Knowsley Safeguarding Children Board

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Learning and Improvement Framework

Introduction

Working Together to Safeguard Children 2015 states that 'good practice should be shared so there is an 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.'

Key themes emerging from Serious Case Reviews, Management Reviews, Child Death Reviews, Good Practice Review, Single Agency reviews, Multi-agency audits and reviews, Section 11 and 175 Audits, Quality Assurance Activity and evaluations of the impact of training will be disseminated into the Training Sub Group and to the Training Officer via a number of channels. This will inform future training programmes and briefing sessions to ensure that practitioners and organisations reflect on the quality of their services and learn from their own practice and that of others.

The KSCB and its partner agencies, have a responsibility to ensure that all sources of learning are considered, recognised and used to drive improved outcomes for children and families.

The Ofsted Inspection Framework for LSCB's states that in order for an LSCB to be judged as 'good' or 'outstanding' it should have a Learning and Improvement Framework in place that ensures that 'Opportunities for learning are effective and properly engage all partners. Serious case reviews are initiated where the criteria set out in statutory guidance are met and identify good practice to be disseminated and where practice can be improved.'

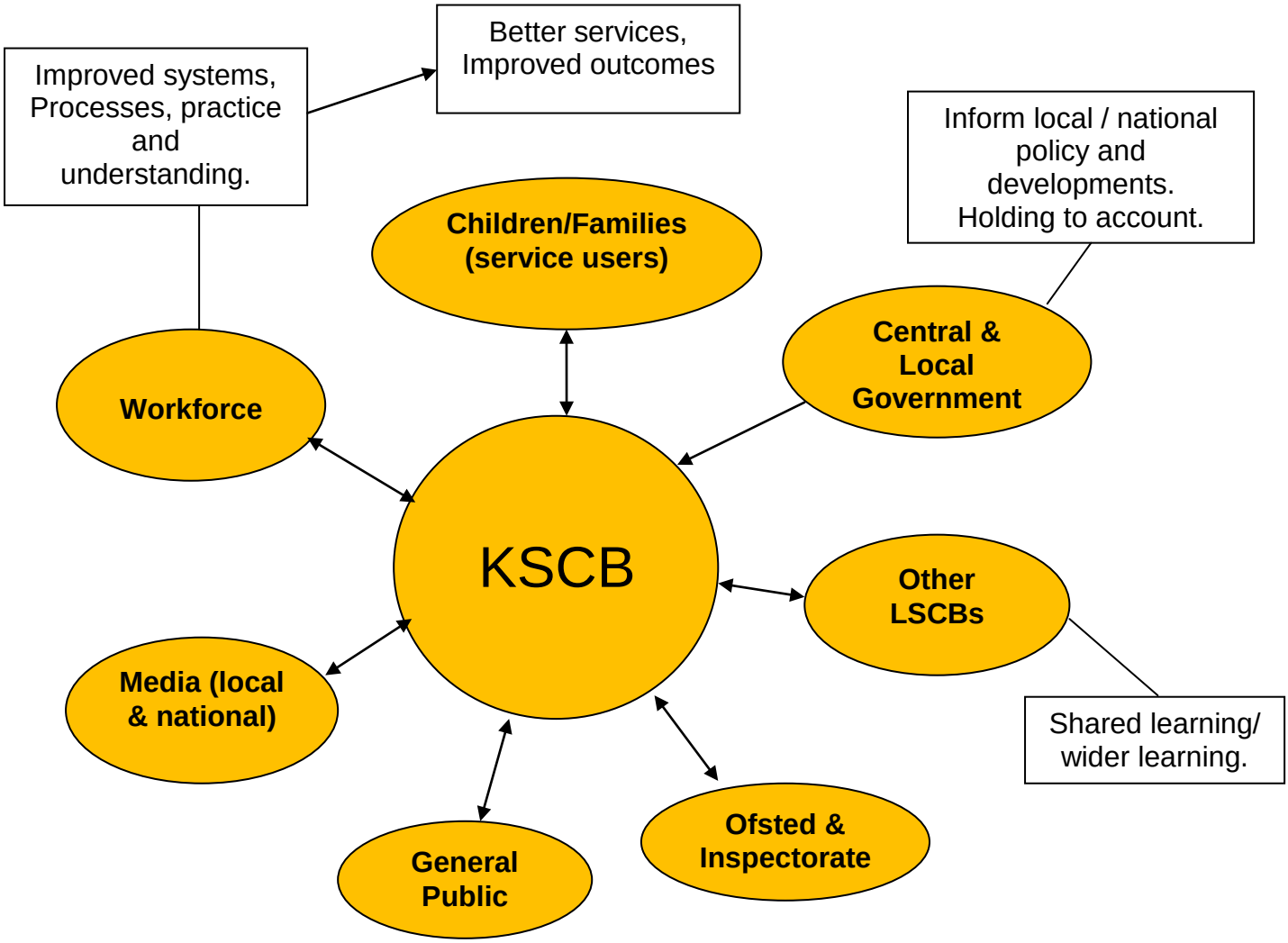
Purpose of the Learning Improvement Framework

This framework is intended to fulfil the following objectives:

- Ensure that the LSCB fulfils its statutory obligations
- Ensure there is a culture of continuous learning and improvement
- Ensure that learning is a shared responsibility between those who commission and provide training, organisations/managers responsible for staff and the staff themselves
- Ensure that services are clear about their responsibilities, to learn from experience and improve services as a result.

Stakeholders

It is important to highlight the key stakeholders who will influence and be influenced by KSCB learning and improvements.



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 and consideration should be given as to what measures can be taken to influence change locally or nationally.

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. Key themes for learning arise from a number of methods and these need to be embedded into programmes of learning, governance and workforce development.

Method of Review/Source of Learning	Description	Learning	Method of Learning	Key Stakeholders	Sub Groups
Serious Case Review (Statutory)	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.	Multi agency and single agency lessons National implications Changes to governance and legislation	Briefings Newsletter Feedback to KSCB and its Sub Groups Implemented in relevant KSCB Training Courses	KSCB Partner Agencies Service Users Media Ofsted General public	KSCB via the Serious Incident Review Group Training Sub Group
Multi-agency Management 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. Independent Author commissioned	Local learning - multi agency and single agency lessons	Feedback to LSCB and its Sub Groups Newsletter	KSCB Partner Agencies Service Users	KSCB via the Serious Incident Review Group Training Sub Group
Child Death Reviews Merseyside CDOP – Local Child Death Reviews and Briefings	A review of all child deaths up to the age of 18 years. Local review of all child deaths up to the age of 18 years.	Themes and trends Modifiable factors	Briefings Feedback to the KSCB Press Release /information on Website	KSCB Partner Agencies Service users Ofsted Media	LSCB Merseyside Child Death Overview Panel (CDOP)

Good Practice Review	Panel to review good practice. This should be shared so there is an understanding of what works well.	Multi agency and single agency lessons	Feedback to KSCB and its sub groups to be cascaded to professionals Newsletter Workforce Conference	KSCB Partner Agencies Service Users	Audit and Review Sub Group Training Sub Group
Single Agency Reviews	Review of a safeguarding incident that falls below the threshold for an SCR and where there are limited concerns about how organisations or professionals worked together to safeguard the child. One particular agency can learn from this incident.	Single agency lessons Changes to governance	Feedback to KSCB and its sub groups to be cascaded to professionals	KSCB Partner Agencies Service Users	KSCB via the Serious Incident Review Group
Multi-agency case audits and thematic 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. Possible theme is identified.	Multi agency and single agency lessons Changes to governance Themes and trends	Feedback to KSCB and its sub groups to be cascaded to professionals	KSCB Partner Agencies Service Users	KSCB via Audit and Review Sub Group
Single agency audits	Audit of practice (case sample), highlighting where things go well as well as opportunities to improve.	Single agency lessons Changes to governance Themes and trends	Feedback to KSCB and its sub groups to be cascaded to professionals	Partner agencies	KSCB via the Serious Incident Review Group
Section 11 audits	Self-assessment of an	Themes and trends	Feedback to KSCB and its sub groups to	KSCB Partner Agencies	KSCB via Executive

	organisation's safeguarding arrangements and practice against Section 11 of the Children Act 2004, highlighting good practice as well as opportunities for improvement.	Changes to governance	be cascaded to professionals		
Section 175 audits	Self-assessment of a school's safeguarding arrangements and practice against S175 of the Education Act 2002.	Themes and trends Changes to governance	Feedback to KSCB and its committee's to be cascaded to professionals	KSCB Schools	KSCB via Executive
Quality Assurance & Performance Management activities (audits, surveys, data analysis, performance indicators)	Variety of methods using Performance Framework	Themes and Trends	Feedback to KSCB and its sub group to be cascaded to professionals	KSCB Partner Agencies Service Users Ofsted	KSCB via Quality and Performance Committee
Evaluation of the impact of training	Evaluation process to understand the impact of training on outcomes for service users	Increase of knowledge, skills and confidence Changes in practice Improved outcomes for children	Feedback to Training Sub Group and to be cascaded to professionals	KSCB Partner Agencies	KSCB via Training Sub Group
Practice Learning Review	Review of a safeguarding incident which falls below the threshold for an SCR and there are lessons to be learnt for multi-agency working.	Increase of knowledge, skills and confidence Changes in practice Improved outcomes for children	Briefing Event	Professionals involved with the case KSCB partner Agencies	KSCB Serious Incident Review group Training Sub Group

Principles for learning and improvement:

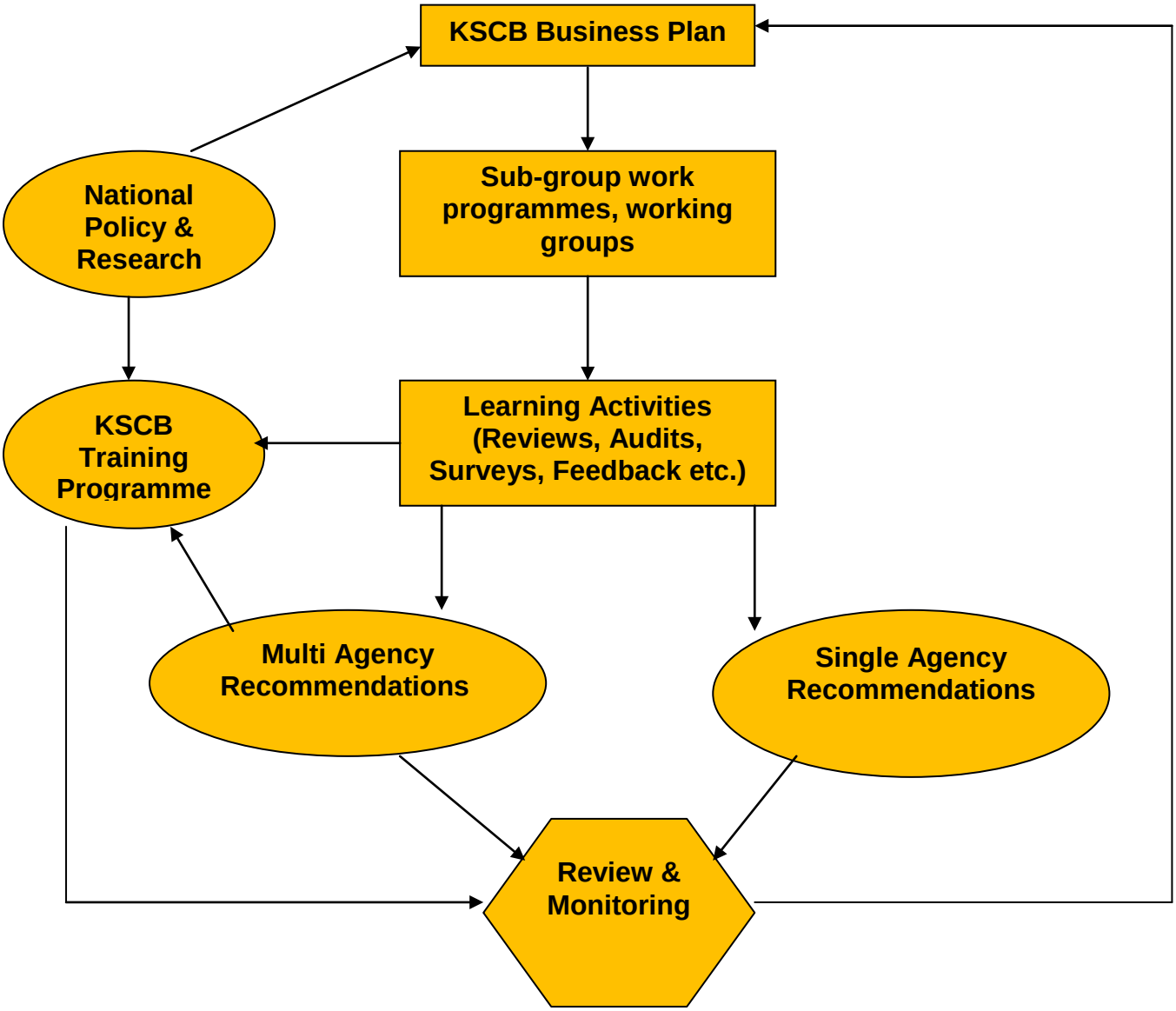
The following principles outlined in Working Together to Safeguard Children 2015 will be applied by Knowlsey SCB and its partner organisations to all reviews:

- 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 children, should be invited to contribute to reviews where this is appropriate. 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 the KSCB 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.

There may be circumstances when a SCR would not be published.

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 above) 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 KSCB's wider strategic planning framework that determines current and future priorities and resource allocation.



Serious Incident Review Group

This panel monitors the implementation of individual agency's action plans from Serious Case Reviews whilst reviewing the effectiveness of the implementation of actions. In relation to individual cases, this panel advises

the Independent Chair on whether a Serious Case Review or Management Review is appropriate.

Audit and Review Sub Group

This sub group undertakes a schedule of audit activity and quality assurance of safeguarding practice. It monitors the implementation of inter-agency and multi-agency safeguarding procedures and uses thematic audits to achieve this. It also undertakes in-depth, multi-agency reviews of cases referred by the Independent Chair after receiving advice from the Serious Incident Review Group.

Training Sub Group

There may be an identified need for a specific training programme to be commissioned or created after a review has taken place. The Training Sub Group will have a pivotal role into how best this can be achieved. The Audit and Review Group (see below) will feed learning into this sub group to ensure that it is cascaded to all partners.

Expectations of Single Agencies

- Agencies are responsible for ensuring that their workforce is suitably recruited, qualified and enabled to safeguard children.
- Agencies are responsible for providing appropriate supervision and support for staff, including access to safeguarding training appropriate to their role.
- Agencies 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.
- Agencies are responsible for offering their staff 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
- Agencies are responsible for ensuring that all professionals have regular reviews of their own practice to ensure they improve over time.
- Agencies are responsible for releasing staff to assist in delivering multi-agency learning activity as well as attending multi-agency learning.
- Agencies are responsible for ensuring that all staff have evidence of suitable basic safeguarding training, refreshed in the appropriate timescales set out in national and/or LSCB guidance.
- Agencies are responsible for responding to audits under section 11 of the Children Act 2004.
- Agencies are responsible for reporting on their compliance and quality of single agency work.
- Agencies are responsible for data collection contributing to the Board's evidence base for the monitoring of attendance.

Conclusion

Biennial Reviews of Serious Case Reviews suggest that the same practice issues recur. This suggests that when training is taking place or learning is shared, it is not being transferred to the workplace. In order to maximise the likelihood of training transfer it is the responsibility of those who commission and provide training and learning opportunities, organisations and managers responsible and the staff themselves to embed learning into practice. As we endeavour to be learning organisations that drive improvements in practice, policy and procedure, agencies need to commit to ensuring that there are the structures necessary to ensure training transfer is maximised.