Title: Revision of chapter 8 - Serious Case Reviews - of Working Together to Safeguard Children (Working Together 2010)	**Impact Assessment (IA)**
IA No:	**Date:** 28/03/2012
Lead department or agency: Department for Education	**Stage:** Consultation
Other departments or agencies: Department of Health, Home Office, Department for Communities and Local Government, Ministry of justice.	**Source of intervention:** Domestic
	Type of measure: Primary legislation
	Contact for enquiries: (Steve Williams 0207 783 8034)

Summary: Intervention and Options

RPC Opinion: GREEN

Cost of Preferred (or more likely) Option				
Total Net Present Value	**Business Net Present Value**	**Net cost to business per year** (EANCB on 2009 prices)	**In scope of One-In, One-Out?**	**Measure qualifies as**
£0m	£0m	£0m	No	NA

What is the problem under consideration? Why is government intervention necessary?

A Serious Case Review (SCR) takes place whenever a child has died or has been seriously harmed when neglect or abuse is known or suspected and there is cause for concern about the way agencies worked together to safeguard the child. Professor Eileen Munro's review of child protection, 'A child-centred sytem', published on 10 May 2011 recommended a fundamental rethink of how to learn about professional practice through the SCR process. The review recommended that the Government should require Local Safegurding Children Boards (LSCBs) to use systems methodology when SCRs are initiated.

What are the policy objectives and the intended effects?

To move to a system of learning from serious child protection incidents which is less about "learning lessons" and more about preventing future harm to children by driving sustained improvements in practice so that agencies and individuals improve the way in which they work both individually and collectively to safeguard children. This approach will allow a focus on deeper understanding about what went wrong, and why, and on preventing recurrence of errors or poor practice. This approach will produce reports which contain less personal detail about family members and individual practitioners than current `traditional' SCR overview reports, so there should be less difficulty about publishing them.

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)

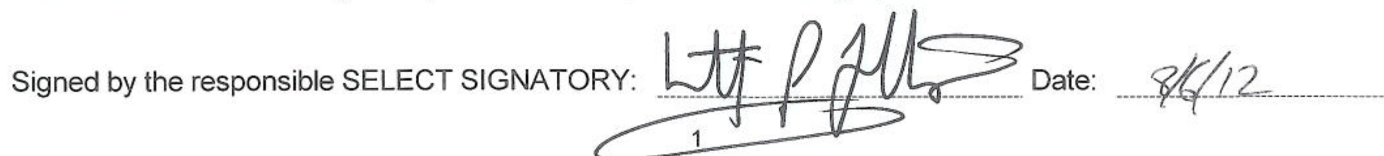
Option 1: to retain the current statutory guidance.

Option 2: to undertake a revision to Working Together to Safeguard Children (2010) in line with the recommendation of the Munro Review. This revision is necessary in order to support a transition to using systems methodologies when undertaking SCRs. The guidance will be a useful lever for reinforcing the statutory duty of LSCBs to conduct SCRs and to publish the full overview reports. Adopting a systems approach will assist when publishing SCR reports. This will mean that important opportunities for learning from incidents and making improvements are not being lost. The guidance sets out a learning and improvement framework, provides a checklist of principles which should be followed when conducting reviews and restates the Government's expectations about publication of SCR reports and set out what those reports should contain.

Will the policy be reviewed? It will be reviewed. **If applicable, set review date:** 10/2013

Does implementation go beyond minimum EU requirements?			No		
Are any of these organisations in scope? If Micros not exempted set out reason in Evidence Base.	**Micro** No	**< 20** No	**Small** No	**Medium** No	**Large** No
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)			**Traded:**	**Non-traded:**	

I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.

Signed by the responsible SELECT SIGNATORY:  Date: 8/6/12

Summary: Analysis & Evidence

Policy Option 1

Description: Do nothing - retain the current statutory guidance.

FULL ECONOMIC ASSESSMENT

Price Base Year 2012	PV Base Year 2012	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: Optional	**High:** Optional	**Best Estimate:** £0

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	Optional		Optional	**Optional**
High	Optional		Optional	**Optional**
Best Estimate	£0		£0	**£0**

Description and scale of key monetised costs by 'main affected groups'

The costs of the other options are expressed relative to this do nothing case.

Other key non-monetised costs by 'main affected groups'

BENEFITS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	Optional		Optional	**Optional**
High	Optional		Optional	**Optional**
Best Estimate	£0		£0	**£0**

Description and scale of key monetised benefits by 'main affected groups'

The benefits of the other options are expressed relative to this do nothing case.

Other key non-monetised benefits by 'main affected groups'

Key assumptions/sensitivities/risks | **Discount rate (%)** 3.5

BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:			In scope of OIOO?	Measure qualifies as
Costs: £0	**Benefits:** £0	**Net:** £0	No	NA

Summary: Analysis & Evidence

Policy Option 2

Description: To undertake a revision to Working Together in line with the recommendation of the Munro Review, which will be supported by the development of an operational tool.

FULL ECONOMIC ASSESSMENT

Price Base Year 2012	PV Base Year 2012	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: Optional	High: Optional	Best Estimate: £0

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	Optional		Optional	**Optional**
High	Optional		Optional	**Optional**
Best Estimate	£0		£0	**£0**

Description and scale of key monetised costs by 'main affected groups'

No additional costs are expected.

Other key non-monetised costs by 'main affected groups'

The cash costs of conducting a SCR currently fall to the LSCB and relate to the employment of a SCR Panel independent chair and an independent overview report writer. There are also time costs associated with senior official and practitioner involvement with SCRs. Anecdotal evidence suggests that the cash and time costs from a change to a systems methodology will be cost neutral at worst but may well lead to cost savings.

BENEFITS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	Optional		Optional	**Optional**
High	Optional		Optional	**Optional**
Best Estimate	£0		£0	**£0**

Description and scale of key monetised benefits by 'main affected groups'

Other key non-monetised benefits by 'main affected groups'

The main non-monetised benefits will lead to improvements in practice in child protection through a better understanding and improvements by individuals and agencies in working together. Evidence from LSCBs that have used the Social Care Institute Excellence's Learning Together systems model has demonstrated greater practitctioner engagement in improving the way they work.

Key assumptions/sensitivities/risks — **Discount rate (%)** 3.5

We will endeavour to quantify impacts in later stages of the IA by collecting information during the consultation and drawing on evaluation results from three pilots where the LSCBs are conducting SCRs using a systems approach. There is a potential risk in moving to a new methodology for SCRs before the system has developed a learning culture. It will take time for the necessary skills and expertise to develop and for experience of new ways of working to become embedded.

BUSINESS ASSESSMENT (Option 2)

Direct impact on business (Equivalent Annual) £m:			In scope of OIOO?	Measure qualifies as
Costs: £0	Benefits: £0	Net: £0	No	NA

Evidence Base (for summary sheets)

Background

This impact assessment accompanies a draft statutory guidance for Local Safeguarding Children Boards (LSCBs) and their partner agencies which is being issued for consultation. The guidance introduces a revised approach to learning and improvement activity led by LSCBs, including in particular a new approach to Serious Case Reviews (SCRs).

SCRs are conducted when a child dies, or is seriously harmed, and abuse or neglect is known or suspected to be a factor. Current statutory guidance on SCRs is contained in Chapter 8 of *Working Together to Safeguard Children* (2010). The purposes of SCRs are to:

- establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children;
- identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result; and
- improve intra- and inter-agency working and better safeguard and promote the welfare of children.

In June 2010 the Government commissioned a wide-ranging independent review of child protection from Professor Eileen Munro. This included consideration of how SCRs could be strengthened. This followed concerns that the existing process of SCRs was overly bureaucratic and was leading to a proliferation of recommendations and actions which were burdensome for agencies, but which were not resulting in improved outcomes for children.

Professor Munro recommended that the Government should change the SCR process by requiring LSCBs to begin using what she called 'systems methodology' when undertaking SCRs. Systems methodology has been developed in investigation processes in the health, aviation, and engineering sectors. It examines human performance in its context and recognises that people's competence in carrying out tasks to a high standard is influenced by the whole system around them. Professor Munro argued that the systems approach could address the problems with the current arrangements for SCRs. This is because it would: provide a clear theoretical framework for learning from incidents, looking not only at what professionals did in a case but also why they acted as they did; free up professionals from bureaucracy in the process; and allow them to develop capacity and expertise to respond to review findings and bring about improvements.

The Government agreed with Professor Munro's recommendation and has been working with review experts in sectors including health and aviation to consider how best to develop the new approach. The draft guidance is the result of that work.

The draft guidance also contains guidance on child death reviews which replaces the current Chapter 7 of Working Together to Safeguard Children. The criteria and processes for child death reviews remain unchanged.

A full, formal 12 week consultation will take place from June 2012 on statutory guidance for learning reviews including SCRs and child death reviews.

Problem under consideration

Problems with the current approach to SCRs

The Government has commissioned a series of biennial research reports on the findings from SCRs in order to inform learning at a national level. These research reports have been very critical of the current approach to SCRs:

1) *Improving safeguarding practice: Study of serious case reviews 2001-2003* (January 2008). This report found that:

> 'Serious case reviews make an important contribution to understanding what happens in circumstances of significant harm. Their effectiveness can be improved and there are examples of promising approaches using the findings of serious case reviews to bring about improvements in safeguarding practice. However, achieving such improvements require Local Safeguarding Children Boards to develop a much stronger learning culture within which serious case reviews are but one important source of knowledge for improving safeguarding practice'.
>
> 'Discussion of how lessons are learned from serious case reviews cannot be concluded without some reference to the wider debate about the apparent failure of public services to learn lessons. There is a widespread perception, publicly, politically and amongst some professionals, that the last thirty years of child welfare is characterised by failure to learn lessons from the findings of local serious case reviews or public inquiries into child deaths, serious injuries or neglect'.

2) Analysing child deaths and serious injury through abuse and neglect: what can we learn. A biennial analysis of serious case reviews 2003-2005 (January 2008). This report concluded that:

> 'After more than thirty years of debate about the purposes of reviews into serious child abuse cases, many of the same mistakes are still occurring. ...serious case reviews need to focus less on who is to blame and whether procedures have been followed and more on wider factors which could explain why these incidents are continuing to occur after decades of new procedures and policies'.
>
> 'The follow up of recommendations did seem, for the most part, to be tightly structured and managed, but it was acknowledged that this did not prevent the same sort of cases re-emerging'. Also 'Interviewees were not always certain that the case had made an impact on the way agencies work together, particularly between health and social care colleagues'.
>
> 'Most of the serious case reviews we scrutinised failed to provide enough information to achieve a clear understanding of the case and the incident which led to the child being harmed or killed'.

Professor Munro found in her Review of Child Protection that 'there has been considerable criticism of the current SCR methods and evidence from professionals. Without being able to explain why professionals acted or failed to act as they did, SCR recommendations tend to take the form of admonishments to professionals of what they 'should', 'need' or 'must' do in specific situations in the future. This, as the review has identified, has ended up reinforcing a prescriptive approach toward practice, corroborated by the conclusions of a biennial review of SCRs' (Para 4.25, A child-centred system, May 2011).

Professor Munro recommended that 'the Government should require LSCBs to use systems methodology when undertaking Serious Case Reviews'. The goal of systems investigations is to build up understanding of how errors are made more or less likely depending on the factors in the task environment. This allows innovations that maximise the factors that contribute to good performance and minimise the factors that contribute to error. In re-designing the system at all levels to make it safer, the aim is 'to make it harder for people to do something wrong and easier for them to do it right' (Institute of Medicine, 1999 p.2) .

Rationale for intervention

The Government agreed Munro's recommendation that systems review methodology should be used in SCRs. Systems methodology would improve the current SCR process in areas such as:

- the lack of engagement by, and meaning for, front line practitioners;
- shallowness of learning that does not become embedded; and
- a lack of consistency in the presentation of findings which makes thematic national learning and sharing of practice more difficult.

The Government acknowledges that further work is needed to test the approach, and also to increase the numbers of suitably qualified reviewers, before this can be a requirement.

The proposed guidance presents a radical change to the current SCR model. It is therefore important that a full, formal consultation is carried out, and that the final gudiance is informed by views from all parts of the child protection system. We therefore intend to put forward a draft version of the guidance for consultation from June 2012.

Policy objective

To take forward Professor Munro's recommendation, the Government has taken advice from review experts in the fields of health, domestic homicide and aviation as well as those in the child protection sector. Experts have endorsed Professor Munro's view that using the systems review methodology in SCRs would improve the quality of learning substantially, because the reviewers would look not only at what professionals did or did not do in a case but also at why they took that course of action. Following advice from these review experts, the proposal is that:

- The statutory criteria for undertaking and publication SCRs should remain unchanged;

- The statutory guidance should be changed to allow LSCBs to use systems methodology. The guidance will not tie LSCBs to using a particular model, but it needs to be sufficiently flexible so that LSCBs are free to choose one of the models which is currently available. This will mean removing guidance on components of reviews which are not consistent with systems models, such as detailed terms of reference and individual management reviews; and

- The current prescriptive guidance on the SCR process should be replaced by a checklist of principles which LSCBs and their partner agencies should follow when conducting reviews. This would free LSCBs and agencies up from the bureaucratic requirements of the current SCR process.

The Government is aware that there is a number of different systems based review models available which could be used by LSCBs. The model with which most LSCBs are familiar is the Social Care Institute for Excellence (SCIE)'s 'Learning Together' model which has been developed specifically for use in child protection. The Government has three pilots underway which are testing the SCIE model in live SCRs in Coventry, Lancashire and Devon. Findings

from the pilots will inform the development of the guidance and the final impact assessment.

The guidance will be drafted in a way which is consistent with the systems review models available to the sector. It will remove the requirements currently in statutory guidance for:

- detailed terms of reference for reviews;
- individual Management Reviews from all agencies which are party to the SCR;
- a health overview report covering involvement of all health services with the child;
- detailed chronologies of the family's history and genograms;
- SCR overview reports and executive summaries.

These requirements are replaced by a set of broad principles which should apply to all reviews, so the bureaucratic burden of the SCR process should be reduced.

The draft guidance will not change the requirement for LSCBs to publish SCR reports.

Description of options considered (including do nothing)

There are two options which have been considered:

1. <u>Do nothing – retain the current guidance.</u>

<u>Costs – none</u>

This option represents the current baseline and therefore would have **no additional costs** to local authorities, social workers, teachers, health professionals, etc.

<u>Benefits – none</u>

This option represents the current baseline and therefore would have **no additional benefits or offer potential savings** to local authorities, social workers, teachers, health professionals, etc.

2. <u>Revision of the statutory guidance *Working Together to Safeguard Children* (2010) and production of a learning and Improvement guidance(preferred option)</u>

This option is the development of a new statutory guidance on learning and improvement for LSCBs and their partner agencies. The guidance will introduce a new process for SCRs based on the systems methodology recommended by Professor Munro.

The guidance will be less prescriptive than the current statutory guidance on SCRs. To be consistent with the systems review approach it will remove the requirements for:

- detailed terms of reference for reviews;
- individual Management Reviews from all agencies which are party to the SCR;
- a health overview report covering involvement of all health services with the child;
- detailed chronologies of the family's history and genograms; and
- SCR overview reports and executive summaries.

These will be replaced by a set of broad principles which should apply to all reviews led by LSCBs.

The merit in moving to a systems approach is that it counters the tendency of the current SCR methods to reinforce prescriptive approaches to practice, focusing instead on professional learning and increasing capacity and expertise. Critically, it explicitly focuses on a deeper understanding of why professionals have acted in the way they have, so that any resulting changes are grounded in practical realities.

LSCBs will not be required to use a particular systems model. The guidance will give them flexibility to select the model which is most suitable to the circumstances of each case.

Any revision of the guidance would constitute a regulatory option as it is a statutory document. This option would achieve the necessary improvements to the guidance in order to address the issues highlighted in the Munro Review. The regulatory framework for undertaking SCRs would, however, not change.

The guidance will also contain guidance on child death reviews to replace the existing statutory guidance in Chapters 7 of *Working Together* (2010).

Objectives

The exact content of the guidance will be decided post-consultation, depending on the responses received. However, we are proposing the following areas will be covered;

- the criteria in regulations for deciding whether a case should lead to an SCR;
- a revised purpose for reviews which is less about "learning lessons" and more about preventing future harm to children by driving sustained improvements in practice;
- a set of principles which should underpin reviews;
- an explanation of the systems approach and how it should be applied; and
- guidance on what should happen after a review, covering publication of reports, transparent follow-up action and a programme of continuous improvement to support sustained impact.

This is the recommended option, and is the basis of the draft guidance which has been developed for consultation.

Resource cost savings or increases

Our current understanding is that the introduction of a systems approach for SCRs should be cost neutral. Costs of conducting SCRs vary widely according to the circumstances of the case being reviewed. At present LSCBs are not currently required to publish precise costs for each SCR they conduct and the cost figures which are published do not always cover the same items of spend However we do have some information from LSCB Annual Reports which gives a useful illustration of the costs of the current approach

The table below gives indicative figures from a sample of published LSCB Annual Reports about in-year spend on SCRs under the current system:

LSCB	SCR spend
Bexley	£17,000 on one SCR
Bournemouth	£20,000 on three SCRs
Bromley	£10,614 on one SCR

Dorset	£25,245 on one SCR
Gateshead	£17,192 on 2 SCRs
Hackney & City	£38,995 on 2 SCRs
Leeds	£45,000 on 3 SCRs
Liverpool	£35,000 on one SCR
Medway	£25,000 on one SCR
North Yorkshire	£12,000 on one SCR
Plymouth	£22,000 on 2 SCRs

Using these examples as illustrations, we can estimate the cost of an SCRs under the current guidance as being an average of around £15,000.

By way of comparison, we know that the costs of conducting a review using the SCIE 'Learning Together' model range from £5,000 to £20,000 depending on the level of complexity of the case. SCIE has provided the following table which shows the costs of using the model at three different levels: full (i.e. a comprehensive model for complex cases); mid range (the standard approach) and focussed (a lighter touch approach for less complex cases):

SCIE 'Learning Together' model: Number of review days and total cost			
	Full	Mid-range	Focussed
Lead reviewers	20+	10-15	5-10
Senior managers	5-10	2-4	1-2
Case workers	2-3	2	1
SCIE QA time	3-5	3-4	3
Total cost (using one external lead reviewer)	£15-20,000	£10-15,000	£5-10,000

The cost of a mid-range SCIE review is therefore slightly less than the cost of an average SCR conducted under the current statutory guidance so may lead to savings for LSCBs.

As well as SCIE there are other systems review models available such as:

<u>Appreciative Inquiry</u> - which involves collaborative inquiry, based on interviews and affirmative questioning, to collect and celebrate the good practice stories that enhance the working relationship between professionals and between professionals and clients. We do not have figures for this approach but it typically it does not involve a lengthy process.

<u>Root Cause Analysis</u> - which aims to understand the underlying causes of incidents rather than identifying individual failure. It aims to encourage attention to failures in the systems within which people work in order to understand the underlying causes of adverse incidents. As yet this approach has not been tested in SCR type cases so no cost information is available.

There will be transition costs associated with the time and effort of professionals who are familiarising themselves with the revised approach. It is therefore likely that there will be a period of transition before the true cost of using the new approach can be assessed and before savings can be realised.

Benefits

Placing a monetary value on improvements in children safeguarding that could result from systems methodology practice during SCRs is not likely to be possible. There is no obvious way of estimating the causal effect on abuse and neglect levels due to the methodology introduction ex ante. Moreover placing a monetary value on this quantitative impact in a way that measures the full welfare effect is, naturally, extremely challenging.

We do not estimate there to be any one-off benefits as a result of the changes. However, we estimate that there are likely to be non-monetised benefits to all professionals, particularly front-line professionals, who we anticipate will benefit from greater involvement in the systems model and better learning as a result. This should lead to improvements in preventative services and reduce the risk of recurrence.

There is often a high chance that other proceedings, particularly criminal proceedings, will run in parallel to the SCR process. Participants in the SCR may be called as witnesses, all the data generated as part of the case review process is potentially admissible in the court process. In the current SCR process, depending on the type of proceedings in question, this could include transcripts from interview with staff, IMR reports, SCR Panel meeting minutes and the overview report. Taking a system approach does not change this situation significantly.

Rationale and evidence that justify the level of analysis used in the IA (proportionality approach)

Although we have some estimates of the cost of the new approach these are not yet robust. We will endeavour to collect more information for the next stage of the IA.

Risks and assumptions

There is a potential risk associated with reducing centrally-issued practice guidance before the system has fostered a learning culture and developed the necessary skills and expertise amongst professionals. This is acknowledged in the Government response to the Munro Review: 'Moving away from a culture of compliance by reducing central prescription and placing a greater emphasis on the appropriate exercise of professional judgment represents a fundamental system-wide change. It will take time for the necessary skills and knowledge to develop and for experience of new ways of working to become fully embedded and effective' (page 13). However, this should not prevent us from reforming the guidance, since the benefits that revision would bring cannot be realised otherwise, and we will take steps to mitigate the associated risk. As Munro stated, 'removing prescription without creating a learning system will not secure the desired improvements in the system. On the other hand, delaying the removal of prescription until services show they can take responsibility prevents them from demonstrating it' (Para 8.28).

Munro stated 'efforts to apply the systems approach to the multi-agency child protection system are still very new relative to other sectors' (Para 4.46), and 'The move to a systems approach to learning will require a radical reconceptualisation of the task and readjustment of the required skills. The extent of the change should not be underestimated' (Para 4.47)

The proposed revision of *Working Together* (2010) should not present a risk to safeguarding; rather, it has the potential to improve outcomes for children and young people by increasing professionals' ability to exercise judgment to respond appropriately to the varied circumstances and needs with which they are faced. However, we are conscious that this is a radical revision of the current guidance, which is why we are planning to conduct a full, 12 week consultation on

both the guidance and the guidance so that any potential risks to safeguarding can be highlighted and addressed.

It must be accepted that an inherent uncertainty will always exist within the child protection. By working towards a culture in which professionals can develop and exercise judgment, both by reducing the degree of over-standardised, centrally prescribed guidance, and by working with sectors to develop evidence-based practice guidance, we will ensure that this risk is managed more effectively, by helping professionals learn to be 'risk sensible'.

Post implementation review

The Government will review the implementation of the new guidance and assess its impact in terms of:

- the numbers of SCRs initiated and successfully published; and

- evidence of improvements in child protection practice which are made by LSCBs and their partners.

The impact of SCRs conducted under the new model will also be reviewed as part of inspections by Ofsted.

Direct costs and benefits to business calculations (following OIOO methodology)

The revision to the SCR process should not have any impact on private sector organisations who may become involved in SCRs. Private sector organisations, for example those providing care services to looked after children, may on occasion be required to contribute to SCRs if they were providing services to a child who died or who was seriously harmed and abuse or neglect was a factor. The nature of this contribution to SCRs will not change as a result of the revised guidance. This proposal is therefore out of scope for 'one in, one out' purposes.

Wider impacts

Statutory Equalities Duties

An adverse impact is unlikely as a result of the proposed revision. On the contrary, a positive impact is likely as the revision will lead to better prevention of future harm and improved outcomes for vulnerable groups of children who we believe are likely to make up a disproportionate portion of the children and young people affected. There is insufficient evidence, however, for this analysis to be made with as much confidence as is desirable, and we will undertake a fuller analysis of the impact on equalities post-consultation, when we are developing the form of the final guidance.

Summary and preferred option with description of implementation plan

The current Working Together to Safeguard Children (Working Together) statutory guidance on SCRs gives agencies responsibility for collecting and analysing data within their own organisation and writing this up as an individual management review (IMR). An overview author is then commissioned to collate and analyse the set of reports and write an overview report. In a systems approach such a division is unhelpful and in place of an overview author a lead reviewer, trained in systems methodology, works with local professionals, to collect and analyse information. Adopting a systems approach will therefore require revising statutory guidance to remove the requirement for IMRs.

Professor Munro's review of child protection, *A child-centred system,* found that the current

version of Working Together (2010) has become too lengthy, through the inclusion of a large amount of non-statutory, practice guidance. It does not clearly distinguish the statutory rules that are essential to safeguard and promote the welfare of children from this non-statutory professional guidance. This is hindering professionals' ability to exercise judgment to respond to the varied needs and circumstances of individual children, encouraging instead a culture of compliance with the guidance as a whole.

By leaving the statutory guidance in place, the regulatory framework for safeguarding would remain unchanged and in force. We therefore recommend revising chapter 8 of the Working Together (2010) as part of the revision of the whole Working Together (2010) guidance.

The Government will instead issue statutory guidance that sets out the new requirement to undertake a SCR using a systems model. It will encourage sectors to lead the development of professional guidance on SCRs which is informed by their research and local evidence bases to give greater opportunity for local innovation.

For such an important and far-reaching revision, we intend to carry out a full 12 week consultation on both Working Together (2010) and the learning and Improvement guidance. We intend to do so from June 2012, to allow enough time post-consultation for a thorough analysis and for responses to influence the final guidance in a meaningful way. This will be supported by a SCR Advisory Group which we have established, comprised of sectoral and local government organisations from all parts of the child protection system. Members will play a role in promoting the consultation to their networks, and will advise on the development of the learning guidance throughout the process.