Kent Safeguarding Children Board

Learning and Improvement Framework

November 2016

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Summary of Purpose	Working Together 2015 requires each LSCB to have in place a local learning and improvement framework as the mechanism by which the LSCB will address its statutory requirements and review the quality effectiveness of local practice.	
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1.0	Original created in response to Working Together 2010	2010
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4.0	Updated in response to revised OFSTED guidance in August 2016	November 2016

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KSCB Learning and Improvement Framework

1. Introduction

A good Safeguarding Children Board is one that '*enables LSCB partners (including the Health and Wellbeing Board) to assess whether they are fulfilling their statutory responsibilities to help (including early help), protect and care for children and young people.'* (OFSTED framework and evaluation schedule for the inspections of services for children in need of help and protection, children looked after and care leavers and Reviews of Local Safeguarding Children's Board 2016). A Local Safeguarding Children's Board (LSCB) should, as a minimum:

- Assess the effectiveness of the help being provided to children and families, including early help.
- Assess whether LSCB partners are fulfilling their statutory obligations.
- Quality assure practice, including through joint audits of case files involving practitioners and identifying lessons to be learned.
- Monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children.

Working Together 2015 states:

"Professionals and organisations protecting children need to reflect on the quality of their services and learn from their own practice and that of others. Good practice should be shared so that there is a growing 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. These processes should be transparent, with findings of reviews shared publicly. The findings are not only important for the professionals involved locally in cases. Everyone across the country has an interest in understanding both what works well and also why things can go wrong. Local Safeguarding Children Boards (LSCBS) should maintain a local ***Learning and Improvement Framework*** *which is shared across local organisations to be clear about their responsibilities, to learn from experience and improve services as a result."*

The local Learning and Improvement Framework is the mechanism by which KSCB will address its statutory requirements and review the quality effectiveness of local practice. This includes the full range of **reviews** and **audits** which are aimed at driving improvements to safeguard and promote the welfare of children, and will ensure that all sources of learning are considered, shared and used to drive improved outcomes for children, young people and their families.

2. Principles for Learning and Improvements

KSCB and partner organisations in Kent will apply the following principals to all reviews:

- 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.

- A **proportionate approach to reviews**, 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 KSCB'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 KSCB Annual Reports and will inform inspections

- **Improvement must be sustained** through regular monitoring and follow up so that 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 organisation 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.

    - Makes use of **relevant research and case evidence** to inform the findings.

- The KSCB Learning and Improvement Framework will function as a 'feedback loop' to ensure that any learning and areas for improvement in practice are identified, shared, embedded and evaluated to evidence impact on outcomes for children and young people.

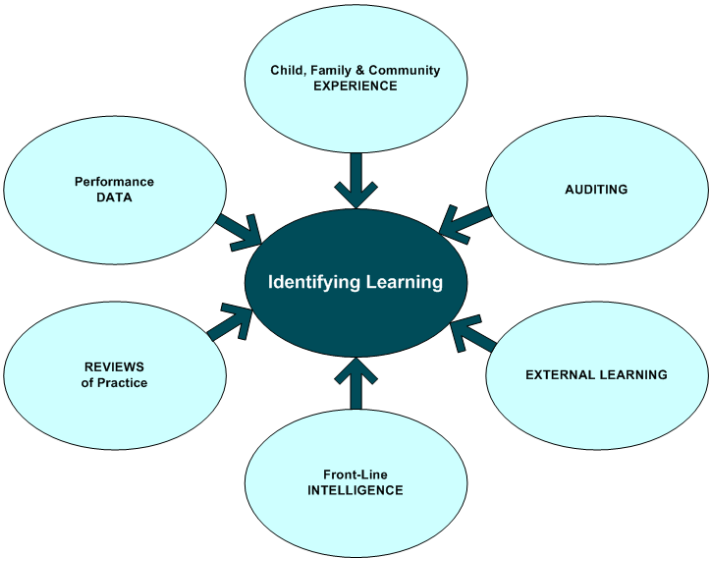

Figure 1: KSCB Learning Loop

3. External Learning

Opportunities for learning from national reviews, feedback from corporate structures and other forums external to KSCB are equally relevant to ensure our system improves. The KSCB will take account of such learning and ensure it is appropriately disseminated or included in related action plans targeting service improvement. Such learning includes National Research and Serious Case Reviews.

4. Scrutiny and Challenge

The process by which scrutiny and challenge is informed is through the collation and coordination for information from a variety of diverse sources. The following diagram confirms this mechanism.

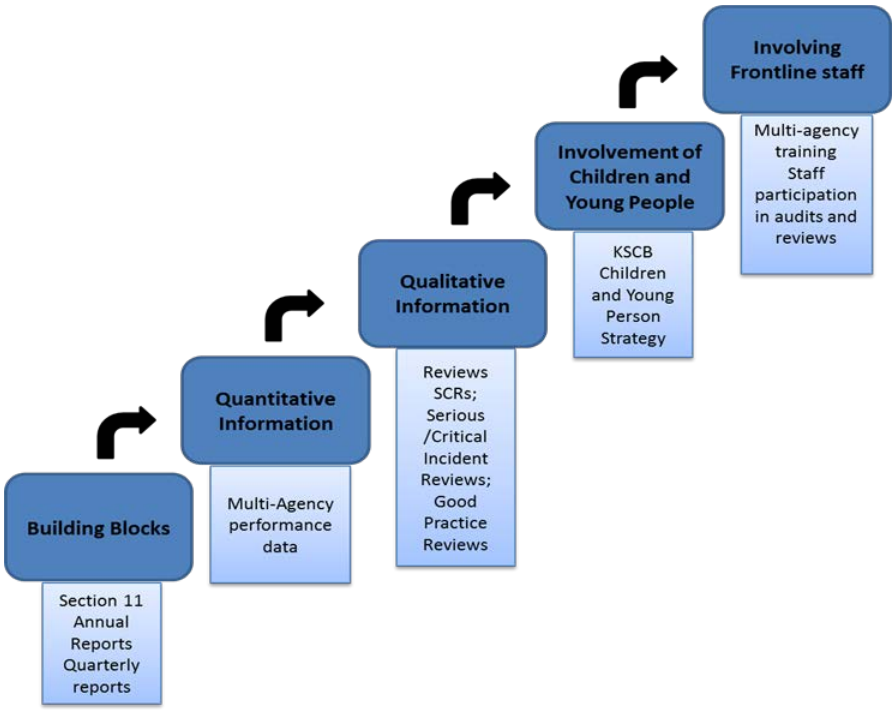

Figure 2: Scrutiny and Challenge Mechanism

It is essential for KSCB to have a structure underpinning its challenge and scrutiny role and a foundation of understanding as to its current position. The following reports provide that understandings:

- **Section 11 Audit –** this provides a benchmark of agency activity and issues. A full audit was conducted in 2014/15. Responses from this have been analysed and KSCB is working closely with all agencies in developing their own actions plans. During 2014/15, follow up audits were carried out with a focus on those thematic topics identified from the original audit (Voice of the Child) and issues identified through other information gathering processes (as outlined below). A full audit will be undertaken every two years.

- **Annual Reports -** key agencies will submit their annual reports to KSCB as part of their statutory responsibility (e.g. Private Fostering). KSCB will also receive annual reports as part of its scrutiny role (e.g. Multi-Agency Risk Assessment Conference (MARAC), Multi-Agency Public Protection Arrangements (MAPPA), Health and Wellbeing Board (HWB). These reports should include some analysis of data, evidence of qualitative service audit including feedback from service users, an analysis of strengths and areas for development and an action plan.

- **Quarterly Reports –** key agencies should provide quarterly reports which should include a detailed analysis of data, including staffing issues, and their key concerns and developments. Each agency should take responsibility for its own analysis which will be scrutinised by KSCB.

5. Quality Assurance

All reports will be presented to the KSCB Quality and Effectiveness Group who are responsible for linking information between agencies to form a comprehensive multi-agency picture. Quality assurance assumes a number of quality management principles including:

- A strong focus on the experiences of children, young people and their families.

- The motivation of senior leaders, top management and the children's workforce.

- A process approach to continually improving the safeguarding children system.

The elements that comprise quality assurance will be annually reviewed to ensure that the most appropriate qualitative, quantitative and outcome performance measures are utilised, mapped against the key priorities so that the members ensure that regular flow of information is reported to the Board.

As well as providing effective opportunities for the safeguarding systems to learn and improve, the functions required to deliver this Learning and Improvement Framework, will also provide evidence to the KSCB in its **assurance** role, i.e. forming a view as t the effectiveness of the system and being assured that through the coordination of services, agencies and their staff work effectively to minimise risk of harm to children and young people and improve their wellbeing and life chances.

6. Quantitative Information

In order for KSCB to see the wider picture of agencies' activities and performance, KSCB has produced (in line with National guidelines) a comprehensive data set. All agencies provide performance data and include their analysis of that data to inform the KSCB of patterns, trends and areas that might need a more detailed follow up.

Multi-Agency Data Set

This includes both key nationally and locally collect multi-agency data.

The purpose of this data set is to highlight:

- Progress to KSCB Business Plan priorities.
- Major changes to performance and quality measures from the KSCB quarterly report.
- Any additional information pertaining to the safeguarding and welfare of children and young people in Kent.
- Prompt discussions within the sub group on where improvements can take place and successes shared.

The Quality and Effectiveness group will review the data in its dataset, alongside qualitative and quantitative information as part of a rolling cycle of quality assurance, performance management learning and improvement.

7. Qualitative Information

These are the essential tools by which the KSCB scrutinises the work of agencies and holds them to account. In using the approach, the Board will understand the nature and quality of the work being undertaken and its impact on service users. The findings from these reviews and audits will inform the priority areas for the Board's future business planning. Information from audits and reviews, together with the findings and actions will be published on the KSCB website.

- **Case Reviews**

Review Type	**Criteria**
Serious Case Reviews	Regulation 5 (2) of the Local Safeguarding Children Boards Regulations 2006 defines a Serious Case Review as one where: a) Abuse and neglect of a child is known or suspected b) Th child has died c) The child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners, or other relevant persons have work together to safeguard the child. In addition, an SCR **should always** be carried out when a child dies in custody, in police custody, on remand or following sentencing, in a Young Offender Institution, in a secure training centre or a secure children's home, or where the child was detained under the Mental Health Act 2005. This includes cases where a child died by suspected suicide.
Critical Incident / Serious Incident Reviews	Criteria for an SCR not met, however, it is felt by agencies, that due to the circumstances, an alternative multi-agency review should be undertaken (the decision will be that of the SCR Sub Group based upon the information recorded and submitted on the 'Notification Form for Consideration of a Case Review).
Best Practice Reviews	There cannot be any tight criteria for this type of review. Where an agency feels that there are examples of good multi-agency practice demonstrated in a particular case which would provide good learning opportunities and positive outcomes for children, the case should be submitted to the CR Sub Group for consideration of a good practice review.

Table 1: Case Reviews

- **Case Audits**

  Multi-Agency – KSCB conducts a series of themed audits in line with issues highlighted from serious and other case reviews, topics under the KSCB Business Plan priorities and areas for specific follow up scrutiny identified from other audits/reviews. The Board has developed an annual audit programme.

  Single- Agency – Partner agencies will, as part of their internal scrutiny process, undertake specific audits of their activity. The findings and recommendations from these will be fed back to the KSCB to assist in building a wider picture of safeguarding activity and effectiveness.

- **Child Death Overview Panel (CDOP)**

  Information from KSCB's CDOP is regularly shared with the Business Group and cascaded more widely as appropriate.

- **Board members' observation (walkabouts) programme**

- **Multi-Agency Deep Dives**

  These reviews will take the form of a multi-agency review session chaired by a senior member of the KSBC Business Unit. Their purpose will be:

  - To consider the quality of multi-agency and multi-disciplinary practice in the chosen topic area for the deep dive (as outlined in the Multi-Agency Audit Programme).

  - To provide evidence assurance to KSCB that practice in these cases is robust and effective.

- **Learning from Research**

  - What's happening elsewhere and what systems do we have in place to get the information and then use it to support the other information

  - Commissioned local research

8. Involvement of Children and Young People

OFSTED's framework and evaluation schedule for the inspections of services for children in need of help and protection, children looked after and care leavers and Review of Local Safeguarding Children's Boards 2016, confirms that inspectors will seek '*Evidence to demonstrate how feedback from children and young people and frontline staff, both individually and collectively, is asked for, taken into account and, where appropriate, impacts on practice, strategy, service development and design.'*

KSCB usage a range of mechanisms to achieve this objective, including:

- KSCB Children and Young Person Strategy – The strategy sets out the mechanisms that KSCB will use to capture the views and experiences of children and young people and the ways in which the Board will develop, publicise and sustain dialogue. The strategy commits KSCB to:

  - Receive and act upon information about the views and experiences of children and young people (quantitative and qualitative data from single and multi-agency performance reporting and audits, serious case reviews and other management reviews).
  - Develop links and build relationships with existing children and young people's groups and forums.

- Raise awareness of safeguarding issues amongst children and young people and equip them with the knowledge to stay safe.
- Promote the direct participation and input of children and young people in the work of KSCB at a strategic and operational level.
- Ensure input from children and young people is communicated outwards.
- Challenge partners to demonstrate how the voice of the child influences their work.

- Feedback from Children in Care – The members of the Children in Care Council are supported and encouraged to provide feedback on existing service delivery and views about future directions directly to the Head of Service for Corporate Parenting. KSCB will ensure that either feedback from children in care informs the work of KSCB.

- Feedback from Kent Youth County Council (KYCC)

- Complaints / Compliments – Feedback from children and families along with information obtained from complaints investigations, provides an insight into how well the safeguarding system is working. Relevant lessons established through KCC's statutory complaints process overseen will be shared with KSCB for identification of learning. Any complaints made directly to KSCB and any cases escalated to the Chair will provide further intelligence in this request.

9. Communication, Consultation, and Engagement with Children, Families and the Community

- KSCB recognises the importance of seeking the experiences of children, families and the community to inform its work. To this end, every Board meeting is prefaced by a presentation by children and young people.

- Targeted face to face engagement is facilitated where KSCB identifies specific issues / groups of children, families and communications with whom it needs to engage. This may result from learning that requires further exploration with children, families and communities themselves.
- The use of social media is recognised as an important communication media securing the views of young people and KSCB will develop the use of this mechanism.

- Lay member feedback – Lay members are involved in specific KSCB Groups and will provide a transparent and independent / non-professional account of their opinions about children's experiences.

- KSCB Partnership Development Officer – KSCB' S Partnership Development Officer works directly with children and young people and a range of partners including community groups. Stakeholder surveys and feedback from young people are regularly used to identify issues and concerns can communicate these to the Board.

10. Involvement of Front Line Staff

KSCB regularly engages with multi-agency front line staff of way e.g.:

- Multi-Agency training
- Delegate feedback forms
- Practitioner groups – used in reviews
- Case audits
- Practitioners' surveys
- Feedback from training sessions, workshops, conferences, seminars
- Learning events from Serious Case Reviews, Case Reviews, Domestic Homicide Reviews, Child Death Overview Panel
- Learning projects e.g. Safer Sleeping Thermometer Care and the development of eCDOP.

11. Evaluating Learning & Evidencing Impact

The aim of this framework is to make a positive impact on frontline practice and in turn improve outcomes for children and young people in Kent and understand the difference that has been made to the safety and wellbeing of children and young people as a result of identifying learning, disseminating lessons and embedding those lessons in day to day practice. A variety of new and existing approaches will be used to achieve this as illustrated in Figures 3 and 4.

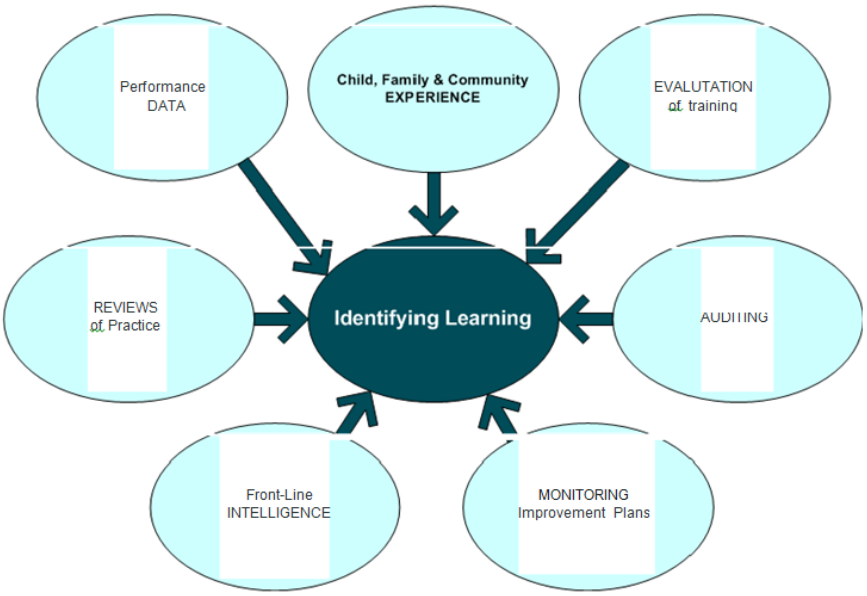

Figure 3: Identification of Learning Cycle

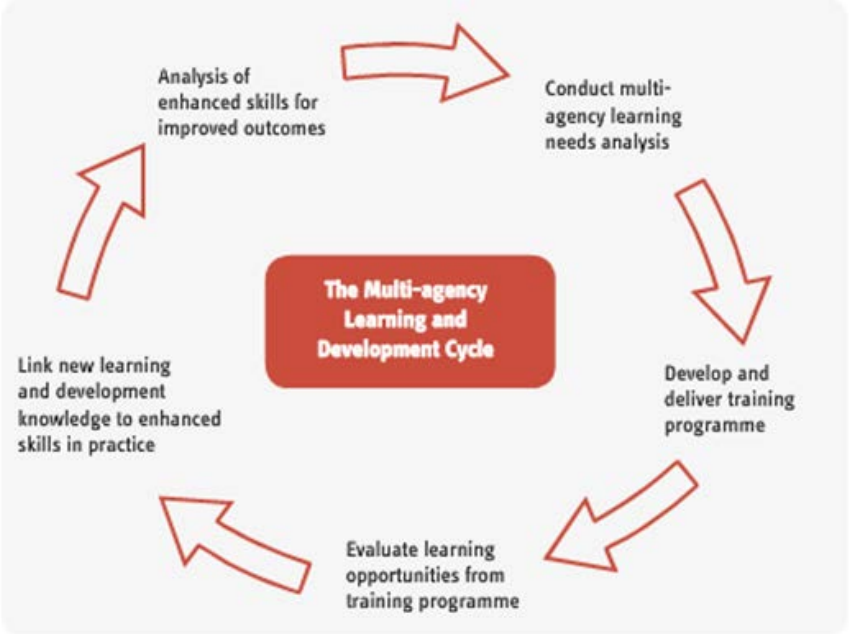

Figure 4: Getting Learning into Practice (RIP 2014)

12. KSCB Reporting and Management of the Process

Reporting and decision making structure / system:

- Role of the KSCB Business Group
- Relationship between the Board and other Boards/organisations

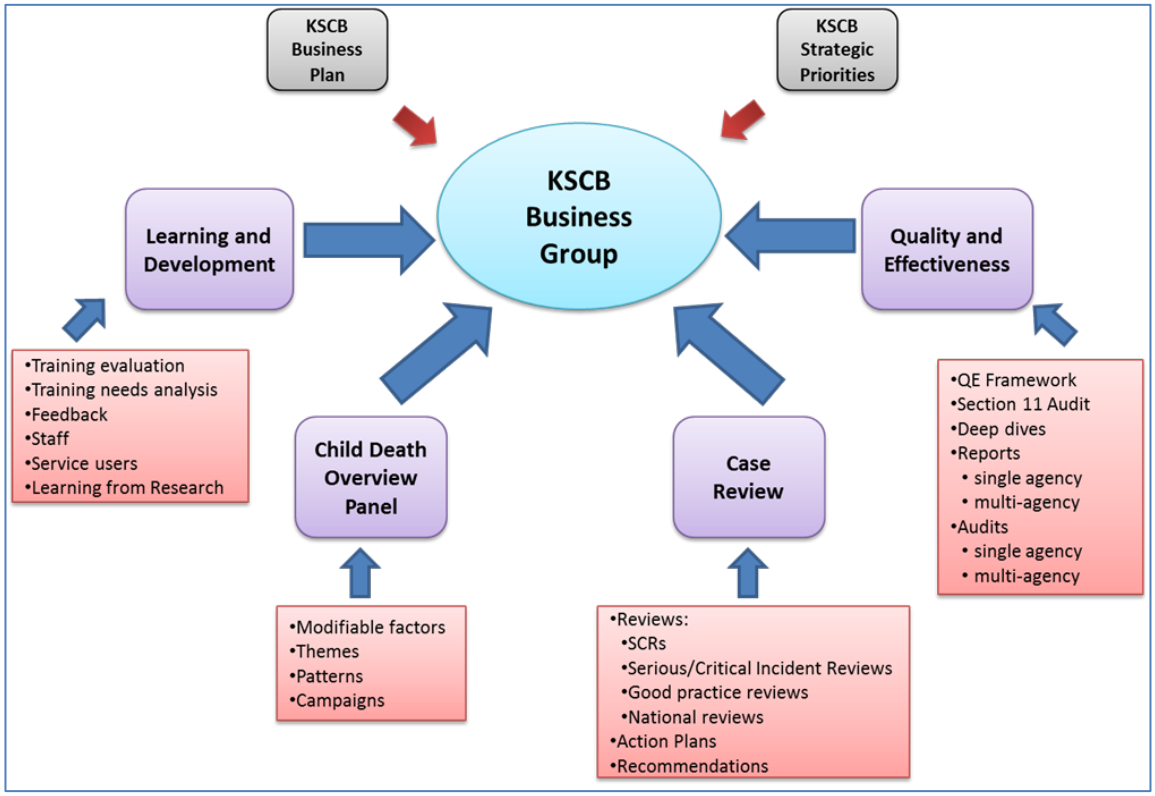

Figure 5: KSCB Reporting & Management Process