Learning and Improvement Framework

April 2016- March 2018

Approved by:	Peterborough Safeguarding Children Board
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This document is adapted from Sheffield Safeguarding Children Board Learning & Improvement Framework. It is used with the agreement of the SSCB

Working Together 2015

Local Safeguarding Children Boards 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.*

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.*

The local framework should cover the full range of reviews and audits which are aimed at driving improvements to safeguard and promote the welfare of children.[1]

[1] DfE (2015) *Working Together to Safeguard Children*, page 72 para 4 and 5

Peterborough Safeguarding Children Board uses data in order to ensure itself of the quality and effectiveness of the safeguarding provision across the city. It is striving to undertake, or commission, regular and effective monitoring and evaluation of front-line practice and the quality of management oversight. This is undertaken in order to achieve assurance of organisations working together to safeguard children and to drive improvements in the quality of service. This framework should be read in conjunction with the PSCB Performance Management framework which includes the use of data analysis, service evaluations, statutory Serious Case Reviews (SCRs) as well as non-statutory reviews and case files audits. The importance of always keeping the child protection system 'child centred' (Munro, 2011) is at the heart of the PSCB's focus. The use of data to provide this information is reflected through the PSCB Business Plan 2016-18 being part of all objectives.

The PSCB are working to increase the numbers of frontline practitioners involved in the learning and improvement work, in addition to this, the involvement of parents and children is a priority and the PSCB are focusing on ways to increase the numbers of service users participating in PSCB projects.

Working Together 2015 highlights that LSCBs should use data and as a minimum should:

- '*Assess the effectiveness of the help being provided to children and families, including early help*
- *Assess whether LSCB partners are fulfilling their statutory obligations;*
- *Quality assure practice, including through joint audits of case files involving practitioners and identifying lessons to be learned; and*
- *Monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children'*.

This Learning and Improvement framework has three aspects:

1. A summary of the reviews, analysis, evaluations and file audits undertaken or commissioned by the PSCB.
2. An outline of organisations responsibilities to learn from experience and improve services in response to these findings.
3. A description of how the learning is disseminated to front line practitioners to improve practice and lead to better outcomes for children.

Section 1. The reviews, analysis and file audits undertaken or commissioned by the PSCB

"The local framework should cover the full range of reviews and audits which are aimed at driving improvements to safeguard and promote the welfare of children."[2]

Learning opportunities, and opportunities to build on examples of good practice from safeguarding practice arise from a variety of sources. This framework sets out the key practice reviews that the Peterborough LSCB, partner agencies and other local organisations undertake. Within all reviews the voice of children and young people will be a central thread, ensuring this is heard and acted upon.

Serious Case Reviews

These will be undertaken as defined in Working Together 2015, where:

> Abuse or Neglect of a child is known or suspected; and either 1) the child has died, or 2) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.[3]

Safeguarding Children Boards can undertake a Serious Case Review using any model that they consider appropriate providing it is consistent with the principles set out in Working Together 2015.

- *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 must 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*

[2] DfE (2015) *Working Together to Safeguard Children*, page 72 para 5
[3] DfE (2015) *Working Together to Safeguard Children*, page 73

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 reports 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.*

Reviews of cases that do not reach the threshold for a Serious Case Review

It is important that the PSCB utilises every opportunity to learn from practice accordingly. Reviews of cases that do not meet the criteria of a Serious Case Review, but that 'can provide valuable lessons about how organisations are working together to safeguard and promote the welfare of children'[4] are also carried out by the PSCB. This provides the Board with the opportunity to use different models of review that best meet the requirements for learning for that specific case. Peterborough has been keen to develop a series of different styles and techniques that can be used for this purpose. There are four main models which are implemented.

Table 1. Models of reviewing cases that do not meet the criteria for a Serious Case Review

Type of Review	Summary	Further details
Case Reviews	Model 1 – Information reports are produced by agencies and a Case Review Panel is established. An Overview author is commissioned. Practitioners are interviewed by their agency. Family members involved	Used when a case gives significant concerns that will lead to learning for the city and there is a lengthy time period to be reviewed. Recommendations developed and monitored by the PSCB.
	Model 2 - Information reports are produced by agencies, in addition there is a focus group of the front line practitioners and the findings feed into the Case Review Panels findings	Small group of key workers involved (e.g. core group) who can assist in pulling out key learning. Recommendations developed and monitored by the PSCB.

[4] DfE (2015) *Working Together to Safeguard Children*, page 72 para 6

Learning Lessons Review	One day review, no information reports produced prior to the day, information presented by agencies at the review day. Learning points developed by the panel. Can include practitioners.	Short time period under consideration. Recommendations made and monitored by the PSCB.
Thematic Enquiry	One day review that focuses on key themes from the case that are identified prior to the learning event	Case identifies clear themes that can be further developed at the learning event into thematic lessons. Recommendations made and monitored by the PSCB
Individual Agency Report	Learning for a single agency who produce a full IMR and actions and present this for consideration to the PSCB	Learning for single agency.

Domestic Homicide & Serious Incident Reviews

When there has been a death of an individual of 16 years or over which has, or appears to have, resulted from violence, abuse or neglect by a person to whom s/he was related to, had been in an intimate personal relationship or was a member of the same household then a Domestic Homicide or Serious Incident review will be undertaken (if the deceased person was 16 – 18 years then a Serious Case Review will be undertaken, with the Domestic Violence fully considered). The PSCB is involved in all reviews where there are children living in the house and the findings and recommendations are fed into the Safeguarding Children Board.

Child Death Reviews

'The LSCB is responsible for ensuring that a review of each death of a child normally resident in the LSCB's areas is undertaken by a Child Death Overview Panel'[5]. The panel meets regularly, recommendations are made and an action plan developed that feeds back to the safeguarding Children Board. The Child Death Overview Panel provides regular updates to the PSCB Operational Chairs group and the PSCB Board scrutinises the performance of the Child Death Overview Panel through their Annual report.

Multiagency Themed Audit

The PSCB have developed a series of themed audits that will run throughout the year. Themed audits are scheduled and will involve a multi-agency audit team auditing a number of cases following a set structure. The themes chosen will be those relevant to local or national

[5] DfE (2015) *Working Together to Safeguard Children*, page 81 para 3

priorities. For 2015-16 this will include cases of Neglect, Children in Need, Missing, Young people transferring from Children's to Adult Services. Frontline practitioners will be involved via focus groups. Parents and young people will be involved wherever possible. The days will focus on the child's lived experience, the quality and impact of practice and will involve 'appreciative elements', to highlight what worked well in cases as well as areas for action. Action plans will be devised and monitored by the PSCB Quality & Effectiveness Group

Audits & Evaluations

- ***Section 11***

Section 11 (s.11) of the Children Act (2004) places duties on a range of organisations to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children.

The PSCB monitors that organisations/agencies are s.11 compliant through on-going s.11 audits that are conducted on a 2 year rolling programme. In addition to this, specific single agency audits are planned. Further details of the years s.11 work is detailed in the PSCB Business Plan.

- ***Parental and Young People feedback questionnaire (parents attending a child protection conference)***

All parents and young people who attend both initial and review child protection conferences are requested to complete a feedback questionnaire at the completion of the conference. The questionnaire focuses on whether the social work report was shared with parents prior to the conference, if this contained their views and that of their children, whether they felt listened to by the professionals involved in their child's case, if they understood the contents of the Child Protection Plan. It also considers their experiences of the child protection conference including the effectiveness of the Child Protection Chair. Findings from the questionnaire are reported to the PSCB at six monthly intervals.

- ***Child Protection Conference Monitoring Forms***

The conference co-ordinators complete monitoring forms regarding every conference and these are analysed on a quarterly basis. This focuses on various aspects of the conference including whether the report was shared with parents, if it included parent's views, was sent to the co-ordinator two days prior to the conference, whether the children's wishes and feelings were sought, if the child protection plan was brought and if this managed risk effectively. The

report summarises the results for each area team. Findings from the monitoring forms are reported at six monthly intervals.

PSCB Data Dashboard

The data dashboard is presented to the PSCB Board and summarises relevant information for the Boards consideration. This has included the progress towards the PSCB Business Plan strategic objectives, action plan monitoring from SCRs and Case Reviews, S.11 self-assessments and action plans and data on the number of children subject to a child protection plans in the city. From that other work has developed, for instance data looking at multiagency attendance at Child Protection Conferences.

Section 2. Outline of organisations responsibilities to learn from experience and improve services in response to these findings.

'Safeguarding is everyone's responsibility: for services to be effective each professional and organisation should play their full part'

(Working Together, 2015, page 9)

It is the responsibility of:

- The PSCB to monitor the effectiveness of local services to safeguard children.
- All organisations to respond to the findings of the reviews, audits and evaluations, in the light of their safeguarding responsibilities. The majority of the members of the PSCB represent agencies that have responsibilities under s.11. The remaining members have a professional responsibility to safeguard children.

In relation to the learning and improvement work undertaken, it is important that these are not seen as an end in themselves but as a progression of the safeguarding work:

'*Reviews are not ends in themselves. The purpose of these reviews is to identify improvements which are needed and to consolidate good practice. LSCBs and their partner organisations should translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children*.' (Working Together, 2015, page 73)

In relation to SCR, non-statutory reviews and section 11, action plans are in place and these are regularly monitored by the Board, using a RAG (Red, Amber, Green) rating system.

For the majority of the other evaluations and audits, recommendations will be made for agencies to take forward. In some instances repeated evaluations/audits are undertaken that can highlight whether improvements have been made.

It is important that organisations are clear about their safeguarding responsibilities and respond to the Board's learning and improvement work, in particular the recommendations for their agency, providing evidence of their organisations response actively using this as a basis for developing their safeguarding work.

Section 3: How the learning will be disseminated to front line practitioners to improve practice and lead to better outcomes for children.

LSCBs should; *'Monitor and evaluate the effectiveness of training, including multi-agency training to safeguard and promote the welfare of children'*

(Working Together, 2015)

Peterborough Safeguarding Children Board goes beyond this minimum requirement by not only monitoring and evaluating training provided by partner agencies, but by developing and delivering a substantial programme of training and learning events that:

- Ensures a comprehensive programme of high quality multi-agency training that is linked to and shaped by; local priorities, learning from Reviews, Thematic Enquiries and the PSCB Business Plan
- Ensures that training meets the needs of a wide range of people, including volunteers
- Actively and effectively promotes the availability of training and adopts measures to increase its accessibility, including employing a range of delivery methods e.g. whole day courses, seminars and workshops, conferences.
- Offers an extensive and responsive programme of short seminars and other learning events that are able to respond efficiently to training needs or to disseminate learning from reviews, audits etc.

In addition, the PSCB seeks to assess the impact of training, not only at the time of delivery but over a period, in order to measure changes in practice resulting from attending training

The PSCB is supported in this role by the Learning and Engagement Group (LEG), a sub group of the Board. The LEG is responsible for developing the city wide Safeguarding Children Training Strategy.

PSCB Training Strategy

The PSCB Training Strategy, which is revised annually, is aligned with the PSCB Business Plan and details;

- How training and learning activity across all partner agencies will support PSCB Business Plan objectives. All partner agencies are required to report on how training activity provided by that agency will contribute to meeting key objectives, and this activity is monitored through the LEG.
- The responsibility of all partner agencies to ensure that training is of high quality, meets the identified needs of staff and will be maintained under constant review to ensure it remains up to date and takes account of learning from case reviews, thematic enquiry and local audit activity. All local learning and lessons for improving practice are disseminated through both LEG and an extensive network of safeguarding representatives within agencies. LEG will monitor how this learning is incorporated into single agency training and practice.
- The responsibility of agencies to ensure that staff are supported to attend training and learning events appropriate to their role - both single agency and multi-agency training provided by the PSCB
- How agencies are required to identify gaps in training provision, or emerging training needs, in order that these can be responded to in an efficient and timely manner.

References

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Peterborough Safeguarding Children Board: Notification of a Serious Case Review Process

Peterborough Safeguarding Children Board: Performance Management Framework