b>	£55,866.12 - £83,799.18			£11,021.26 - £16,531.90		

Table 6: Total calculated costs for case

### Controlling for hourly rate and time on case

Once we had calculated the actual for the six cases, we looked to calculate the difference between of the Traditional method and the Welsh model in terms of salary costs and time taken to understand which had the largest impact on the overall cost.

#### *Controlling for hourly rate*

Firstly, we analysed the data from each case by controlling for the differences in salary of individuals who took part in the Traditional and Welsh model cases. Using the lower average salary of £27.11/hour from the three Welsh cases, we re-costed the Traditional cases using this hourly rate, see table 7. This resulted in an average cost of £46,871.42 for the Traditional method compared to £13,776.58 using the Welsh model. Therefore controlling the salary per

## Comparing safeguarding review methodologies



hour still gave an overall reduction of **70.61%** in the cost when using the Welsh model to conduct a review.

It is important to control for hourly rate due to the significant difference in hourly rate found in table 5.

	Traditional method			Welsh model		
	Child N	Child O	Child G	Child LA	Child LE	Child LC
<b>Total cost (of responding team assuming average hourly rate of £27.11 for Traditional cases)</b>	<b>£16,735.98 (7 of 14)</b>	<b>£7,983.54 (5 of 10)</b>	<b>£18,238.34 (9 of 14)</b>	<b>£5963.17 (5 of 7)</b>	<b>£2150.46 (4 of 9)</b>	<b>£5248.48 (7 of 7)</b>
<b>Total cost (of full team)</b>	£33,471.95	£15,967.07	£28,370.75	£8,348.44	£4,838.535	£5,248.48
<b>Reviewer cost</b>	£35,757.40	£13,737.28	£12,639.37	£8,809.50	£8,300.00	£5,454.28
<b>Venue / food cost</b>	£670.45	£0.00	£0.00	£106.25	£106.25	£118.00
<b>Final total</b>	£69,899.80	£29,704.35	£41,010.12	£17,264.19	£13,244.79	£10,820.76
<b>Average cost by method</b>	<b><u>£46,871.42</u></b>			<b><u>£13,776.58</u> (29.39% of Traditional method)</b>		

Table 7: Cost/hr levelling

### Controlling number of hours on case

We repeated the analysis on the original data, controlling for the number of hours spent on each case. For this calculation we used the average number of hours taken to complete a Traditional method review (60.11 hrs) and substituted this figure into the calculations for the Welsh method reviews, see table 8. In this calculation with the number of hours controlled, the cost for completing a Traditional method review was calculated at £77,267.82 and £25,476.73 for completing a review using the Welsh model. Thus when controlling for the number of hours taken to complete a review, the Welsh model produced a reduction in overall cost of **67.03%**.

## Comparing safeguarding review methodologies



	Traditional method			Welsh model		
	Child N	Child O	Child G	Child LA	Child LE	Child LC
<b>Total cost</b> (of responding team assuming average number of hours 60.11 across the board)	£23,551.22 (7 of 14)	£17,654.40 (5 of 10)	£55,663.52 (9 of 14)	£17,213.34 (5 of 7)	£6,784.61 (4 of 9)	£14,171.85 (7 of 7)
<b>Total cost</b> (of full team)	£47,102.45	£35,308.80	£86,587.70	£24,098.68	£15,265.37	£14,171.85
<b>Reviewer cost</b>	£35,757.40	£13,737.28	£12,639.37	£8,809.50	£8,300.00	£5,454.28
<b>Venue / food cost</b>	£670.45	£0.00	£0.00	£106.25	£106.25	£118.00
<b>Final total</b>	£83,530.30	£49,046.08	£99,227.07	£33,014.43	£23,671.62	£19,744.13
<b>Average cost by method</b>	<u>£77,267.82</u>			<u>£25,476.73</u> (32.97% of Traditional method)		

Table 8: Number of hours levelling

Therefore, the overall reduction seen in the average cost of completing a review using the Welsh model is comprised of both a reduction in number of hours spent on completing the review and the lower average hourly rate of those people involved in the process.

## CONCLUSION

The evidence points to significant advantages of the Welsh model compared to the Traditional Model at three levels: clarity of purpose, resource (time), and economic cost.

The data triangulated (interviews content analysis and economic costs) suggests the Welsh reports are shorter in length (whilst not losing rigour and clarity); are significantly less resource intensive, and costs less to commission.

On average, the Welsh model can produce a report in a quarter of the time required for a Traditional Report and at two thirds of the cost.