Oldham
Local Safeguarding Children Board

Learning & Improvement Quality Assurance Framework 2018-2019

Oldham Partnership

Introduction

Working Together 2015 requires Local Safeguarding Children Boards (LSCBs) to maintain a local learning and improvement framework which is shared across local organisations who work with children and families. This framework should enable organisations to be clear about their responsibilities, to learn from experience and improve services as a result.

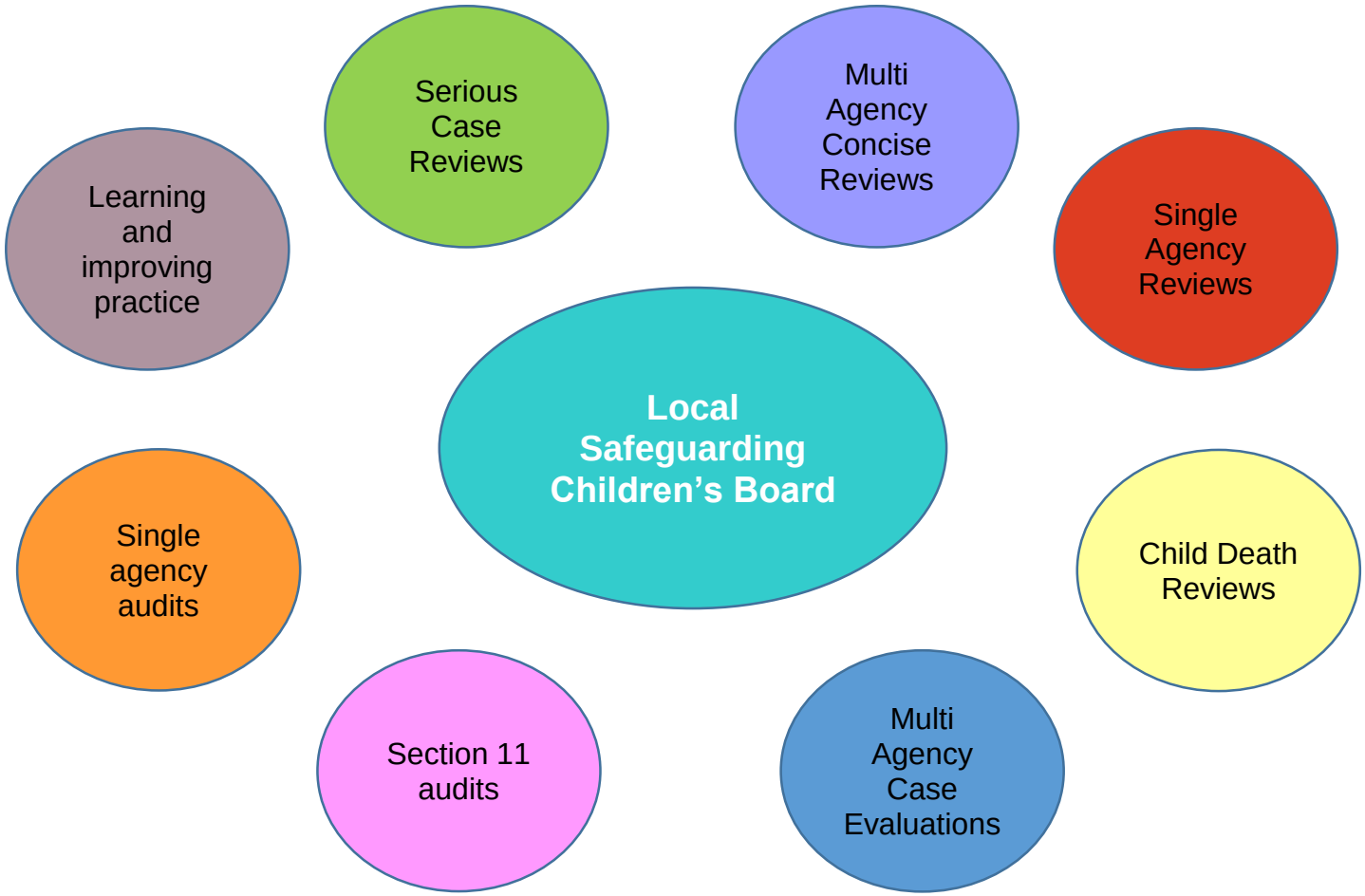
Each local framework should support the work of the LSCB and their partners so that:

- reviews are conducted regularly, not only on cases which meet statutory criteria, but also on other cases which can provide useful insights into the way organisations are working together to safeguard and protect the welfare of children and that this learning is actively shared with relevant agencies;
- reviews look at what happened in a case, and why, and what action will be taken to learn from the review findings;
- action results in lasting improvements to services which safeguard and promote the welfare of children and help protect them from harm; and
- there is transparency about the issues arising from individual cases and the actions which organisations are taking in response to them, including sharing the final reports of Serious Case Reviews (SCRs) with the public. (Working Together 2015)

Oldham LSCB is committed to the continuous improvement of local organisations working with children and families. This framework details the methods by which safeguarding partners will review their individual and collective response to practice and determine whether it resulted and/or continues to result in the best outcomes for children and families in Oldham.

The framework is designed to complement safeguarding partner's single agency quality assurance processes as well as other statutory review processes such as Domestic Homicide Reviews and Safeguarding Adult Reviews. The learning from these processes will be presented to the Serious Case Review subgroup and/or Audit and Scrutiny subgroup of the LSCB to ensure a coherent and consistent approach to learning and improvement.

Learning and Improvement model



WHAT DOES 'GOOD' LOOK LIKE?

1. Serious Case Reviews (SCR)

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the requirement for LSCBs to undertake reviews of serious cases in the following circumstances:

- when a child dies (including death by suicide) and abuse or neglect is known or suspected
- when a child has been seriously harmed and abuse or neglect is known or suspected;
- when a looked after child has died (including cases where abuse or neglect is not known or suspected); or
- when a child in a regulated setting or service has died (including cases where abuse or neglect is not known or suspected).

Seriously harmed" includes, but is not limited to, cases where the child has sustained, as a result of abuse or neglect, a potentially life-threatening injury and/or serious and/or likely long-term impairment of physical or mental health or physical, intellectual, emotional, social or behavioural development.

In addition, even if one of the criteria is not met, an SCR should always be carried out:

- when a child dies in custody, either in police custody, on remand or following sentence, in a Young Offender Institution, a secure training centre or secure children's home;
- where a child dies who is detained under the Mental Health Act 1983;
- where a child aged 16 or 17 was the subject of a deprivation of liberty order under the Mental Capacity Act 2005.

LSCB's should also consider undertaking a review when the above criteria has not been met but where the panel and the Independent Chair of the Board feel that there was a risk of significant harm that was not recognised or acted on appropriately by agencies.

The referral form for a Serious Case Review can be found here: https://www.oldham.gov.uk/lscb/downloads/file/100/case_review_notifications_procedure_and_form

The final decision for a review will be made by the independent chair of the LSCB.

Serious Case Reviews should be led by an independent reviewer and aim to be completed within six months of the notification. Final reports should be published on the LSCB website and a copy sent to the National Panel.

Oldham LSCB follow the Greater Manchester Serious Case Review Systems Approach which can be found here: http://greatermanchesterscb.proceduresonline.com/chapters/g_gm_ser_case_rev.html?zoom_highlight=serious+case+review

Notifiable Incidents

A notifiable incident is an incident involving the care of a child which meets any of the following criteria:

- a child has died (including cases of suspected suicide), and abuse or neglect is known or suspected;
- a child has been seriously harmed and abuse or neglect is known or suspected
- a looked after child has died (including cases where abuse or neglect is not known or suspected); or
- a child in a regulated setting or service has died (including cases where abuse or neglect is not known or suspected).

Any incident that meets the above criteria must be reported to Ofsted and any other relevant LSCB(s) promptly, and within five working days of becoming aware that the incident has occurred.

This notification will be made the LSCB business manager. When agencies become aware of a notifiable incident they must inform the LSCB business manager as soon as possible in order to allow the notification to Ofsted to be made.

National Panel

Since 2013 there has been a national panel of independent experts to advise LSCBs about the initiation and publication of SCRs. The role of the panel is to support LSCBs in ensuring that appropriate action is taken to learn from serious incidents in all cases where the statutory SCR criteria are met and to ensure that those lessons are shared through publication of final SCR reports.

LSCBs should have regard to the panel's advice when deciding whether or not to initiate an SCR, when appointing reviewers and when considering publication of SCR reports. LSCB Chairs and LSCB members should comply with requests from the panel as far as possible, including requests for information such as copies of SCR reports and invitations to attend meetings.

2. Multi Agency Concise Reviews (MACR)

Multi-agency concise reviews are reviews of all cases falling below the SCR threshold. Cases can involve incidents where a child has been harmed and there are concerns about multi-agency practice, or involve incidents where multi-agency practice is considered to be good (after a child has been harmed or where a child has been prevented from being harmed) and agencies seek to identify the characteristics and enablers of that good multi-agency practice.

The North West Safeguarding Steering Group recommends the following criteria to follow in selecting cases for a multi-agency concise review:

- A child is harmed through abuse / neglect and the case gives rise to concerns about the way in which local professionals and services worked together to safeguard the child that could lead to significant and new learning that improves multi-agency communication, procedures, policy and / or practice.

The SCR panel will make a recommendation, following the screening of a case, as to whether a Multi Agency Concise Review is necessary. The final decision will be made by the Independent Chair of the Board.

3. Single Agency Reviews (SAR)

Where a case is considered for a serious case review or multi-agency concise review but does not meet the criteria, as practice requiring further analysis and learning is limited to a single agency, the SCR Panel may recommend a Single Agency Review.

If a Single Agency Review is agreed by the SCR Panel and the Independent Chair of the LSCB, a letter will be sent to the LSCB representative from the relevant agency requesting that the review is undertaken, with lines of enquiry provided by the Panel.

A standard template for Single Agency Reviews can be seen at Appendix A. The review should be completed within three weeks of receipt of the letter from the Independent chair of the LSCB.

4. Child Death Reviews (CDR)

Regulation 6 of the Local Safeguarding Children Boards Regulations 2006 states that the LSCB is responsible for:

- collecting and analysing information about each death with a view to identifying –
  - any case giving rise to the need for a review mentioned in regulation 5(1)(e);
  - any matters of concern affecting the safety and welfare of children in the area of the authority;
  - any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area; and
- (b) putting in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

The responsibility for determining the cause of death rests with the coroner or the doctor who signs the medical certificate of the cause of death and therefore is not the responsibility of the Child Death Overview Panel (CDOP). The purpose of the child death review is to help prevent further such child deaths.

Child Death Overview Panel (CDOP)

The LSCB is responsible for ensuring that a review of each death of a child normally resident in the LSCB's area is undertaken by a CDOP. The CDOP for Oldham is a tripartite arrangement with Bury and Rochdale, chaired by a Public Health consultant and inclusive of representative from a range of agencies from all three areas. The representation along with the chair is rotated on a bi-annual basis across the three areas.

Upon receipt of a notificaiton of a child death, whereby the criteria for a Serious Case Review is not met the relevant agency must notify the CDOP officer (BROCDOP@rochdale.gov.uk) who will begin the Child Death Review process. A flow chart for the process can be found at: https://www.oldham.gov.uk/lscb/info/1/about_the_board/10/child_death_overview_panel

Information from CDOP is shared regularly with Oldham's Serious Case Review subgroup.

5. Multi-Agency Case Evaluations (MACE)

Full case evaluations

Oldham LSCB has implemented a robust and engaging multi agency case evaluation process, based on the methodology used in the Joint Targeted Area Inspections (JTAI). By adopting this methodology it has enable us to undertake challenging evaluations of safeguarding practice across all of our key partner agencies whilst at the same time ensuring that we are "JTAI-ready" in the event of an inspection.

The Multi-Agency Case Evaluations are focused on thematic areas of practice and to date have included domestic abuse, neglect and child sexual exploitation. Themes arising from the JTAI inspections will always be considered, alongside themes from Serious Case Reviews and inspections but the Audit and Scrutiny subgroup will continue to operate with a level of flexibility to enable evaluations to consider other emergent issues pertinent to the Board.

Each case evaluation will identify cases known to partner agencies and will concentrate on 5-7 cases for full multi agency evaluation. Each agency will be required to complete a chronology and a self-evaluation of their involvement over the previous six month period. The timetable for the process, which takes seven weeks in total, can be found at Appendix B.

Agencies are required to identify a lead person to undertake their agency evaluations. The lead person should be independent to the case being reviewed and be of sufficient seniority to make decisions on behalf of their agency. The lead person will be the single point of contact during the case evaluations and will be expected to be part of the Multi-Agency panel.

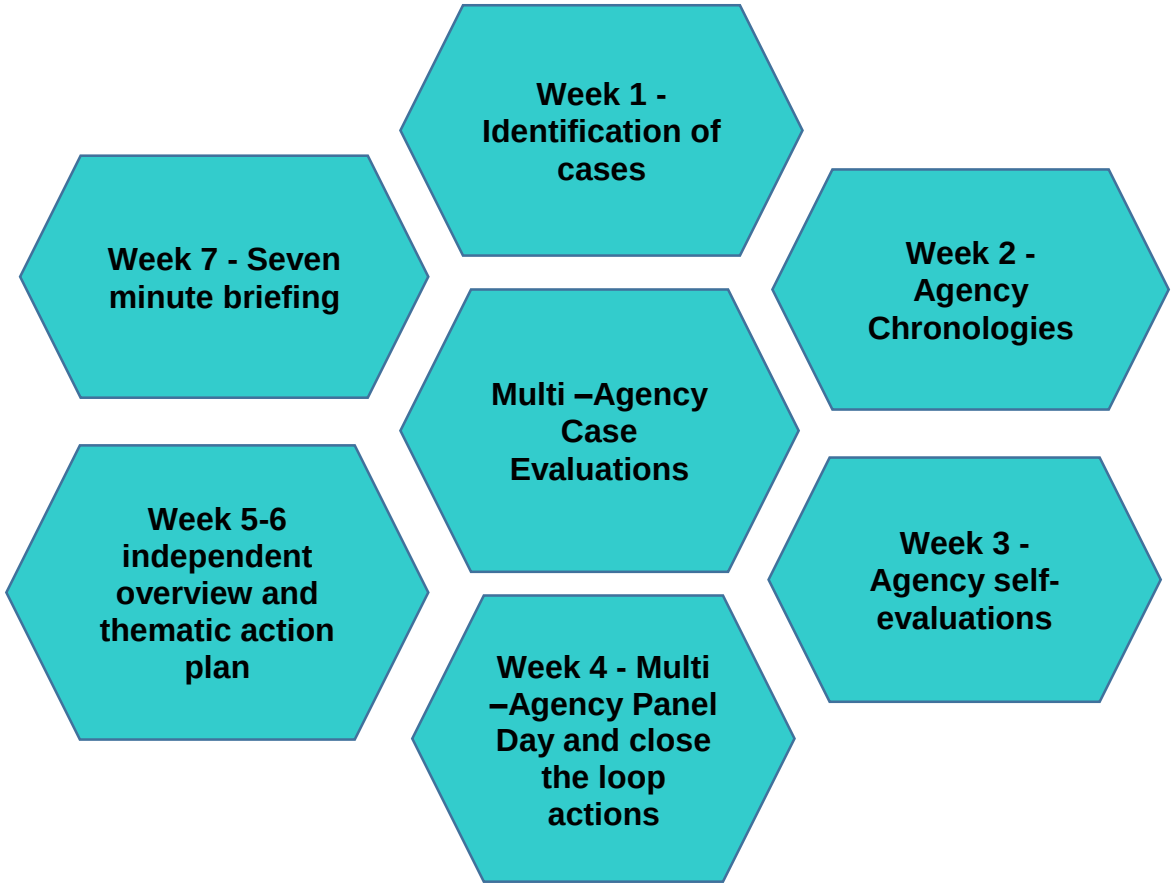
In the case of Health the lead person for the Clinical Commissioning Group (CCG) will collate all health chronologies and self-evaluations and will represent the following health agencies (GP's, Pennine Acute, Pennine Care, Bridgewater) at the multi-agency panel.

School and education information will be routed through the LSCB Safeguarding lead for schools, however schools, academies and colleges will be invited to present their own evaluations to the multi-agency panel.

Close the loop actions will be identified for each case and must be completed with the relevant form being returned to the LSCB within 10 working days of the multi-agency panel day. The close the loop form can be found at Appendix C.

Independent oversight of the audit findings will be invited and a thematic action plan will be produced by the LSCB business manager and Quality Assurance Service manager. This will be monitored by the LSCB's Audit and Scrutiny subgroup.

An overview of each agency's performance will be provided to the relevant LSCB representative. Seven minute briefings will be developed following each multi-agency case evaluations to highlight strengths and areas for improvement. Agencies will be expected to cascade the learning from the evaluations to staff within their agencies and to report back to the Audit and Scrutiny subgroup when this has been completed.



Condensed case evaluations

There may be instances when the Audit and Scrutiny subgroup determine that a full case evaluation is unnecessary and therefore a condensed case evaluation process has been agreed.

The condensed process will take place over two weeks and will focus on themes that are not JTAI related. A timetable for condensed case evaluations can be found at Appendix D.

Five cases will be identified based on a theme agreed by the Audit and Scrutiny subgroup. The theme will relate to findings from a serious case review, previous audit or inspection.

Agencies will be asked to provide relevant information such as a chronology or assessments, as well as a shortened self-evaluation of their agency's involvement.

Agencies are required to identify a lead person to undertake their agency evaluations. The lead person should be independent to the case being reviewed and be of sufficient seniority to make decisions on behalf of their agency. The lead person will be the single point of contact during the case evaluations and will be expected to be part of the Multi-Agency panel.

The Multi –Agency Panel will consider the cases and relevant documentation, providing appropriate challenge to relevant agencies.

Close the loop actions will be identified for each case and must be completed with the relevant form being returned to the LSCB within 10 working days of the multi-agency panel day.

The LSCB business manager and Quality Assurance Service manager will develop a thematic action plan which will be overseen by the Audit and Scrutiny subgroup.

Seven minute briefings will be developed following each case evaluations to highlight strengths and areas for improvement. Agencies will be expected to cascade the learning from the evaluations to staff within their agencies and to report back to the Audit and Scrutiny subgroup when this has been completed

6. Section 11 Audits

The LSCB has a statutory responsibility to ensure that agencies are fulfilling their duties under Section 11 of the Children's Act 2004. In order to do this the Board undertakes a cycle of section 11 audits every two years.

The Section 11 audit tool covers the following eight key standards that allow agencies to evidence that they are meeting their statutory duty:

1. Leadership and Accountability
2. Policies and Procedures
3. Recruitment and Selection
4. Staff Induction, Training and Development
5. Complaints, Allegations and Whistleblowing
6. Information Sharing, Communication and Confidentiality
7. Listening to Children and Young People
8. Equality of Opportunity

Agencies are asked to provide evidence against each of the questions under the eight categories and to self-assess their organisation against the score descriptors.

The audit is completed online via Virtual College site and agencies are given six months to complete their audit and submit their evidence. If areas for development are identified agencies are expected to develop an action plan which will be submitted alongside their completed audit.

An overview report will be prepared by the Performance analyst for the LSCB which will be presented to the Audit and Scrutiny subgroup. Four agencies will be invited to attend a peer review "Moderation Panel" which will be made up of members of the Audit and Scrutiny subgroup, the LSCB business manager, the Independent Chair of the LSCB and a representative from the Youth Council or Children in Care Council.

Full guidance for the Section 11 audits can be found at: http://www.gmsafeguardingchildren.co.uk/project/project1162/

School and education audits

Oldham LSCB has recently rolled out a revised Section 11 audit for schools and education establishments which is based on "Keeping Children Safe in Education" guidance.

The new audit tool comprises of 14 areas which include:

1. Senior designated person for safeguarding
2. Staff induction, Training and Development
3. Information to staff
4. Pupils
5. Risk assessment
6. Record Keeping
7. Parents
8. Curriculum
9. Multi-Agency safeguarding meetings
10. Governors
11. Recruitment and Selection of staff
12. Allegations and complaints against staff
13. Other adults in school
14. Links with other agencies

The audit for schools will be completed on a two yearly basis and will be sent schools and education establishments at the start of the Summer term. Completed audits and actions plans are required to be returned to the LSCB by the end of the Summer term.

An overview report will be prepared by the Safeguarding Lead for Schools which will be presented to the Audit and Scrutiny subgroup. Four schools/education establishments will be invited to attend a peer review "Moderation Panel" which will be made up of members of the Audit and Scrutiny subgroup, the LSCB business manager, the Independent Chair of the LSCB and a representative from the Youth Council or Children in Care Council.

A full copy of the schools and education audit template can be accessed from David Devane, Safeguarding lead for schools and education: David.Devane@oldham.gov.uk

7. Single Agency Audits

The purpose of the single agency audits is allow agencies to evidence their internal quality assurance work and to demonstrate good practice and areas for improvement.

The audit, which is completed annually, asks agencies:

- What audit activity they undertake?
- How they use and challenge performance information within their agency?
- What agencies have learned from the audits and how the information has been used to improve outcomes?
- What recommendations and actions plans have been implemented as a result?

An overview report will be prepared by the performance analyst for the LSCB which will be presented to the Audit and Scrutiny subgroup. Four agencies will be invited to attend a peer review "Moderation Panel" which will be made up of members of the Audit and Scrutiny subgroup, the LSCB business manager, the Independent Chair of the LSCB and a representative from the Youth Council or Children in Care Council.

The single agency audit template is available at Appendix E.

8. National and Regional learning

Oldham LSCB maintains a consistent link with other Greater Manchester LSCBs which allows us to benefit from shared learning, informing local practice.

Findings published from other Serious Case Reviews and Multi Agency audits are also reviewed regularly to ensure learning can be implemented locally.

9. Learning and Improving Practice

To ensure that learning from the variety of review activities undertaken by the LSCB are effectively disseminated we will:

- Develop clear action plans for each review and/or evaluation which will be monitored regularly by the Serious Case Review subgroup or the Audit and Scrutiny subgroup of the LSCB.
- Organise a range of learning opportunities to support the dissemination of the learning including multi agency briefing sessions and seven minute briefings, all of which will be evaluated in terms of effectivness.
- Ensure that the training offer reflects the learning needs identified across the Partnership
- Ensure that the Board's business plan priroties reflect the learning from the previous year.

It is the responsibility of safeguarding partners to ensure and evidence that learning is embedded within their agency's practice.

The Serious Case Review subgroup, the Audit and Scrutiny subgroup and the Training subgroup will each produce an annual report detailing the activity undertaken and the evidencing the impact of learning and improvement in practice.

Appendix A

Single Agency Review template

Oldham
Local Safeguarding Children Board

Oldham Partnership

Title: Single Agency Analysis Report – Child

Report of:

Date:

Introduction:
This should include the circumstances of the agency's involvement with the child / family including reason for referral.

The Facts:

This should include:

- The family background and circumstance;
- Include completed chronology

Analysis:

This section should critically assess the key circumstances of the agency's engagement with the child/family.

Using the terms of reference consider the following:

- Were the responses appropriate?
- Were key decisions justifiable?
- Was the relevant information sought or considered?
- Were there early, effective and appropriate interventions?
- Were the family and child's circumstances sufficiently assessed?

Learning Points:

This section should highlight the key learning points from the review – again the focus here should not be on 'what happened', but the reasons for why it happened as it will be these areas that agencies can actively take forward and address. This section should also address strengths and good practice identified as well as the

learning that has taken place since the case, any changes in practice and policy that have been implemented and the outcome of changes.
Recommendations:
These should be SMART: **S**pecific, **M**easurable, **A**chievable, **R**ealistic, **T**imed.
Action Plan:
The Action plan should reflect the required activity to achieve the recommendations and be owned by the whole agency. Mechanisms to review the outcomes and impacts of such actions should be agreed and formally built into the improvement programme.

Appendix B

Multi Agency Case Evaluations

Dates of Audit.	Audit Theme – case details sent out. **Week 1**	Submission date for Chronologies **Week 3**	Submission date for case evaluations **Week 3**	Multi-agency panel day **Week 4**	Overview Report **Week 4**	Independent overview **Weeks 5-6**	7 Minute Briefings **Week 7 onwards**
7 May 2018	Children associated with gangs and at risk of exploitation – **full audit**	21 May 2018	23 May 2018 (24 May for Health)	6 June 2018	8 June 2018	11- 22 June 2018	25 June 2018
6 August 2018	Quality of assessments & Management oversight	TBC	TBC	TBC	TBC	TBC	TBC
5 November 2018	Child Sexual abuse within a familial context – **full audit**	19 November 2018	21 November 2018 (22 November for Health)	28 November 2018	29 November 2018	3- 14 December 2018	17 December 2018

February 2019	Annual review/ impact assessment of all audits

Section 11 Audits

Start date	Completion date
April 2018	**30 September 2018**

School and education audits

Start date	Completion date
14 March 2018	**29 June 2018**

Single agency audits

Start date	Completion date
1 July 2018	**31 October 2018**

Timetable for multi-agency case evaluation

Week 1		
Day	**Action**	**Responsible Officer/ Agency**
	Wide cohort identified using the child level data lists that will be provided to the inspection team. This will be cases that have been open in the last 6 months. (some of these may be closed by the time the audit commences.)	**LSCB performance analyst**
	20 cases from the wide cohort to be selected and shared with agencies initially to identify cases with the most appropriate multi-agency working, including the names of all adults associated with the family, and their familial relationships.	**LSCB Business Manager, QA Service Manager, supported by LSCB Performance Analyst.**
	Agencies to feedback about their involvement with the family.	**ALL Agencies**
	Using the information provided from all agencies 5-7 cases will be selected for the agencies to audit. The final cases will be communicated to agencies by day the end of day 4 in the timeline. Final cases should include as much agency involvement as possible, and should always include cases across the thresholds, (some being assessed, some CIN, some CP). Agencies should also receive all appropriate documents and guidance for completing the multi-agency case evaluation	**LSCB Business Manager, QA Service Manager**
	Auditors can commence single agency audit process using the multi -agency case evaluation tools	**All Agencies**
Week 2		
	Agencies undertake single agency audits and chronologies for each case. Where possible the Lead agency should meet with the	**All Agencies**

	family to triangulate the findings of the audit and the gain the child's view of the effectiveness of multi- agency involvement.	
	All Agencies send completed chronologies to the LSCB Business Manager to begin to pull together the multi-agency chronology for each child Health services Service Lead to receive all health partners' audits to QA and develop a shared understanding of the impact of services provided to the family.	**LSCB Business Manager with support of LSCB performance analyst** **Designated Nurse – Oldham CCG**
	Agencies undertake single agency sign off of all audits and agree on judgements of their own agencies performance and impact on outcomes for the child.	**All Agencies**
	All agencies, excluding health services, to send completed audits to the LSCB business manager. Alongside supporting documents such as initial referral/contact/notification (where applicable) • most recent assessment, including a common or early help assessment • strategy or other multi-agency discussion or equivalent • section 47 investigation documentation/ICPC minutes • most recent plan for the child and/or review of the plan • latest return home interview and any subsequent risk assessments (where appropriate) • the most recent pre-sentence report relating to the child or any relevant adult (where applicable) • details of any specialist services involved with the family Completed multi-agency chronology is sent the QA Service manager so that they are able to begin to understand the child's journey through services in order to frame the conversation during the panel discussion	**All agencies excluding health** **LSCB Business Manager, QA Service Manager**

	Completed multi-agency chronologies to be sent to all Panel members so that they can begin to prepare any relevant questions/ challenge of individual agencies contributions and understand their own agencies performance in a multi-agency context.	**All Agencies**
	Health services to provide all health audits, and their shared understanding of the impact of services provided to the family that have impacted the child.	**Designated Nurse – Oldham CCG**
	All documents for each case to be saved. Audit outcome tracker to be completed and high level summary of agencies own scores to be written about each case.	**LSCB Business Manager** **LSCB performance analyst**
Week 4		
	QA service will have an understanding of the cases and the multi-agency impact on each child. QA service manager to present the case stories, and observations about strengths and weaknesses to the Panel Chair in order for her to lead the challenge discussion	**QA Service Manager and Director of Early Help and Children's Social Care**
	Panel Chair to prepare for the Panel	**Director of Early Help and Children's Social Care**
	Multi-Agency Case Panel Day **First half of day** QA service manager, using the multi-agency chronology as the centrepiece for discussion, will identify the journey the child has	**All agencies to attend** **QA Service manager**

	experienced throughout their time in contact with services. Comments should be expected about how well the child's voice is evidenced in the cases, and the story of agency's' involvements should be seen through the eyes of the child. For example if there is clear evidence in the multi-agency chronology of concerns being raised by the child about how they feel, but little evidence of agency's being aware of this, this should be highlighted. Agencies will contribute when appropriate about the effectiveness of their own service throughout the discussion led by the Panel Chair Notes from the panel to be written on a case by case basis, documenting the challenge, and any regrading of agencies work along with the rationale for doing so, and any actions that arise from the multi-agency discussion. An assessment of the partnerships effectiveness of multi-agency working for each case should be agreed. **Second half of day** Action Plan for each case to begin to be constructed	**All agencies** **LSCB Business Manager and QA Service Manager**
	Overview of the Partnerships strengths and weaknesses to be written, and accompanying action plan to be constructed	**LSCB Business Manager and QA Service Manager** **Assistant Director Safeguarding and Partnerships**
	Action plan for each case to be shared with agencies, alongside the notes of the discussion from the Panel – updates to be provided by week 7, day 31.	**LSCB Business Manager**

	Overview of the partnerships strengths and areas for improvement to be shared with panel members By the end of Day 20 the process for multi-agency evaluation is complete.	
Week 5 -6 (Days 21-30) Independent overview of the cases to be completed		
Week 7		
	Independent overview to be shared with all panel members and updates on actions from cases to be received from agencies	**LSCB Business Manager**
	LSCB Audit and Scrutiny subgroup to meet and review progress, receive any close the loop information on the cases from agencies and to prepare and agree information to be reported to the LSCB Exec Group. This is to include how the subgroup will monitor the wider actions for the partnership to improve the effectiveness of multi- agency working.	**Chair of the Audit and Scrutiny subgroup.**

Appendix C

Closing the Loop on Multi Agency Case Evaluation

This form is to be used by the lead person in order to close the loop on a Multi agency case evaluation graded **requiring improvement** or **inadequate**.
The lead person must ensure that recommendations have been communicated clearly to the allocated worker and rigorously monitored to ensure required actions have taken place in a timely manner. In order for the QA activity to deliver the improvement it is essential to "close the loop" to ensure learning informs practice.

Lead Person Details	
Lead Person:	**Date completed:**
Service:	**Date Reviewed:**

Case details copied from audit	
Case ID: **Date case currently opened:**	**Child name:** **Child DOB:** **Child Age today:** **Gender:** **Ethnicity:** **Religion:**
Type of Case: ☐Child in Need ☐Child Protection ☐Child in care ☐Care Leaver ☐Adoption	**Name of Case Worker:** **Supervising Manager:** **Team:**

Case worker to complete	
Overall Grade of the audit	
Who were the auditors?	
When was the audit completed?	
Has the social worker been notified of findings?	☐Yes ☐No

Present at the close the loop meeting	
Overview/background	
Reflections	
Learning Opportunity	

Actions	

Completed:

Appendix D

Condensed evaluation timetable

Week 1		
Day	**Action**	**Responsible Officer/ Agency**
Day 1	20 cases to be randomly selected based on agreed criteria from the Audit & Scrutiny subgroup and sent out to agencies.	**LSCB Business Manager and QA Service Manager,**
Day 2	Agencies to feedback about their involvement with the cases.	**ALL Agencies**
Day 3	Using the information provided from all agencies, 5 cases will be selected for the agencies to evaluate. The final cases will be communicated to agencies by the end of day 3 in the timeline. Final cases should include as much agency involvement as possible. Agencies should also receive all appropriate documents and guidance for completing the multi-agency case evaluation	**LSCB Business Manager, QA Service Manager**
Days 4 and 5	Evaluators to commence single agency evaluation process using the multi -agency case evaluation tools. This may include production of a brief chronology of involvement, submission of relevant documents such as assessments and completion of a short evaluation of agency involvement.	**All Agencies**

Week 2		
Day 6	Completed evaluations, chronologies and documentation (where required) to be submitted to LSCB Business Manager	**All agencies**
Day 7	All cases information to be collated and sent out to agencies in readiness for the Multi Agency panel session on Day 9.	**LSCB Business Manager**
Day 8	QA Service Manager to brief the chair of the panel	**QA Service Manager** **Chair of Panel**
Day 9	Multi Agency Panel session to be held.	**All Agencies**
Day 10	Brief overview report to be written	**TBC**

Appendix E

Oldham
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Agency Name

Completed by:
Date:

Audit activity undertaken for evaluating frontline practice:
What audits have been undertaken and what have they told you?
Evaluation of Performance information for evaluating frontline practice:
What is you PI telling you about practice, how do you monitor your PI, and how do you challenge the PI when necessary?
Executive Summary:
Headlines from the report…..
Outcome for children and young people:
What have you learnt and how will this go towards improving outcomes/safeguarding for children?

Main Body of the Report:
The full audits and PI information.
What does this tell the board how safe practice is and what needs to be done?
Recommendations and Action Plan (if appropriate)
How to be actioned: ☐ Report author attending ☐ Discussion item ☐ Presentation ☐ Workshop ☐ Circulate to Board members outside of Meetings for information
Appendices