Windsor and Maidenhead
LOCAL SAFEGUARDING CHILDREN BOARD

Learning and Improvement Framework

1 Introduction

1.1 The W&M LSCB and its Subgroups engage in a wide range of activities to identify what is working well and what needs improving in local safeguarding arrangements and practice. The Learning and Improvement Framework enables the Board to make the links between the identification of what needs improving and the mechanisms available to achieve these improvements. The framework builds on the draft W&M LSCB Learning and Improvement Framework (developed in 2013) and it incorporates key elements of Chapter 4 of Working Together (HM Government, 2013).

1.2 Working Together states that the objectives of LSCBs are:

(a) to coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and

(b) to ensure the effectiveness of what is done by each such person or body for those purposes.

1.3 An 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; and
- monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children.

1.4 Working Together 2013 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 who work with children and families. This framework should enable organisations to be clear about their responsibilities, to learn from experience and improve services as a result.

The local framework should cover the full range of **reviews** and **audits** which are aimed at driving improvements to safeguard and promote the welfare of children".

2 Principles for learning and improvement (Working Together 2013)

2.1 The following principles should 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 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 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.

2.2 SCRs and other case reviews should be conducted in a way which:

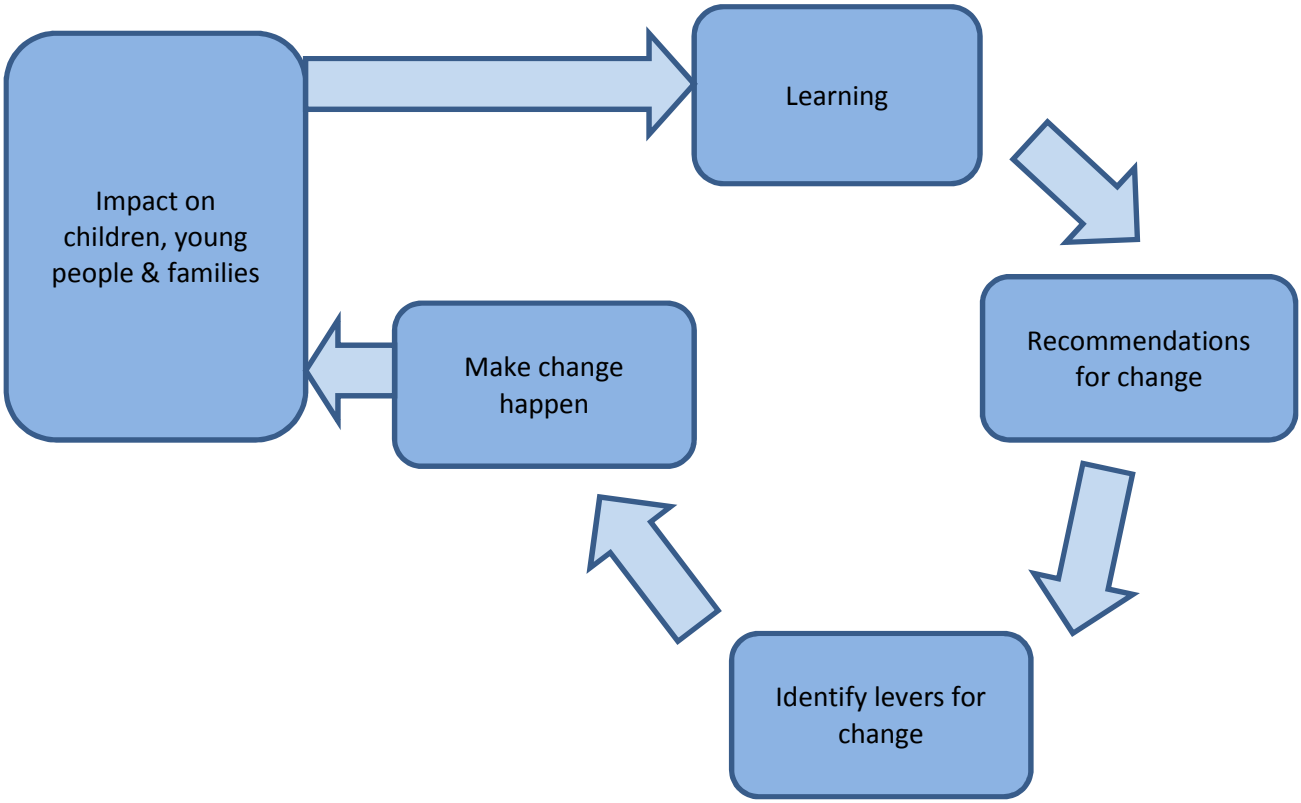
- recognises the complex circumstances in which professionals work together to safeguard children;
- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- seeks to understand practice from the viewpoint of the individuals and 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.

3. How the W&M LSCB supports learning and improvement.

3.1 The W&M LSCB has a Subgroup structure (see Appendix 1) with clear terms of reference for the Board and all Subgroups. Despite the distinct functions covered by each group it is vital to effectiveness that they interact with each other. This is achieved through the Chairs of groups having regular meetings and communications with the Independent Chair of the Board and the Business Manager.

3.2 The Board has overall responsibility for ensuring there is continuous learning and improvement and that it is making a difference. How the various elements of the Board's structure promote learning and improvement is set out below.

3.3 Our approach will focus on ensuring what we do (our effort in terms of quantity and quality) makes a positive difference to children's lives (the effect in terms of impact).



4 The relationship of the LSCB with other bodies

4.1 Learning and improvement is not exclusive to the W&M LSCB we are open to importing learning from, and exporting learning to, other bodies, including the Health and Wellbeing Board, the Children & Young People Partnership, the Community Safety Partnership and the Safeguarding Adults Board. The W&M LSCB Annual Report will be an important means of communicating the Board's learning to local stakeholders.

5 Scrutiny and Challenge

5.1 The process by which scrutiny and challenge is informed is through the collation and coordination of information from a variety of different sources. Some of these will be through the Board and Subgroups (see Appendix 2). The following description of a 'library' of distinct but inter-related activities and reports is based on the Quality Assurance Framework for the SE Region LSCBs:

The W&M LSCB Learning & Improvement 'Library'

KEY REPORTS	QUANTITATIVE INFORMATION	QUALITATIVE INFORMATION	PARTICIPATION & ENGAGEMENT WITH CHILDREN & YOUNG PEOPLE	PARTICIPATION & ENGAGEMENT WITH PARENTS & CARERS	INVOLVING FRONT LINE STAFF & MANAGERS	CONSULTATION WITH THE PUBLIC & OTHER STAKEHOLDERS	FUTURE INITIATIVES (THE NEXT VOLUME)

Key Reports

5.2 It is essential for the W&M LSCB to have a structure underpinning its challenge and scrutiny role. In order to commence this, there is a need to have a core understanding of the Board's work and related functions. These reports provide that foundation:

- LSCB Annual Reports
- Section 11 & Section 175 Audit
- Agency Annual Reports

Quantitative Information

5.3 In order for the W&M LSCB to see the wider picture of agencies' activities and performance, the Board has produced a comprehensive data set. All agencies provide performance data and include their analysis of that data to inform the W&M LSCB of patterns, trends and areas for action. The Multi-agency data set includes both key nationally and locally collected multi-agency data. The purpose of this data set is to highlight:

- progress towards meeting the W&M LSCB Business Plan priorities
- major changes to performance and quality assurance measures from the W&M LSCB management information report
- any additional information that is needed pertaining to the safeguarding and welfare of children and young people in Windsor & Maidenhead, and
- prompt discussions within the Board and Subgroups on where improvements can take place and successes shared.

5.4 The M&E Subgroup will monitor the W&M LSCB Dataset to analyse the data for trends and comparisons with similar local authority areas and will produce recommendations for the W&M LSCB arising from this analysis.

Qualitative Information

5.4 The W&M LSCB recognises the importance of information that may be less straightforward to quantify, but is nevertheless vital to understanding the 'whole picture' about safeguarding locally (e.g. feedback from service users). The work stream of the W&M LSCB includes opportunities to analyse and consider outcomes from monitoring the children's social care complaints process and other complaints processes in partner agencies. The W&M LSCB will develop a regular face to face dialogue with representatives of local children and young people's forums. The M&E Subgroup will consider developing processes that will provide the W&M LSCB with answers to the 24 questions in the local information part of the Children's Safeguarding Performance Information Framework (DfE, 2012).[1]

5.5 These are the essential tools by which the W&M LSCB scrutinises the work of agencies and holds them to account. By using this approach, the Board will better 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. Audits and reviews, together with the findings and actions, will be published on the W&M LSCB website as appropriate.

[1] Children's Safeguarding Performance Information Framework

Audits

5.6 Up to four multi agency case audits (also known as deep dives) will be carried each year. These are focused on themes identified by the LSCB business planning process.

5.7 Bespoke commissioned multi-agency audits will be conducted as necessary (e.g. in response to a serious case review or learning review). And, bespoke commissioned single agency audits will be carried out (e.g. Children's Social Care audits).

Case reviews

5.8 Working Together sets out the criteria for initiating a serious case review or other learning 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 or neglect of a child is known or suspected; and (b) either (i) the child has died; or (ii) 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 worked together to safeguard the child Thus cases meeting **either** of these criteria must always trigger a Serious Case Review: 1. Abuse or Neglect of a child is known or suspected AND the child has died (including by suicide); OR 2. Abuse or Neglect of a child is known or suspected AND 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 worked together to safeguard the child. In this situation, unless it is clear that there are no concerns about inter-agency working, a Serious Case Review must be commissioned. Additionally, even if these criteria are not met a Serious Case Review 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.
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.
Best Practice Reviews	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 demonstrate positive outcomes for children, the case should be submitted to the SCR Committee or the Professional Practice Committee for consideration of a good practice review.

5.9 Working Together 2013 does not prescribe any particular methodology to use in such continuous learning, except that whatever model is used it must be consistent with the following 5 principles for learning and improvement (see 2.1 & 2.2 above). Whilst Working Together stops short of advocating any specific method the systems methodology as recommended by Professor Munro (**The Munro Review of Child Protection: Final Report: A Child Centred System**) is cited as an example of a model that is consistent with these principles. The following list gives examples of models for consideration:

- **SCIE Learning Together** (LT) has been piloted and evaluated during the Working Together consultation period 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. (References: Fish, S., E. Munro, and S. Bairstow, Learning together to safeguard children: developing a multi-agency systems approach for case reviews. 2008, Social Care Institute for Excellence: London) and Undertaking Serious Case Reviews using the Social Care Institute for Excellence (SCIE) Learning Together systems model: lessons from the pilots. March 2013).
- **Root Cause Analysis (RCA)** has been used within health agencies as the method to learn from significant incidents. RCA 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.[2]
- **Child Practice Reviews** replaced the Serious Case Review system as the statutory guidance in Wales in January 2013. This process consists of several inter-related parts: Multi-Agency professional Forums to examine case practice, Concise Reviews in order to identify learning for future practice, and Extended Reviews which involves an additional level of scrutiny of the work of the statutory agencies.[3]
- **Significant Incident Learning Process (SILP)** 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 (AI)**, 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.

5.10 Learning reviews may be completed for child protection incidents which fall below the threshold for a serious case review. These may be within single agencies or carried out by the multi-agency Serious Case Review (SCR) Subgroup of the W&M LSCB using a preferred case audit process. The SCR Subgroup supports a process of reflective practice review meetings where professionals involved in a case come together to reflect on case management and decision making in individual cases using a systems approach.

[2] National Patient Safety Agency (NPSA)
[3] Protecting Children in Wales: Guidance for Arrangements for Multi-Agency Child Practice Reviews (2013)

5.11 Other types of qualitative information activity:

- Board Member 'Walkabouts' e.g. visiting frontline practice where child protection referrals are received and decisions made on action.
- Planned 'on a day' surveys by Board members or Subgroup members.
- Learning from research
  - Such as, drawing on lessons from other Serious Case Reviews, national studies of Serious Case Reviews and other research
- Commissioned surveys on relevant safeguarding topics where this will support improved outcomes.
- Working closely with the academic establishments to produce research outcomes that will inform service improvements.

Participation & Engagement with Children and Young People

5.12 The LSCB will develop a programme 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 the W&M LSCB at a strategic and operational level;
- Ensure input from children and young people is communicated outwards; and
- Challenge partners to demonstrate how the voice of the child influences their work.

Participation & Engagement with Parents and Carers

5.13 The LSCB will develop a programme to:

- Receive and act upon information about the views and experiences of parents and carers (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 parents' and carers' groups and forums;
- Raise awareness of safeguarding issues amongst parents and carers and equip them with the knowledge to ensure children stay safe; and
- Challenge partners to demonstrate how the voice of parents and carers influences their work.

Involving Front Line Staff and Managers

5.14 The current methods being used by the W&M LSCB include:

- Multi-agency training
- Engagement and feedback through case audits
- Feedback on learning through training sessions, workshops, conferences

Consultation with the Public and Other Stakeholders

5.15 This will involve communicating what the W&M LSCB does and seeking to understand from the public what the key child safety issues are within the local community and their preferred solutions. This will include:

- Improving the use of the W&M LSCB webpages as a means of communicating messages and receiving feedback
- Exploring the use of social media as a means of communicating messages and receiving feedback
- Developing the role and responsibilities of Lay Members
- A W&M LSCB Communication Strategy will be developed to clarify and expand the methods of communication both from and to the Board.

Future Initiatives

5.16 The W&M LSCB will keep the Learning & Improvement Framework under review and when needed will adapt the Framework to ensure learning has a demonstrable impact on improving services for children and families in Windsor & Maidenhead.

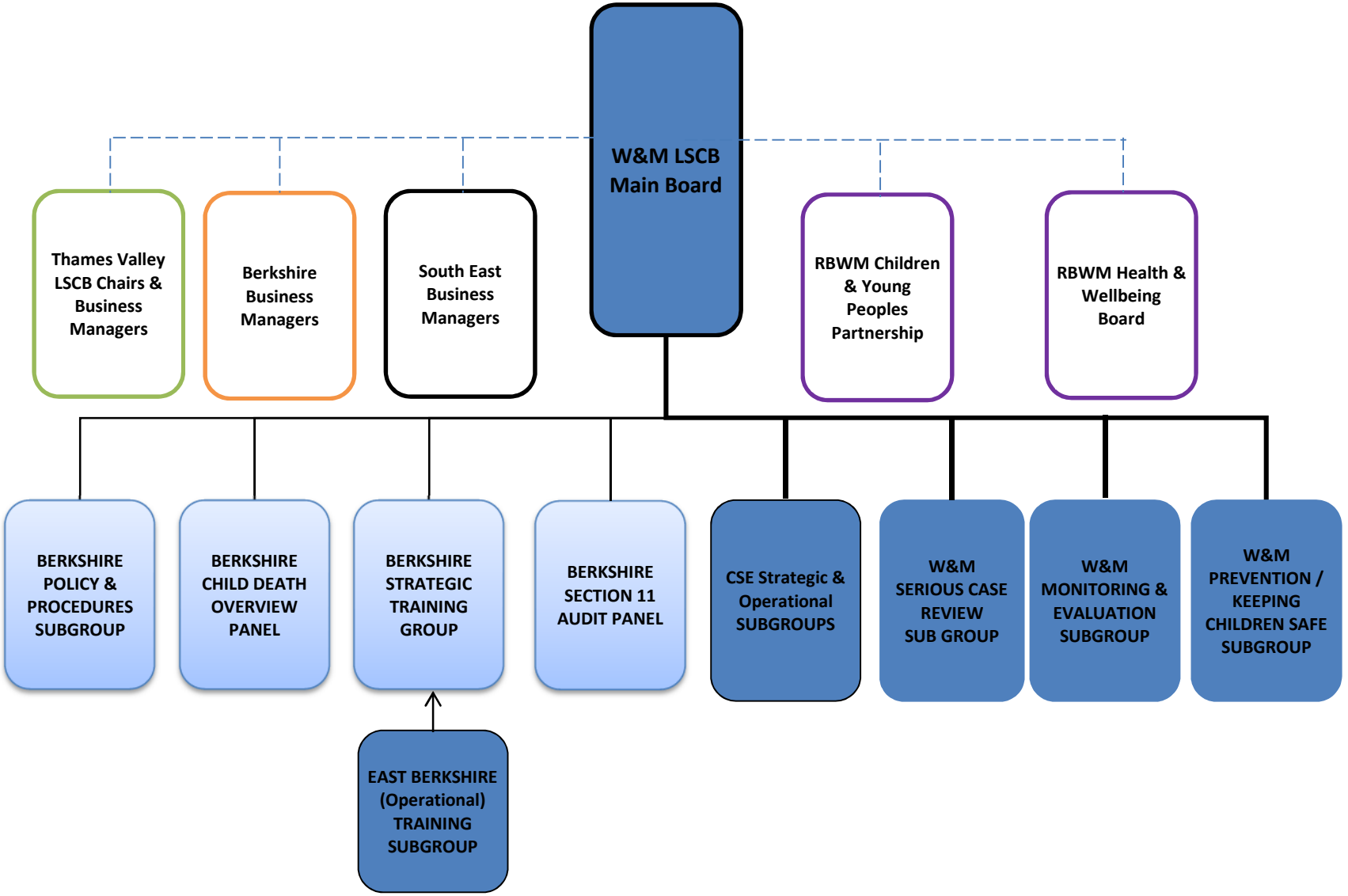
6 Evaluating the impact of the Learning and Improvement Framework

6.1 The effectiveness of the Learning and Improvement Framework is reviewed at each annual development day for the W&M LSCB as part of its own learning about how to improve its ways of working.

6.2 The W&M LSCB will look to all the Subgroups to implement this framework and to use it to identify areas requiring improvement that partner agencies can work on individually and together. It will form the focus of the W&M LSCB Annual Report and will provide the evidence base for challenges to the Children & Young People Partnership (CYPP), the Health and Wellbeing Board (HWB) and other local partnerships as appropriate. The W&M LSCB will seek to develop a learning culture where the Board and each of its partners play an active part in achieving good or improving outcomes for children and young people.

Appendix 1:

Windsor and Maidenhead
LOCAL SAFEGUARDING CHILDREN BOARD



Appendix 2: Board and Subgroups

The Board

Identification of need for learning or improvement	The means of improvement	The measure of effectiveness
• Issues emerging from service presentations to the Board • Issues reported to the Board by Subgroups • Issues identified in Board Reviews • Issues emerging from the JSNA • Issues emerging from agencies presentation of strategic issues from their complaints system	• Agreeing the action to be taken by agencies • Request for further clarification to be presented to the Board • Challenge by the Board • Reporting in annual report of the Board	• Follow up reports to be presented to the Board • Internal agency audits • Multi-agency audits • Review of Business Planning priorities • Reporting in Section 11 challenge meetings

Serious Case Review Subgroup

Identification of need for learning or improvement	The means of improvement	The measure of effectiveness
• Learning from Windsor and Maidenhead serious case review • Learning from other Windsor and Maidenhead reviews • Learning from 'good example' case reviews	• Adopting inclusive approaches to reviews that enhance the potential for learning • Implementation of recommendations • Identification of key themes from the review • Identification of key learning points into the training programmes of the Board and its partners	• Evaluation workshop • Targeted questions in audits
• Learning from serious case reviews undertaken elsewhere • Learning from Safeguarding Adult Board reviews • Learning from Homicide reviews	• Identification of transferable learning	• Transferable learning taken to the coordination meeting

Training Subgroup (pan Berkshire – strategic, East Berkshire - operational)

Identification of need for learning or improvement	The means of improvement	The measure of effectiveness
• Issues arising from other subgroups • Feedback from course participants • Feedback from training audits • National policy initiatives • Local policies and protocols	• Regular review of the content of training courses • Updating of the training objectives of courses • Updating of the content of courses • Identification of training need from new policies	• Evaluation by participants against the objectives of training • Periodic review with supervisors of the impact of training against the training objectives • Specific audits undertaken to establish the effectiveness of training • Including questions of practitioners on the

		effectiveness of training in reviews and audits • Analysis of individual agency's reports on attendance at safeguarding training events • Analysis of attendance at safeguarding board multi-agency training

Policy and Procedures Subgroup (Pan Berkshire)

Identification of need for learning or improvement	The means of improvement	The measure of effectiveness
• New national policies and strategies • Policy development identified from local serious case reviews and audits	• Development of new procedures • updating of current procedures • clear implementation process	• knowledge of policy by practitioners • application of policy as demonstrated by audits

Prevention Subgroup

Identification of need for learning or improvement	The means of improvement	The measure of effectiveness
• Identify areas in which the Board can be pro-active in providing information to prevent significant harm to children and young people	• The Board web-site • Electronic forms of communication • Leaflets	• A reduction in the incidence of the targeted behaviour

Monitoring & Evaluation Subgroup

Identification of need for learning or improvement	The means of improvement	The measure of effectiveness
• Scrutiny of management information available to the Board • Establishing performance indicators for new board policies and Protocols	• Raising concerns about performance at the Board • Requiring relevant feedback from agency	• Improved performance data from agency
• Learning from individual agency's audits	• Identification of relevant actions from audits to be reported back to the subgroup	• Reporting back from agencies on implementation of audit actions plans
• Targeting Board's multi-agency audits to maximise learning within the resources available • To develop and commission audits as agreed at the Board's Business planning day	• Reporting Board's audits and recommendations to the Board	• To oversee the implementation of audit recommendations • To report the key themes for improvements from audits to the coordination meeting • To initiate follow up audits, as required

Child Death Overview Subgroup (pan Berkshire)

Identification of need for learning or improvement	The means of improvement	The measure of effectiveness
• All cases reviewed	• Modifiable factors identified • Modifiable Factors reported in annual report • Action taken in response to modifiable factors	• Increased public awareness of risk factors • Reduction in number of deaths linked to known modifiable factors
• Review of rapid response activity	• Feedback to agencies involved	• Future reviews demonstrate improved performance

Section 11 Panel (pan Berkshire)

Identification of need for learning or improvement	The means of improvement	The measure of effectiveness
• Section 11 audit process • Section 11 challenge meetings	• Reporting back to agencies on the agreed development areas	• Reporting by agencies on the actions taken in relation to the development points • Scrutiny by the Board of the actions taken • Reporting in future audits