Shropshire's Safeguarding Children Board

Keeping our Children Safe From Harm

LEARNING AND IMPROVEMENT FRAMEWORK

SSCB's approach to embedding learning

This Framework complements the guidance outlined in Inter-Agency Procedures: (Chapter 5 http://westmerciaconsortium.proceduresonline.com/chapters/p_learn_improve_frame.html)

September 2016

1. Introduction

Working Together 2015 states that 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.'

Working Together to Safeguard Children, 2015

Statutory guidance also sets out the following principles which should be applied by the LSCB and their 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 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 the reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.

- Final reports of SCRs must be published, including the LSCBs 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. " (WT 2015)

Furthermore Working Together states that "LSCBs may use any learning model which is consistent with the principles in this guidance, including the systems methodology recommended by Professor Munro. " (WT 2015)

This framework provides a vehicle for the SSCB to meet these statutory requirements and go beyond this to ensure all sources of learning are considered, recognised and used to drive improved outcomes for children and families.

Working Together 2015 identifies four types of review that should be included in the learning and Improvement Framework, namely:

- Serious Case Reviews
- Child Death Reviews
- Review of a child protection incident which falls below the threshold for an SCR
- Review or audit of practice in one or more agencies

In order to support a culture of continuous learning and improvement this document sets out a model to identify, act upon and disseminate learning and improvement opportunities to consolidate good practice within Shropshire. This local Learning and Improvement Framework does not seek to replace Inter-agency Procedures but is rather intended to enhance and support these by outlining how SSCB will support the implementation of local learning.

This framework is set out with 3 strands:

- Quality Assurance and Performance Activity
- Multi-agency learning and improvement from case reviews, Serious Case Reviews, Case Reviews, Child Death Reviews and Domestic Homicide Reviews.
- External reviews of our effectiveness and self-evaluation

2. Types of Review

Type of Review	Description	Who	Reporting
Serious Case Review	Initiated when: (i) Abuse or Neglect of a child is known or suspected AND (ii) Either the child has died OR the child has been seriously harmed AND (iii) 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. Additionally, even if these criteria are not met a Serious Case Review should always be carried out when: • A child dies in custody, in police custody, on remand or following sentencing, in a [Young Offender Institution], in a secure training centre or a secure children's home or where the child was detained under the Mental Health	Partner agencies Relevant organisations Independent Reviewer SSCB Business Unit	SSCB via the Learning and improvement sub-group and or SCR Panel/Review Team

	Act 2007. • A child dies by suspected suicide.		
Learning Review	A Learning Review should take place when a 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. Or: There appears to be learning for how agencies could work together better to safeguard children in the future. The case raises issues that require the development of policy or practice guidance Cases which feature excellent multi-agency practice, particularly where the case was difficult to manage, should also be reviewed as they will provide valuable learning about improving local safeguarding arrangements	Partner agencies Relevant organisations Possible Independent Reviewer SSCB Business Unit	SSCB via the Learning and Improvement sub-group
Deep-dive audits of practice	Undertaken when: The criteria for a SCR or learning review have not been met; however lessons could be learnt in relation to certain aspects of the case. Themes are emerging across a number of cases.	Learning and Improvement sub-group Partner agencies	SSCB via Learning and Improvement sub-group
Child Death Review	A review of all child deaths up to the age of 18.	Child Death Overview Panel (CDOP)	SSCB via annual CDOP report
Multi-agency themed audits	Audit of practice relating to a specific safeguarding issue.	Quality Assurance and Performance sub-group (QAP) Partner agencies	SSCB via QAP quarterly report
Single agency audits	Audit of practice	Partner agencies	SSCB via QAP
Section 11 audits (Children Act 2004)	Self-assessment of an organisations safeguarding arrangements and practice.	Partner agencies	SSCB via QAP
Section 175/157 audits (Education Act 2002)	Self-assessment of a schools safeguarding arrangements and practice	Schools	SSCB via Education Assurance Report

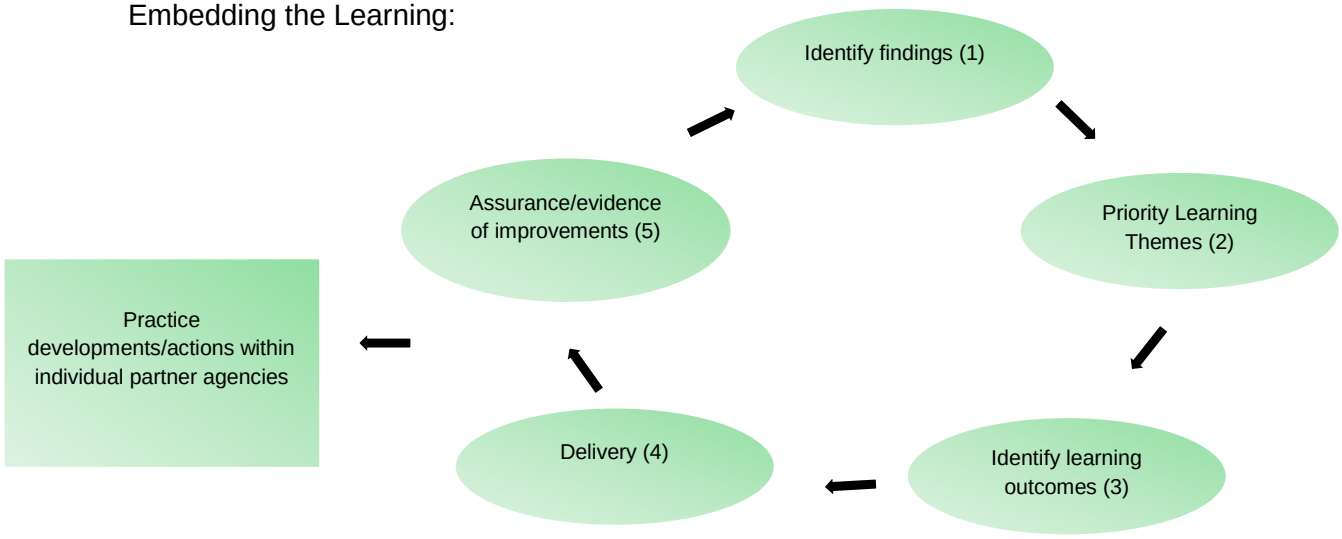
National research, SCRs etc..	Key messages from research, other LSCB's SCRs	Learning and Improvement sub-group Training sub-group	SSCB

Programmes of action should stem from these reviews, as reviews are not ends in themselves. Therefore, in addition to reviewing practice SSCB will seek to embed the learning, seek assurance about practice improvements in services provided and review outcomes for children, young people and families in Shropshire.

3. Local Framework

To implement learning and improve outcomes SSCB and partner agencies follow the model outlined below:

Embedding the Learning:



3.1 Identify Findings

Findings could be generated from the following sources:

- Serious Case Reviews
- Learning Reviews
- CDOP
- Quality Assurance and Performance Management Activities
- Practitioner feedback
- Parent's and young people's feedback
- Inspections/Peer Reviews
- Learning Activities
- Guidance and policy briefings

3.2 Priority Learning Themes

Findings from SSCB's SCRs/Learning Reviews/Child Death Reviews and other quality assurance activities will be collated on a regular basis and priority themes will be identified. The basis for identifying the themes will ensure that due regard is given to SSCB's strategic priorities in order to make sure that resources are used to maximum effect.

3.3 Identifying Learning Outcomes

Learning outcomes will be generated from the priority learning themes and set out as a detailed schedule of activities identifying how they can be achieved. This will include planning for future processes to monitor and evaluate the impact of the learning over time. The Learning outcomes will be presented to the SSCB Executive for discussion as to how these can be best achieved.

3.4 Delivery

Learning outcomes could be achieved by a combination of:

- Incorporation of learning into SSCB core multi-agency training modules
- Events on themes or in response to specific learning requirements for identified key practitioners and/or managers
- Publication of Learning and Improvement briefings
- Reviewing and development of inter-agency policies
- Identifying further areas of practice development
- Commissioning specific training/events

3.5 Practice Development

Practice development within individual agencies will need to be driven from within the organisation and could be monitored by a combination of:

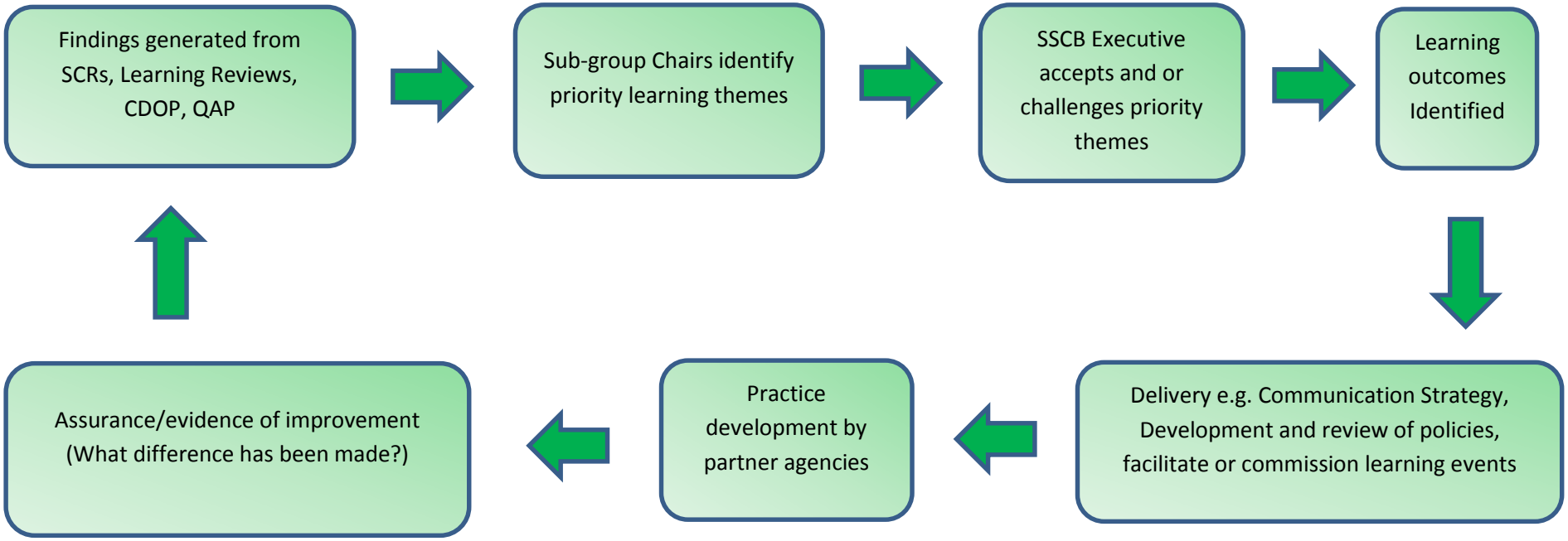
- Training evaluations of impact on practice
- Single agency case file audits
- Multi-agency case file audits
- Performance framework
- Case review action plans

3.6 Assurance/evidence of improvement

This could be obtained via a combination of:

- Assurance reports from partner agencies
- Quality Assurance and Performance sub-group interrogating performance data to monitor activity and prompt further interrogation if necessary
- Multi-agency case file audits
- Service user feedback

Embedding Learning Process Chart



Further information can be found on the Learning and Improvement page and the Safeguarding Training page of the SSCB website.