NORTH EAST LINCOLNSHIRE SAFEGUARDING CHILDREN BOARD

LEARNING AND IMPROVEMENT FRAMEWORK

SCOPE OF THE CHAPTER

This chapter covers the requirements within **Chapter 4 of Working Together to Safeguard Children 2015,** which describes the way that professionals and organisations protecting children need to reflect on the quality of their services and learn from their own practice and that of others. It explains the requirements for an integrated local learning and improvement framework.

CONTENTS

1. PRINCIPLES – LEARNING AND IMPROVEMENT FRAMEWORK

Working Together 2015 requires that the Local Safeguarding Children Board maintain a shared local learning and improvement framework across those local organisations working with children and families. See **NEL Learning and Improvement Framework.**

This local framework covers the full range of single and multi-agency reviews and audits which aim to drive improvements to safeguard and promote the welfare of children. The different types of review include:

- Serious Case Review for every case where abuse or neglect is known or suspected and either:
  - A child dies; or
  - A child is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child.

Child death review (see chapter 5): a review of all child deaths;

- Review of a child protection incident which falls below the threshold for an SCR; and
- Review or audit of practice in one or more agencies.

2. PURPOSE OF THE LOCAL FRAMEWORK

All The aim of this framework is to enable NELSCB to improve services through being clear about our responsibilities to learn from experience and particularly through the provision of insights into the way our organisations work together to safeguard and protect the welfare of children.

The framework is shared across all agencies that work with families and children. Working Together states that 'This framework will enable organisations to be clear about their responsibilities, to learn from experience and improve services as a result'.

This should be achieved though:

- Reviews 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;
- Such reviews to encompass both those cases which meet statutory criteria (i.e. Serious Case Reviews and child death reviews) and cases which may provide useful insights into the way organisations are working together to safeguard and protect the welfare of children;

- Reviews examining what happened in the case, why it did so and what action will be taken to learn from the findings;
- Learning from both good and more problematic practice about the NELSCB strengths and weaknesses within local services to safeguard children;
- Action results in lasting improvements to services which safeguard and promote the welfare of children and help protect them from harm; and
- Transparency about the issues arising and the resulting actions organisations take in response to the findings from individual cases, including sharing the final reports of Serious Case Reviews with the public.

Reviews are not an end in themselves, but a method to identify improvements needed and to consolidate good practice. The NELSCB and partner organisations will translate the findings from reviews into programmes of action which lead to sustainable improvements.

3. PRINCIPLES FOR A CULTURE OF CONTINUOUS IMPROVEMENT

about There should be a culture of continuous learning and improvement across the NELSCB and partners to safeguard and promote the welfare of children, so as to identify what works and what promotes good practice.

Within this culture the principles are:

- A proportionate response: According to the scale and level of complexity of the issues
- 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 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.

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.

LSCBs may use any learning model which is consistent with the principles in this guidance.

There is an understandable focus on Serious Case Reviews given the profile of this type of review, however it should be remembered that they are not the only process that should drive learning and improvement. LSCB's should pay equal or greater attention to the dissemination processes for learning giving consideration to:

- The need to reach a multi-agency audience;
- An understanding of adult learning;
- The on-going training and development needs of certain professional groups.

4. ACCOUNTABILITY

NEL LSCB is committed to these principles and this learning will be implemented and monitored through the LSC B Leadership Board and its subgroups.

- Operational Board;
- Quality Assurance and Best Practice;
- Neglect;
- Serious Case Review;
- Learning and Development sub group;
- Child Death Overview Panel;
- Safeguarding in Education;
- Keeping Children Safe:
  - Domestic Abuse;
  - Child Sexual Exploitation;
  - Harmful Sexualised Behaviour;
  - Missing from Home and Care.

The LSCB Leadership Board through the work of the Operational Board, Learning and Development Sub Group, LSCB Sub Groups and the challenge of the Quality Assurance Sub Group will challenge services to improve practice and therefore outcomes for children. The LSCB operational board will be responsible for overseeing the progress against the Learning and Improvement Framework.

The NEL LSCB sub groups are responsible for the implementation of elements of the learning and improvement framework overseen by the Operational Board, in particular:

- To develop horizon scanning practice that will inform the development of learning opportunities and allow managers and professionals to keep informed of changing issues relating to safeguarding children;
- To communicate key safeguarding messages, research, lessons and procedural expectations to agencies, and professionals, to ensure a consistent approach to safeguarding children and continuous learning;
- To develop strength based approach to learning from Serious Case Reviews which looks to promote the factors that impact on good practice and minimise those that can contribute to problematic practice;
- To disseminate the learning from the local Child Death Overview panel and evidence impact made;
- Ensure safeguarding training is directly informed through learning from interagency safeguarding practice audits and from safeguarding reviews;
- To demonstrate what difference has been made as a result of the voice and influence of children and young people.

Evidence of progress/ transparency and public accountability will be achieved through:

- The operational board will evidence the impact of the learning and improvement framework by;

- Demonstrating improvements to practice within the LSCB composite performance report as a result of learning from audit and safeguarding reviews;
- The involvement of children, young people and their families and lay members in improving the work of the LSCB including the section 11 process;
- Production of an annual report on the learning from the local Child Death Overview panel;
- Production and publication of the LSCB Annual Report evaluating the effectiveness of Safeguarding arrangements in North East Lincolnshire.

The framework will measure the effectiveness of meeting the Board's four main priorities as outlined in the Business Plan:

1. Multi-Agency Early Help and Support for Families;
2. Addressing Neglect: Linked to Early Help and Prevention;
3. Addressing Child Sexual Exploitation;
4. Reduce the Impact of Domestic Abuse on children and young people.