Local Safeguarding Children Board Learning and Improvement Framework

Introduction

Working Together to Safeguard Children 2013 states that Local Safeguarding Children Boards (LSCBs) should maintain a local learning and improvement framework which is shared across local organisations who work with children and families. Each local framework should support the work of the LSCB and their partners so that:

- Reviews are 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.
- Reviews look at what happened in a case, and why, and what action will be taken to learn from the review findings.
- Action results in lasting improvements to services which safeguard and promote the welfare of children and help protect them from harm.
- There is transparency about the issues arising from individual cases and the actions which organisations are taking in response to them, including sharing the final reports of serious case reviews (SCRs) with the public.

The aim of this framework is to enable organisations in Northamptonshire 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.

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

The Northamptonshire Learning and Improvement Framework will set out the range of reviews and audits conducted jointly which are aimed at driving improvements to safeguard and promote the welfare of children. Some of these reviews (i.e. SCRs and child death reviews) are required under legislation. This framework will form Northamptonshire's learning model and enable partner organisations to be clear about their responsibilities, to learn from experience and improve services as a

result. This is done via a number of reviews and Working Together 2013 lists these as:

- Serious case reviews, 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 a child.
- Child death review.
- Review of child protection incident which falls below the threshold for an SCR.
- Review or audit of practice in one or more agencies.

Also included in the Learning and Improvement Framework is a brief description of how individual partner agencies in Northamptonshire organise their internal quality assurance programmes and processes. Each agency is required to provide an annual impact report of their quality assurance work as part of the LSCB annual report.

The Learning and Improvement Approach in Northamptonshire

The Northamptonshire LSCB is committed to ensuring that there is a culture of continuous learning and improvement across partner agencies and that systemic changes results from learning so that improvements are sustained. Prompt and timely action is required by all professionals in order to identify opportunities to draw on what works to promote good and effective multi-agency practice. Case reviews, practitioner forums and audits should provide regular opportunities to address multi-agency collaboration and practice through learning, reflection and development.

Learning and reviewing methods recognise the complex circumstances in which professionals work together to safeguard children. As much effort in the process of reviewing should go into identifying and analysing areas of good practice as well as practice that requires improvement. Learning and reviewing methods should be transparent in the way they collate and analyse data and make use of research and evidence to inform findings.

The impact of case reviews, practitioner forums and audits should be to improve services for children and families and on reducing the incidence of harm. The impact of serious case reviews should be to reduce the incidence of serious harm and death in children.

There are a number of ways in which learning and improvement is embedded in the agencies in Northamptonshire and these are brought together by membership of the Local Safeguarding Children Board (LSCB) and through LSCB Sub Groups and

Task and Finish Groups. A key element of the Learning and Improvement Framework is the joint quality assurance initiatives undertaken across the partnership.

There are a number of aspects that will inform the LSCB learning and improvement activity and outcomes in Northamptonshire and triangulation of the findings in each area is critical in order to stay focused on the core business of child protection:

- **Section 11 audits** - A requirement set out in the Children Act 2004 is the completion a self assessment against a safeguarding checklist carried out on an annual basis. All agencies take part.

- **Single and joint agency case file audits and reviews** – Each agency has a quality assurance programme that includes case file review against agreed standards and methodology for assessing safeguarding practice and a joint programme of audits.

- **Performance management information** – The LSCB dataset identifies trends in performance across the partnership and is used to monitor progress against targets and identify hot spots for further investigation.

- **Child death overview panel** - LSCBs have a statutory responsibility for reviewing information on all child deaths in their areas through this panel, using the findings to take action to prevent future child deaths and more generally to improve the health and safety of the children in the area.

- **Serious case reviews** – This is a requirement of Working Together and is based on SCR threshold criteria that if met, require learning from these cases to be identified and addressed.

Implementing the Learning

Integral to the success of this framework will be the sharing of learning widely to ensure transparency, accountability and consistent improvement to practice. As such, in addition to the statutory requirements for the publication of SCRs the Northamptonshire LSCB will seek to develop mechanisms to share, where practicable, the outcomes of case reviews and multi-agency audit findings. There will be an expectation placed to identify a lead reviewer for each audit/SCR and for that individual to develop a concise learning summary documentation that will form part of all review reports. A format for the Learning Summary can be found in Appendix 1. For SCR's this should also include a set of PowerPoint slides for a learning workshop for practitioners about the lessons learnt.

All of the above areas feed into single agency and LSCB multi agency training and development programmes so that the learning is embedded and sustained. Evidence of the systemic change must be captured and shared across the partnership so that there is a clear understanding of what is working well and what isn't, and the best learning style for the range of practitioners across the different partner agencies. These programmes also include the key learning from national SCR's.

Multi Agency Audits

The LSCB will determine the most suitable process to use in deciding if a case meets the criteria for a multi agency case review, or nominating areas/safeguarding themes for case file audits. The focus must be based on local priorities and a clear rationale for the learning outcome that is being sought from this activity.

The Quality and Audit Sub Group is the key co-ordinating forum for setting the terms of reference for the joint programme of audits and collating and reporting on the findings of the audit activity. The findings should identify what needs to be learnt, the areas of practice that need improvement and what the programme of action is that will lead to sustained improvements. Each agency taking part will take responsibility for ensuring that the learning is disseminated in their agency and progress should feed into their annual review of progress in safeguarding.

Appendix 2 sets out the agreed work plan for multi agency audits. The areas of focus are derived from the findings of inspections, analysis of performance information and serious case reviews.

Serious Case Reviews

For cases that are considered for a serious case review, the final decision if a case meets the serious case review criteria will rest with the LSCB's Independent Chair. Decisions on whether to initiate a serious case review should be normally made within one month of the LSCB being notified of the incident triggering the threshold. In line with Working Together 2013 the National Panel of Independent Experts on serious case reviews will be notified within 14 days of the LSCB Chair's decision on whether a serious case review is to be initiated.

Where a case is considered for a serious case review and the LSCB Chair decides the threshold is not met, additional information to justify the decision will be required to be provided to the National Panel of Independent Experts on serious case reviews. Where the notification to the National Panel of Independent Experts on serious case reviews is to initiate a serious case review, the notification information should also contain the name(s) of the independent Lead Reviewer(s) appointed by the LSCB Chair.

The SCR should be conducted within 6 months and should result in a report which is published and readily accessible on the LSCB's website for a minimum of 12 months after which it should be available on request. The LSCB will oversee the process of agreeing with partners what action they need to take in light of the serious case review findings.

Working Together 2013 does not prescribe any particular methodology to use in continuous learning, except that whatever model is used it must be consistent with the following 5 principles:

- 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
- Transparency about the way data is collected and analysed
- Makes use of relevant research and case evidence to inform the findings

Some examples of models which may be considered are:

- **SCIE Learning Together** has been piloted and evaluated and is recognised as one which values practitioner contributions, is sympathetic to the context of the case and is experienced as a more transparent process by those involved.

- **Root Cause Analysis** has been used within health agencies as the method to learn from significant incidents. Root cause analysis sets out to find the systemic causes of operational problems. It provides a systematic investigation technique that looks beyond the individuals concerned and seeks to understand the underlying causes and environmental context in which the incident happened.

- **Child Practice Reviews** is a process consisting of several inter-related parts: multi-agency professional forums to examine case practice, concise reviews in order to identify learning for future practice, and an extended review which involves an additional level of scrutiny of the work of the statutory agencies.

- **Significant Incident Learning Process** was developed as a way of providing a process to review cases just below the mandatory threshold for serious case reviews. It has subsequently been used in formal serious case reviews. This approach explores a broad base of involvement including families, frontline practitioners and first line managers view of the case,

accessing agency reports and participating in the analysis of the material via a 'Learning Event' and 'Recall Session'.

- **Appreciative Inquiry**, rooted in action research and organisational development, is a strengths-based, collaborative approach for creating learning change. SCR's conducted as an appreciative inquiry seek to create a safe, respectful and comfortable environment in which people look together at the interventions that have successfully safeguarded a child, and share honestly about the things they got wrong. They get to look at where, how and why events took place and use their collective serious case reviews hindsight wisdom to design practice improvements.

Partner Agencies in Northamptonshire

Northamptonshire's partners comprise a number of agencies (providers as well as commissioners) who are directly involved in safeguarding work through the LSCB and are therefore contributors to the Learning and Improvement Framework. Each agency has mechanisms by which it quality assures its work seeking to identify both good practice and areas for learning. This section summarises what these mechanisms are in each main constituent agency of the LSCB partnership.

Northamptonshire Children, Families and Education Directorate:

- Monthly case file audit programme of children in need, child protection, looked after children cases and supervision.
- Planned and unannounced Thematic or one off audits of identified themes.
- Unannounced Deep dive audits of 5 days duration.
- Reflective practice mentoring for social workers.
- Observations of front line practice.
- Surveys of children and young people's experiences.
- Case file audits by the Corporate Management Team.
- Audits of Local Authority Designated Officer cases.

Northamptonshire Police

- HMIC child protection inspection regime 2013 and now 2014/15 regime
- Internal monthly serious crime reviews for child rape, child deaths and NIA under 2s
- PVP Quarterly journey of the child peer reviews – first call tom closure
- Crime registrar audits including rape recording standards
- First line manager case file audits and supervision
- First line manager conference reviews
- Thematic case file audits – eg all reported CSE 2012/13

East Midlands Ambulance Service (EMAS) NHS Trust:

- Safeguarding is embedded in the organisation from Board to frontline staff and it forms part of the essential education for all clinical and non-clinical staff
- Safeguarding forms part of the Director of Nursing & Compliance's portfolio and is reported on through a number of forums-Quality Integrated Board Report, Clinical Governance Group, Divisional & Strategic Learning Review Groups.
- In 2012 a Safeguarding Forum was introduced into the organisation, this enables local and national activity good practice and learning to be discussed and disseminated to key individuals within the Trust who have a vital role to play in the safeguarding agenda.
- The Markers of Good Practice Self-Assessment framework is used within this organisation to provide assurance on organisational responsibilities under Children Act (2004) to safeguard and promote the welfare of children (Section 11).
- EMAS complete regular audits related to safeguarding- audit of safeguarding referrals, knowledge retention of safeguarding linked to Individual Performance Review (IPR) and Station audits related to safeguarding information.
- EMAS produce regular Clinical Bulletins and the safeguarding team contributes to these. In addition a number of bulletins are produced wholly on safeguarding e.g. "Child Death & Poor Prognosis Roles & responsibilities within EMAS"
- EMAS has central processes for responding to significant incidents or identified risks through the quality and risk team with input from the safeguarding team as necessary.

Northamptonshire Health Visitor and School Nurse Provision

- Health Visitors and School Nurses and all team members are subject to mandatory supervision within groups, with trained child protection supervisors, on a quarterly basis. Staff also receive management and clinical supervision. Practitioners receive a minimum of 10 sessions of supervision annually pro rata. In addition, any member of staff can access 1:1 supervision and support from a member of the safeguarding team when required.
- Safeguarding Post Conference supervision is offered to all staff following Initial Child Protection Conference.
- Themes that arise from supervision are embedded into training and identify topics for the 'Learning Lessons' events.
- Safeguarding level 3 training is mandatory for all health visitors and school nurses and team members, records of compliance are kept.
- Level 3 Managers training in respect of Safeguarding with NHFT is offered to all Managers within HV and CYPN teams
- If a child sustains a suspected non-accidental injury then a datix (incident report) is completed and reviewed by the risk and quality team.

- Safety Bulletins have been sent out to all CYPN/HV staff focusing on the processes they should be completing when significant concerns are raised about a child or young person.
- Health Visitor and Safeguarding involvement in NHFT Serious Incident (SI) process.
- NHFT has central processes for responding to issues or identified risks through the risk, quality and line management processes.
- NHFT also offer non-mandatory training for continuous professional development which includes essential training: CAF; Domestic Abuse; Lessons Learned Events.
- NHFT has an audit team within the quality team and they conduct records audits which review: quality of records, including evidence of assessment including the voice of the child; practice against the standard operating procedures (SOP) for health visiting. SOPs for school nursing are expected by September 2014.
- NHFT health visiting and school nursing teams both have quarterly newsletters through which the teams are updated on key messages and lessons learned. Training opportunities and outcomes of audits and consultations. Feedback to individual teams from central audits is given through team meetings.
- For quality assurance and monitoring NHFT use the “Friends and Family Test” and “Patient Experience Questionnaire” and collect patient’s stories.
- Audit programme for safeguarding referrals by NHFT safeguarding team
- Audit of safeguarding record keeping and safeguarding supervision
- Themed Learning lessons events across the organisation
- Section 11 audit across the organisation which includes school nursing
- Regular service user feedback

Northamptonshire Healthcare Foundation Trust CAMHS

- Record of all Safeguarding referrals that come in via CAMHS
- Multi-agency learning events
- Need to review case file audit process for Young People assessed through 136 Suite

Northampton General Hospital

- Three year cycle of cumulative learning, supported with a safeguarding learning passport.
- Journal / research articles circulated for interest and inclusion into practice where relevant
- Gap analyses against local / national reports to support practice development
- Bespoke training packages for clinical areas as a result of incidents [either local or national] with particular impact.

Kettering General Hospital

- Research articles/items of interest are uploaded on the Trust Intranet site and circulated to relevant staff for information and to inform practice changes
- Training programmes include learning from Serious Case Reviews and Serious Incidents and issues discussed at the Trust internal Safeguarding Steering Group with the expectation that members cascade the learning to their respective teams.
- Bespoke training packages are delivered to areas with high Paediatric footfall to reinforce key messages and embed learning from events.
- Safeguarding Training is mandatory for all staff groups and recorded centrally. Data distributed monthly and monitored at local and strategic level.
- The audit programme is developed and monitored through the internal Safeguarding Steering Group and presentations made to same. This includes Section 11 audit and Markers of Good Practice as well as other self assessment tools. Areas of deficit are actioned appropriately and supported through the Director of Nursing.
- There are quarterly Clinical Governance meetings within Paediatrics to examine cases, discuss/reflect on what went well and what lessons could be learned to change future practice.

NHS England

- Quarterly monitoring of the safeguarding quality schedule within the contracts with Health Visitor providers,
- Ensuring good practice is shared across the NHS
- Establishment of a Safeguarding Forum as set out in the Accountability Framework.
- Audit of compliance with SCR actions across primary care.
- Triangulation of information received from complaints, serious incidents and other intelligence to inform assessment of risk and agree actions with providers in relation to the risk.
- Ensure safeguarding is included within the commissioning cycle and part of the quality requirements of contracts held by NHS England.
- Work with the CCGs on the wider delivery of health actions arising from various improvement activity

Nene and Corby Clinical Commissioning Group:

- Monthly review of safeguarding data from commissioned services through the Northamptonshire CCG Quality Committee.
- Quarterly monitoring against a safeguarding quality schedule which includes a requirement to complete regular audits against practice standards e.g. appropriate CAF implementation.

- Scrutinising Section 11 self-audits at regular safeguarding/quality visits to request evidence and progress against action plans for CCG commissioned Services.
- All NHS providers and CCG signed up to one overall health Safeguarding Strategy with strategic priorities based on SCR and Inspection findings with a county wide health action plan.
- Ensuring good practice is shared between NHS providers by CCG providing opportunities and expectations this will be done.
- Ensuring all commissioned services have appropriate and active participation and engagement with LSCBN activity and all providers contribute to the multi-agency pool to undertake LSCBN led programme of themed audits.
- Monitoring of SCR action plans through the Clinical Quality Risk Group process.
- Ensuring safeguarding is included in all aspects of the CCG Commissioning cycle. This includes surveys and feedback from parents, carers and children/young people about experience to inform future service development and design.
- Ensuring triangulation of information received from complaints, serious incidents, feedback from Children/young people surveys and feedback from staff including whistle blowing to inform assessment of risk and/or emerging concerns with providers.
- Oversight of audits undertaken by CCG commissioned Services.
- Regular audits of cases referred to specialist CAMHS to ensure appropriate management, support and use of CAF at point of step down from CAMHS provision.

Northamptonshire's Voluntary Sector:

- Annual Section 11 Audits for publicly funded voluntary sector organisations.
- Periodic auditing of a sample of voluntary sector organisations to quality assure against nationally recognised safeguarding standards Thematic or one off audits of identified themes (via the LSCB QA Group).

Northamptonshire Schools:

- LA commissioned safeguarding training for schools "Are You Keeping Your Children Safe"
- External safeguarding audits in place for 25 schools annually targeted to needs or where schools request assistance.
- Council and LSCBN office joint development of a S11 audit and self-assessment tool designed around schools and their needs.
- Research-based project to benchmark and inform practice on use of the pupil premium in Northamptonshire.
- Quality and standards addressed through Council reviews of school progress and achievement with safeguarding integrated (maintained schools).

- Best practice shared through County-wide inclusion network for SEN co-ordinators and annual inclusion conference.
- Intensive CAF work and training on thresholds with targeted schools to increase quality, relevance and support for families.
- Expectations reinforced through Headteacher briefings, improvement leads for school sectors.

Northamptonshire's Colleges

- Representation on LSCBN Board and Learning & Development group.
- Network of senior safeguarding officers across all the FE colleges, sharing practice across sector, with invitations to other agencies.
- Review of child protection policies and procedures with annual reports on safeguarding activity / S11 audits.
- Register and review of attendance and progress in education for LAC, children leaving care and vulnerable learners. Bursary and hardship funds allocated to needs.
- Moulton College self-assessment and inspection of residential provision, Ofsted outstanding (March 2013).

Probation:

- Thematic child safeguarding audit completed by NOMS in March 2014.
- E-learning on safeguarding rolled out in January 2014 for completion by 31 May 2014.
- Staff are required to attend the one-day LSCBN safeguarding training.
- Review of safeguarding cases in staff supervision. All staff are required to notify and discuss safeguarding cases in supervision.
- Professional guidance linked to safeguarding routinely updated and disseminated to all staff.
- Performance data regularly updated to ensure both Probation IT systems have the appropriate safeguarding flags accurately recorded.
- Strategic and operational leads for safeguarding are identified and all staff aware.
- Section 11 audit

Cafcass:

- The Service Manager (SM) and Enhanced Practitioners (EPs) scrutinise and endorse case plans on each allocated case and would refer directly to the allocated guardian as necessary.
- The SSM is responsible for the performance review of each guardian, conducted on a 3-monthly basis, undertaken in the form of a Performance and Learning review. Safeguarding is one of the four core objectives for which evidence is obtained and discussed after which the guardian's performance is graded.

- The SM also checks the Case Management System (CMS) where guardians are expected to confirm safeguarding checks have been completed following allocation, in Private Law cases. If incomplete, the SM follows this up with the allocation Guardian requiring immediate action.
- Also the SM and EPs routinely quality assure reports to the Court and in order for a report to be graded good, safeguarding must be completed.
- Feedback from LSCB's is a standard item at monthly team meetings which help to improve practice. Learning from Serious Case Reviews takes place as and when findings are received. Learning from CAFCASS IMR's is disseminated on an annual basis internally, and the findings from this are shared at the LSCB SCR subcommittee annually.
- Finally case discussion with practitioners in the form of situational supervision or case consultation provides us with another opportunity to assess safety and ensure concerns are appropriately escalated.

Appendix 1
Learning Summary Template

Date Learning Summary completed	
Type of review conducted and overall purpose	(Please include details of methodology, chairing/authoring, how case(s) were selected)
Month/year of incident	
What you learnt about the case: key themes/early learning	(Specific issues or general areas of concern or good practice)
What you learnt about the review/methodology	(What worked/didn't?; Who was involved, how long did it take, chairs, authors etc)
Key learning points – single agency	(Indicate transferrable learning, not necessarily all recommendations)
Key learning points - Multi-agency	(As above, focus on transferrable learning)
How do you intend to make changes? Who's doing what?	
How will you audit the impact? i.e. how will you know anything has changed?	
Any other comments, advice, suggestions – about the case, the method, embedding change or evidencing impact/ change	
For SCR's – please provide a set of PowerPoint slides setting out the learning for practitioners about the learning for a learning workshop	

Appendix 2

Multi Agency Quality Assurance Plan

Regular monthly QA audit meetings have been scheduled for 2014. The aim in 2014 is to establish an audit pool with a number of representatives from each of Health, Social Care and Police, along with links for education, housing, probation and other key agencies. Three priority areas have been agreed for multi agency audits in 2014 which are, Child Sexual Exploitation, Self Harm and Domestic Violence.

Thematic audit topics will be identified by the QA committee, for example, pre-birth referrals, injuries to infants, sexual abuse concerns, referrals by housing. Topics will in turn be informed by SCR and other case learning, and other priorities identified by LSCBN board or subcommittees.

The LSCBN multiagency audit tool will be used. This covers the safeguarding process from early intervention and prevention stages and consideration and use of CAF, through recognition of likely or actual significant harm, effective referrals, thresholds and responses, and the quality of assessments and child protection plans.

The audit meeting report will include:

- Very brief anonymised summaries of the cases reviewed
- Comments on any issues in relation to the audit process
- Key learning points
- Any recommended actions for individual agencies
- Any proposed multiagency action

Once a sufficiently large audit pool has been established, there will be capacity within this process to undertake additional in-depth single case audits, for example cases referred to the SCR committee where a multiagency audit rather than an SCR is considered appropriate.