HALTON SAFEGUARDING CHILDREN BOARD

LEARNING AND IMPROVEMENT FRAMEWORK

Version 2.0	**Ratified:**	**June 2015**
Status: Final	**Review:**	**May 2016**

Halton Local Safeguarding Children Board Learning Improvement Framework

1. Introduction

Supporting children, young people and families with safeguarding needs is important, necessary and complex work. Consequently practitioners and organisations need to reflect on the quality of their services and learn from their own practice and that of others. Good practice should be shared so that there is a growing understanding of what works well. Conversely, when things go wrong there needs to be a rigorous, objective analysis of what happened and why, so that important lessons can be learnt and services improved to reduce the risk of future harm to children.

Working Together to Safeguard Children 2015 states that Local Safeguarding Children Boards (LSCBs) should 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.

2. Objectives

This framework should drive lasting improvement to the outcomes for children and families and will:

- Ensure that the LSCB fulfils its statutory obligations.
- Ensure that the workforce is suitably skilled.
- Improve services through workforce development.
- Ensure that the expectations of the LSCB and partner organisations are clear.
- Ensure that single and multi-agency learning and development activity is appropriate, accessible and of good quality.

The aim of the framework is to: keep children safe; manage the risk inherent in this area of work; drive improvement in outcomes for children and families; and promote organisational reflection.

3. Roles and Responsibilities

This framework is for Halton LSCB, partner agencies and all local organisations that work with children and families.

The LSCB will maintain and develop this framework in response to local and national policies, legislation and guidance.

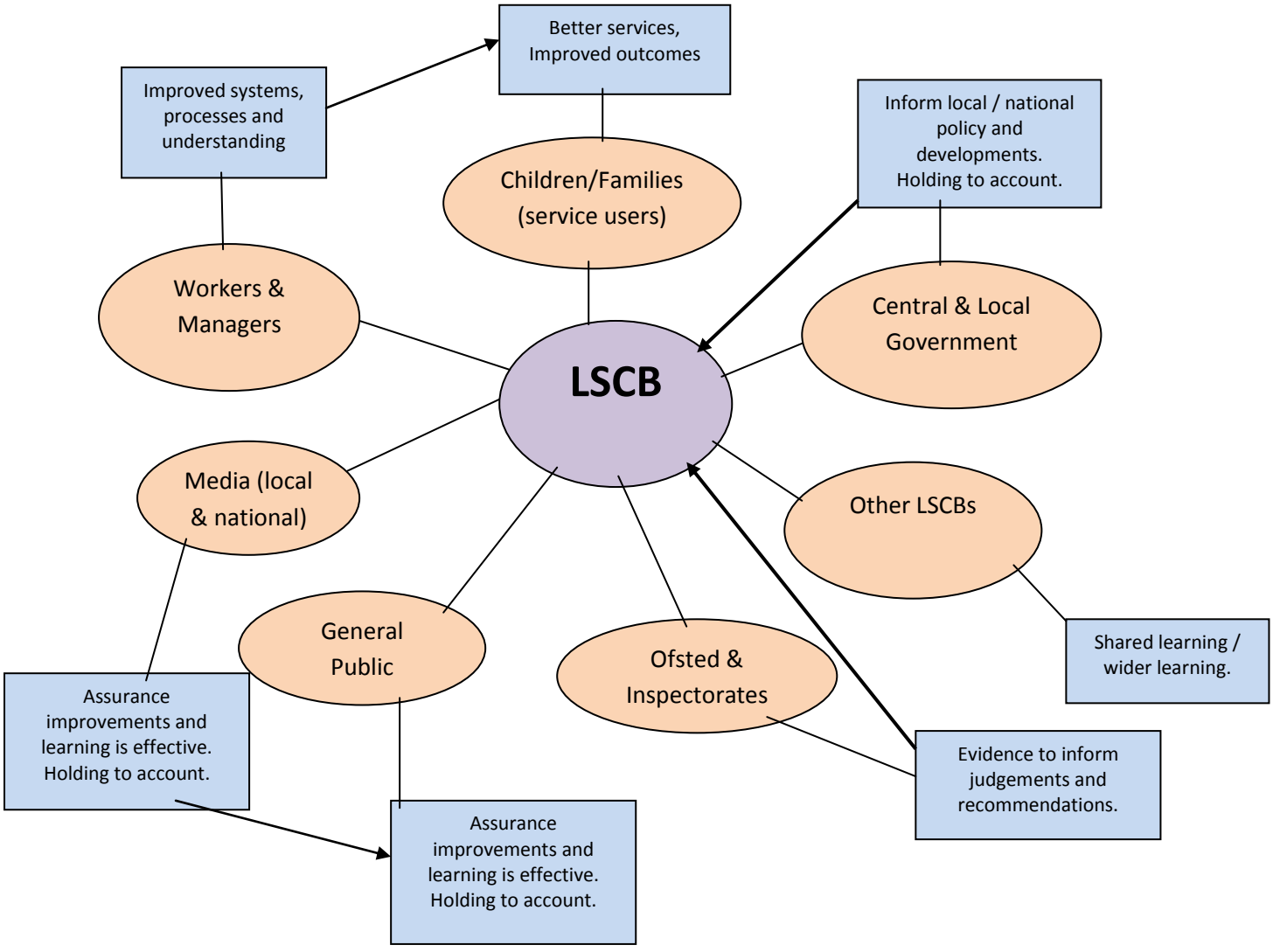
Partner agencies and all local organisations who work with children and families are expected to endorse this framework and embed this into their organisational and workforce learning and development policies. In addition partner agencies and local organisations are responsible for:

- Providing resources, including staff, to deliver the framework.
- Contributing to all learning and improvement activity undertaken by Halton LSCB; this includes reviews of practice and child deaths and audit activity.

- Ensuring lessons learnt from this activity are disseminated widely within their organisations; this includes: training, policies & procedures, implementing action plans.
- Ensuring that lessons learnt from this activity are embedded into practice.

4. Stakeholder Map

It is important to identify the key stakeholders who will influence and be influenced by LSCB learning and improvements. These are illustrated below showing the key needs of each group.



The key point to note here is that any learning and recommendations identified by the LSCB or its member agencies will need to meet different expectations and requirements specific to the stakeholder group. It should also be noted that some learning will be much wider than the LSCB and its member agencies.

5. Methods of Learning

The LSCB is a learning organisation and through its provision, scrutiny and challenge functions contributes to a significant amount of multi and single agency learning. The LSCB has an expectation that in all of its learning activity the voice of children and families is a golden thread, with consultation taking place at every level.

Type of review	Description	Key Stakeholders	Reporting
Serious Case Review	Where abuse or neglect is known or suspected and either: 1) a child dies; or 2) a child is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child.	LSCB Partner Agencies Service Users Media Ofsted General public	LSCB via the Critical Incident Panel
Multi-agency Practice Learning Reviews	Review of a safeguarding incident which falls below the threshold for an SCR or where a complex case has identified good outcomes for the child and there are lessons to be learnt for multi-agency working.	LSCB Partner Agencies Service Users	LSCB via the Critical Incident Panel
Child Death Reviews	A review of all child deaths up to the age of 18 years.	LSCB Partner Agencies Children & Families Ofsted Media	LSCB via Pan-Cheshire Child Death Overview Panel (CDOP)
Single Sector or Single Agency Reviews	Review of a safeguarding incident which falls below the threshold for an SCR and where there are limited concerns about how organisations or professionals worked together to safeguard the child.	LSCB Partner Agencies Service Users	LSCB via the Critical Incident Panel
Multi-agency case audits	Audit of practice relating to a child's journey through the safeguarding system (case sample), highlighting where things go well as well as opportunities to improve.	LSCB Partner Agencies Service Users	LSCB via Scrutiny & Performance Sub Group
Single agency audits	Audit of practice (case sample), highlighting where things go well as well as opportunities to improve.	Partner agencies as detailed in the forward plan or reports	LSCB via Scrutiny & Performance Sub Group
Section 11 audits	Self assessment of an organisation's safeguarding arrangements and practice against Section 11 of the Children Act 2004, highlighting good practice as	LSCB Partner Agencies	LSCB via Scrutiny & Performance Sub Group

	well as opportunities for improvement.		
Section 175/157 audits	Self assessment of a school's safeguarding arrangements and practice against S175/157 of the Education Act 2002.	LSCB Schools	LSCB via Scrutiny & Performance Sub Group
Focussed Studies/Research	Issue specific learning.	LSCB Partner Agencies	LSCB, Executive and Sub Groups
Quality Assurance & Performance Management activities (audits, surveys, data analysis, performance indicators)	Variety of methods using Performance Framework	LSCB Partner Agencies Service Users Ofsted	LSCB via Scrutiny & Performance Sub Group
Evaluation of impact of training	Audit to understand the impact of training on outcomes for service users	LSCB Partner Agencies	LSCB via Safer Workforce & Development Sub Group

6. Principles for learning and improvement:

The following principles outlined in Working Together to Safeguard Children 2015 will be applied by Halton LSCB and its partner organisations to all reviews:

- There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice;
- The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined;
- Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- Professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- Families, including surviving children, should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring that the child is at the centre of the process;
- Final reports of SCRs must be published, including the LSCB's response to the review findings, in order to achieve transparency. The impact of SCRs and other reviews on improving services to children and families and on reducing the incidence of deaths or serious harm to children must also be described in LSCB annual report and will inform inspections; and

- Improvement must be sustained through regular monitoring and follow up so that the findings from these reviews make a real impact on improving outcomes for children.

7. Methodology for learning and improvement

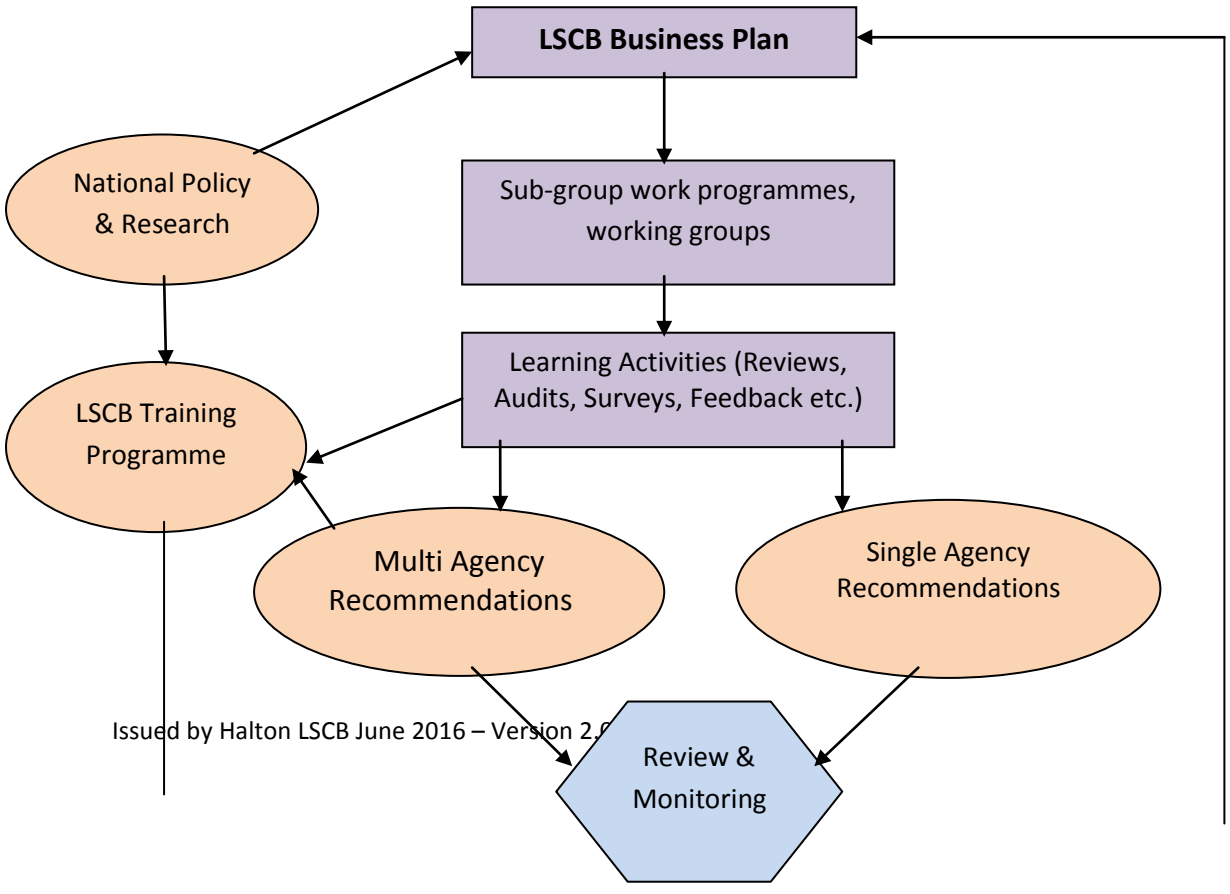
SCRs and other case reviews should be conducted in a way which:

- Recognises the complex circumstances in which professionals work together to safeguard children;
- Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- Is transparent about the way data is collected and analysed; and
- Makes use of relevant research and case evidence to inform the findings.

The LSCB may use any learning model consistent with the principles in Working Together to Safeguard Children 2015. Halton LSCB will consider systems-based methodologies when undertaking reviews.

8. Translating learning into continuous improvement

As a learning organisation it is important to be clear how the learning from this wide variety of review activity (as illustrated in section 5) is used to drive improvement in practice, policy and procedure. It is therefore important that organisational learning is seen as a dynamic, cyclical and multi-layered process that informs the LSCB's wider strategic planning framework which determines current and future priorities and resource allocation.



The learning and recommendations from the various learning activities illustrated above can be implemented in a number of ways, such as improved procedures and policies, and supported through training programmes. In some cases individual agencies will be required to consider how these recommendations can best be implemented and in turn provide assurance to the LSCB that this has been achieved effectively. Where the learning is applicable to a number of agencies or the LSCB itself, the LSCB should ensure this happens effectively. Depending on the nature of the learning much of this will take place through the LSCB sub-groups as appropriate. Appendix 1 illustrates the learning lessons feedback loop to ensure this is embedded in practice.

9. Safer Workforce & Development Sub Group

Where it is felt specific training programmes should be considered the LSCB Safer Workforce & Development Sub Group will consider how best this can be achieved.

The Sub Group provides a key function in coordinating learning needs from a variety of sources to inform the planning and commissioning of multi-agency training. The quality of this training is reviewed through participant feedback, including post course evaluation. Evidence is collated and reviewed to inform future training delivery and the wider LSCB strategy.

The LSCB provides a variety of multi-agency training courses for safeguarding practitioners and managers to ensure they are equipped with the necessary skills, knowledge and values required to deliver quality safeguarding services that improve outcomes for children and families. The details of how the LSCB provides this, operationally, are contained within the LSCB Learning & Development Strategy.

10. Critical Incident Panel

The role of the Critical Incident Panel is to:

- Monitor the SCR and Multi-Agency Practice Learning Review processes and oversee changes to these processes.
- Consider whether a Serious Case Review, or any other type of review should be undertaken and make a recommendation to the LSCB Independent Chair.
- Nominate members of the SCR Review Panel and identify lead reviewer(s).
- Identify lead reviewer(s) for Multi-Agency Practice Learning Review or other types of review.

- Formulate actions from SCR findings, once the Case Review Group has presented its findings to the LSCB Main Board.

- Monitor the progress of any actions from all types of review until all are completed.

11. Scrutiny & Performance Sub Group

The Scrutiny & Performance Sub Group oversees a schedule of audit activity across the continuum of the child's journey. This includes single and multi-agency audits. Themed audits may also be commissioned by the LSCB which the Sub Group will oversee. The activity of this Sub Group is outlined in the LSCB's Performance Framework.

12. Expectations of Individual Organisations

- Employers are responsible for ensuring there are safe recruitment practices for individuals whom the organisation will permit to work regularly with children, including policies on when to obtain a criminal record check.

- Employers are responsible for providing appropriate supervision and support for staff, including undertaking safeguarding training.

- Employers are responsible for ensuring that their staff are competent to carry out their responsibilities for safeguarding and promoting the welfare of children and creating an environment where staff feel able to raise concerns and feel supported in their safeguarding role.

- Employers are responsible for ensuring their staff are given mandatory induction, which includes familiarisation with child protection responsibilities and procedures to be followed if anyone has any concerns about a child's safety or welfare; and

- Employers are responsible for ensuring that all professionals have regular reviews of their own practice to ensure they improve over time.

- Organisations are responsible for releasing staff to assist in delivering multi-agency learning activity as well as attending multi-agency learning.

- Organisations are responsible for ensuring that there is evidence that staff have received suitable basic safeguarding training, refreshed in the appropriate timescales set out in national and/or LSCB guidance.

- Organisations are responsible for responding to audits under section 11 of the Children Act 2004.

- Organisations are responsible for reporting on their compliance and quality of single agency work.

Appendix 1: HSCB Learning Lessons Feedback Loop