Derby and Derbyshire Safeguarding Children Boards'

Learning and Improvement Framework

June 2016

This framework will be subject to formal review on the dates below, but the SCR element will be kept under review throughout the first year of implementation.

First Review Date	September 2014	Reviewed no change
Second Review Date	September 2015	Updated following revision to Working Together 2015
Third Review Date	Following update to national guidance on serious case reviews due 2016	

1 Introduction

1.1 **Working Together 2015** requires Local Safeguarding Children Boards to develop and maintain a shared local learning and improvement framework across those local organisations working with children and families. This local framework is expected to cover the full range of single and multi-agency reviews and audits undertaken by the Board and would therefore include:

- Serious Case Reviews
- Child Death Reviews
- Reviews of incidents which fall below the threshold for a Serious Case Review
- Reviews and audits of practice in one or more agencies

1.2 **Working Together 2015** sets out the following principles to be applied by LSCBs 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 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 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.*

(Working Together Chapter 4)

1.3 LSCBs may use any learning model which is consistent with these principles but Working Together 2015 is explicit that Serious Case Reviews 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.*

2 Purpose and Scope of the Learning and Improvement Framework

2.1 The purpose of this framework is to set out the ways in which LSCB will gather evidence about the quality of safeguarding practice within and across agencies and use that evidence to drive safeguarding practice improvement and better outcomes for children and young people.

2.2 Serious Case Reviews are a key, and often very high profile, process for learning where there has been a serious incident. They are, however, but one of a number of ways in which safeguarding boards review practice and provide a window on the safeguarding system. Professor Eileen Munro, in her review, emphasised the importance of the wider context of individual professional practice and advocated a systems methodology for Serious Case Reviews.

2.3 The systems methodology assumes that practitioners generally act from good intentions and try to act in the best interests of their clients, but that organisation's systems, processes and culture can lead to poor decision-making and poor practice.

2.4 It is therefore these organisational systems that should be the focus any review and learning and any scrutiny of practitioners cannot be divorced from these critical variables. Such an approach rightly places responsibility for ensuring effective safeguarding practice on everyone in the system from front line practitioners to chief executives.

2.5 A truly systemic approach also looks beyond agencies and organisations to the wider community, which is of course critical to safeguarding the children and young people in its midst. A systems view will guide all the activity in this learning and improvement framework.

2.6 The framework will cover the following methods of learning:

- Serious Case Reviews
- Serious Incident Learning Reviews
- Child Death Overview Processes
- Thematic reviews
- Thematic audits
- Single agency audits
- Multi-agency audits
- National research and reports
- Peer review

These will identify areas of good practice as well as areas for improvement.

3 Assessing Impacts and Outcomes

3.1 In assessing the effectiveness of provision through, audit or review and in monitoring the impact of recommendations from case reviews and the impact of training the LSCB will use both qualitative and quantitative data and information.

Outcomes How are children and families better off?

For example: Percentage of vulnerable children where risk is shown to be reduced

Qualitative information How well are services doing?

For Example: Percentage of children who report that they felt listened to

Qualitative information How much or how many did we do?

For Example: How many Early Help Assessments?

How many children in care?

3.2 Information will be drawn from the following sources:

The experience of children, carers and parents.

Feedback from frontline staff

Case records

Other organisational activity

4 Range of Learning and Improvement Activity

Serious Case Reviews

4.1 All incidents that may reach the criteria for a Serious Case Review will be referred to the Serious Case Review sub group at the earliest opportunity. Extraordinary meetings will be called where necessary to ensure that

recommendations to the independent chair are made to enable decision as quickly as possible and within one month.

4.2 The LSCB has agreed that the Child Practice Review (CPR) methodology used in Wales will be trialed for Serious Case Reviews. The reports from reviews will place emphasis on the analysis and explaining why actions were or were not taken. Reviews will be proportionate to the incident. Whilst the decision has been taken to trail the CPR approach another methodology may be recommended by the Serious Case Review sub group should they seem more appropriate for a particular incident.

4.3 All recommendations from Serious Case Reviews will be tracked by the Boards and agencies required to submit evidence of actions taken, changes to practice and impact on outcomes for children.

4.4 All review report will be written for publication in compliance with any legal restrictions in place, the Data Protection Act 1988 and the protection of siblings.

4.5 The expert panel will be informed on SCRs as required by Working Together 2015.

Serious Incident Learning Reviews

4.6 Serious Incident Learning Reviews (SILRs) will be carried for incidents that do not meet the criteria for a SCR will be the subject of a Serious Incident Review. The expertise of colleagues, particularly those in health, in Root Cause Analysis, will be employed where applicable. As for Serious Case Reviews, the report will be written for publication.

Child Death Overview Processes

4.7 All child deaths across Derbyshire are reviewed by the Child Death Overview Panel. The panel produces quarterly reports and an annual report for the Boards. Any issues raised by reviews of child deaths will be raised with the Boards and allocated for action to the appropriate sub group. Responses may involve further review, audit activity, training or the refinement of procedures or protocols.

Thematic Reviews

4.8 Thematic reviews will be undertaken where performance monitoring indicates that a better understanding of an area of practice is required or to test the implementation and impact of actions taken as a consequence of earlier SCRs or SILRs. Appreciative Enquiry will be used as part of these reviews to ensure that examples of good and outstanding practice are

understood and disseminated. The Boards will consider using the Failure Modes and Effects Methodology, trialed by the City Board, to test new safeguarding processes, pathways or structures.

Thematic Audits

4.9 Thematic audits are similar to thematic reviews but will include more detailed case analysis. As with thematic reviews, thematic audits will be undertaken where performance monitoring indicates that a better understanding of an area of practice is required, or to test the implementation and impact of actions taken as a consequence of earlier SCRs or SILRs. They may also arise from a thematic review when it is deemed that a more detailed practice information is required.

Single Agency Audits

4.10 All agencies are expected to conduct their own audits and to report these through the Section 11 reporting processes of the Board. Wherever possible these will involve other partner agencies to strengthen the multi-agency scrutiny and challenge functions of the Boards.

Multi-agency Audits

4.11 Each Board will have an annual programme of multi-agency audits determined by priorities.

National Developments, Research and Reports

4.12 All Board members are expected to draw the attention of the Board to national developments, research and reports and to ensure that the implications of these are addressed by the appropriate sub group.

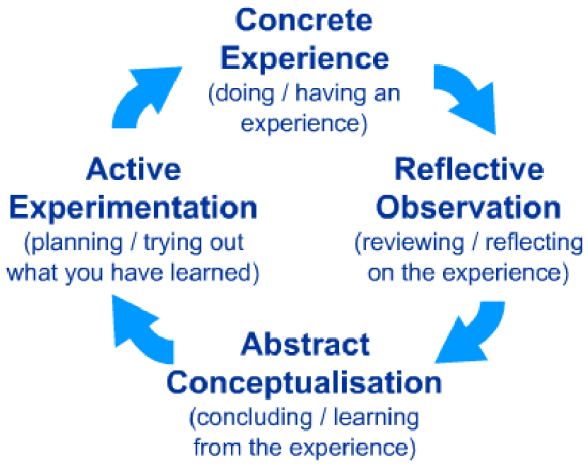
Peer Review

4.13 The Boards will participate fully in the regional sector led improvement peer review processes. The Boards will also commission other peer reviews as part of wider self-evaluation processes.

5 Learning into Practice

5.1 All learning opportunities will be part of a continuous cycle of improvement, as described the Kolb Learning Cycle (below), driven through the sub groups of the Boards.

5.2 The Kolb Learning Cycle



5.3 The **workforce development group** will be responsible for ensuring that learning from reviews and audits is disseminated across all agencies and that training programmes are adapted to include the key learning points. The SCR e-learning package will be regularly updated in response to new reviews and bespoke e-learning packages produced on specific issues (such as the private fostering package and the Don't Shake the Baby film). An externally commissioned review of staff training needs across agencies will also inform the training and development programme of the Boards.

5.4 The **quality assurance and quality and performance groups** of the Boards will monitor the implementation and impact of the learning points. The effectiveness and impact of training and other learning activity will be assessed through the range of audit and review processes described above and through annual staff questionnaire.