# Learning and Improvement Framework

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## 1. Principles

### 1.1 Learning and Improvement Framework

Working Together 2015 requires that the Local Safeguarding Children Board (LSCB) maintain a shared local learning and improvement framework across those local organisations working with children and families in Gateshead.

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 in Gateshead. The different types of review include:

- **Serious Case Review** (see **Serious Case Review Process**);
- Child Death Review (see **Working Together 2015, Chapter 5: Child death reviews**): a review of all child deaths under the age of 18;
- Review of a child protection incident which falls below the threshold for a Serious Case Review but where there are still lessons to be learned;
- Review or audit of practice in one or more agencies;
- Reviews of best practice;
- LSCB inquiries.

### 1.2 Purpose of Local Framework

The aim of this framework is to enable local organisations in Gateshead (and organisations working with children and families from Gateshead) to improve services through being clear about their responsibilities to learn from

experience and particularly through the provision of insights into the way organisations work together to safeguard and protect the welfare of children.

The purpose of this document is to set out how Gateshead LSCB reflects on the quality of safeguarding provision across services in Gateshead, challenges and scrutinises practice, and learns from this reflection. This ties in with Gateshead LSCB's priorities of **Leadership**, **Challenge** and **Learning**.

This should be achieved though:

- Reviews conducted regularly;
- 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;
- Reviews should contain rigorous, objective analysis when things go wrong so that lessons are learned and services improved to reduce the risk of future harm to children;
- Reviews should also consider good practice to promote understanding of what works well and understand organisational strengths;
- Learning from both good and more problematic practice about the organisational strengths and weaknesses within local services to safeguard children;
- Implementation of actions arising from the findings which result in lasting improvements to services;
- 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;
- Appreciative inquiries to reflect those cases where multi-agency work has had good outcomes for children and their families.

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

### 1.3 Principles for a Culture of Continuous Improvement

There should be a culture of **continuous learning and improvement** across the organisations that work together 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 being examined i.e. the scale of the review is not determined by whether or not the circumstances meet statutory criteria;

- **Independence**: Reviews of serious cases to be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- **Involvement of practitioners and clinicians**: Professionals should be fully involved in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- **Offer of family involvement**: Where appropriate, families, including surviving children, should be invited to contribute to reviews and be provided with an understanding of how this will occur;
- **The child to be at the centre of the process**;
- **Transparency** achieved by publication of the final reports of Serious Case Reviews and the LSCB's response to the findings. The LSCB annual reports will explain the impact of Serious Case Reviews and other reviews on improving services to children and families and on reducing the incidence of deaths or serious harm to children. This will also inform inspections;
- **Sustainability**: 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.

See also **Serious Case Review Process**.

## 2. Summary of Learning and Improvement Activities

**Click here to view the Summary of Learning and Improvement Activities table**.

## 3. Using the Framework to Support Learning and Improvement

It is the responsibility of Gateshead LSCB to ensure that the activities identified in this framework are used to promote improvements in practice and, ultimately better outcomes for children and young people in Gateshead.

Lessons learned from these activities may be single or multi-agency issues; they will impact on training programmes and will inform the business planning cycle for the LSCB. It will be for the Board to monitor and challenge partner agencies to ensure that learning is disseminated across organisations and that actions are taken to embed learning in practice.

**Click here to view the diagram seeks to illustrate the learning and improvement cycle in Gateshead**.

## 4. Further Guidance

In addition to the information that partner agencies are required to contribute to the LSCB Annual Report, Board members are expected to regularly demonstrate how their agency is fulfilling its statutory safeguarding responsibilities, including Section 11 requirements. This includes sharing the process and findings from audits and inspections that have taken place, and how this information was used to improve outcomes for children in

Gateshead and practice. Agencies should also share pressures and challenges that they are facing and the positive solutions introduced and the impact of their work for children and families in the borough.

This process is used for Board members to learn from and hold each other to account using this open scrutiny and challenge approach. Again, this links directly with the LSCB's priorities of **Leadership**, **Challenge** and **Learning**.

### 4.1 Operational Assurance Reports

Board members are asked to provide an update at every Board meeting on issues impacting on their agencies and partnerships and safeguarding children. This should include an Operational Assurance Report when requested by the Board.

In the majority of operational reports, Board members will be looking for:

a. Examples of good practice;

b. Examples of effective multi-agency working and those where improvements could or should be made;

c. How the voice of the child is heard;

d. Pressures that may prevent or delay children and young people from receiving services that could safeguard them.

### 4.2 Board Member Observation of Practice

Gateshead LSCB members have previously identified a need to raise the profile of the Board. Other LSCBs in the North East have reported that an effective way to do this is for Board members to observe frontline practice in partner agencies. This also assists Board members in understanding more about each other's agencies, to listen to frontline staff and families more, and to have a more direct influence on outcomes for children and young people. Gateshead LSCB has agreed to adopt this model and Board members have agreed to be seen, and see current practice as a means of improving their visibility whilst directly observing some practice that each of them would not normally be part of.

A programme has now been introduced for Board members to annually attend a meeting that they would not normally be part of and feed back their observations, identifying areas of good practice and where improvements can be made. The findings are then collated, shared and analysed to gather learning points. Examples of meetings included in this process are:

- Strategy meeting;
- Core groups;
- Child protection conferences;
- Home visits;
- Planning meetings;
- Team Around the Child/Team Around the Family meetings;

- MARAC and MAPPA meetings.

The process for this activity is detailed below:

1. The LSCB chair contacts all Board members and asks them to arrange an observation at a multi-agency operational safeguarding meeting. Board members can select which meeting to attend unless pre-arranged theme has been chosen by the Board. The meeting should be one that operational staff and preferably a child and/or their family attend, and not a high-level strategic meeting;
2. The LSCB Business Manager will send members a proforma for recording their observation and guidance notes;
3. Board members should advise the LSCB Business Manager which meeting they will be attending and this will be recorded in the Practice Observation Log;
4. The Board member will attend the meeting, complete the proforma and return it to the LSCB Business Manager;
5. The LSCB Business Manager will update the Practice Observation Log and collate the proformas;
6. The LSCB Admin Officer will send out periodic reminders to Board members;
7. The LSCB Business Manager will produce an analysis report of findings;
8. Board members will then identify areas of good practice and areas for improvement;
9. The findings will then be included in a Gateshead LSCB briefing which will be disseminated to all staff.