A Learning and Improvement Framework

Learning from practice, improving children's outcomes.

Approved by BSCB February 2014

Introduction

1. Protecting and safeguarding children is complex and important work. Professionals and organisations have a role to play in this vital area and need to reflect on the quality of services and learn from their practice and that of others. Bromley's Safeguarding Children Board has a vision of building a better Bromley for its children and young people through listening to children, young people and their families, learning from professional practice and taking a lead on change. This involves developing a culture of reflective practice, through sharing best practice to promote a growing understanding of what works well and rigorous analysis when things go wrong. This Learning and Improvement Framework sets out Bromley Safeguarding Children Board's commitment and statutory obligation to ensure learning and improvement takes place. It sets out the processes for how Bromley will foster a culture of listening and learning in a blame-free culture. Our commitment is to ensure that learning is disseminated effectively to the local professional network and becomes embedded in practice which improves outcomes for children and young people.

2. *Working Together to Safeguard Children*: a guide to inter-agency working to safeguard and promote the welfare of children and young people (March 2013), sets out the LSCB's responsibilities in monitoring effectiveness of local agencies involved in safeguarding and child protection. The guidance states:

3. *"LSCBs should maintain a local learning and improvement framework which is shared across local organisations who work with children and families. The framework should enable organisations to be clear about their responsibilities, to learn from experience and improve services as a result." WT 2013, para 3, page 65).*

4. The framework supports the Bromley Board and its partners to:

- Understand child protection and safeguarding processes from the child's perspective.
- Know and understand how organisations are working together to safeguard and protect the welfare of children in order to enhance practice
- Identify and share good practice in safeguarding.
- Review cases rigorously and in detail showing what happened, how things went wrong, or well and why and accompanied by actions that show the learning from the review.
- Drive forward lasting improvements to services to safeguard children and families as a result of the actions from reviews and audits
- Foster transparency about issues and actions arising from reviews and audits.

A key purpose of the framework is to identify improvements which are needed and to consolidate good practice. Showcasing examples of good practice occurring within organisations promotes continuous learning and improvement. All audits will highlight areas of good practice where they occur and this will be shared through Practice Guidance and briefing events.

The different types of reviews covered by this framework are:

- Serious Case Reviews
- Domestic Homicide Reviews
- Child Death review
- Review of a child protection incident which falls below the threshold for an SCR
- A review or audit of practice in one or more agencies.

This Improvement Framework is not dependent on the learning from reviews alone. Other data and information also usefully informs practice:

- Performance data on safeguarding and child protection
- Agency inspection reports
- Agency annual safeguarding reports
- Single agency audits and Section11 Safeguarding Self-Assessment
- Feedback on services from children and young people

Principles for Learning and Improvement

5. All reviews conducted by the Board and its partners should meet the following principles[1]:

- Seek to understand what is happening from the perspective of the child's experience.
- Foster a culture of continuous learning within and across partner organisations
- Adopts an approach proportionate to the scale and level of complexity of issues being examined.
- Be rigorous with objective analysis where things go wrong and developing a growing understanding of what works well.
- Reviews of serious cases should be led by individuals who are independent of the case under review and the organisations whose actions are being reviewed.
- Frontline professionals are be involved fully in reviews and invited to contribute without fear of blame.
- Families, children and young people should be invited to contribute to reviews. Expectations must be managed appropriately and sensitively so that they understand how they are going

[1] Working Together to Safeguard Children para 9, p66 (March 2013)

to be involved. It is important that young people's views and experiences are heard as this is key to shaping services.

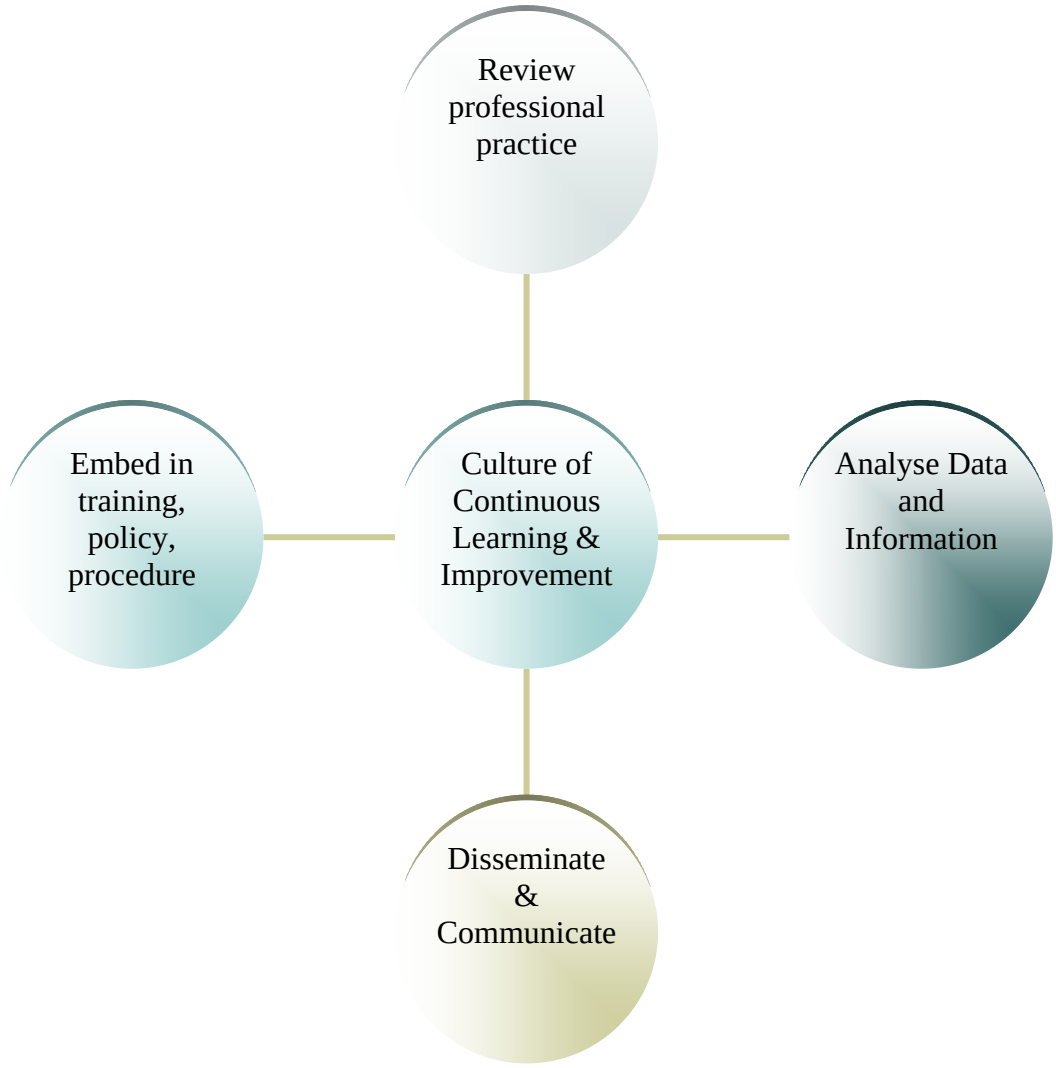
- Learning from reviews including serious case reviews should be made public. Practice guidance should be disseminated.
- Regular monitoring and follow-up from findings should be undertaken to ensure that the impact is real and lasting.

Accountability

6. When a Serious Case Review is to be considered or conducted a Serious Case Review Sub-Committee comprising Board members will be convened to manage the process of the review. Membership will be at a level of appropriate independence from the case and it may include member agencies which are not directly involved. The Serious Case Review Committee will report to the Board.

7. A Multi- Agency Audit Group (MAAG) comprising partner agencies will have oversight of the multi-agency audit/ review process and actions emerging from audits. It will report directly into the Quality Assurance & Performance Monitoring Committee (QA&PM) which is Chaired by the Board's Independent Chair, QA & PM Committee will be able provide robust challenge to the local network in its drive to improve practice and therefore outcomes for children. It will monitor actions and their dissemination.

The Learning and Improvement Wheel



Review Professional Practice

STATUTORY REVIEWS

Serious Case Reviews

8. Serious Case Reviews are statutory reviews of cases where a child has died or suffered significant harm and where abuse or neglect is suspected and there is concern about the way in which authorities and their partners and other have worked together to safeguard the child. They are required under Regulation 5 of the Local Safeguarding Child Board Regulations 2006. Such reviews provide an important source of learning for local professionals and agencies.

9. Bromley has set out a procedure for conducting serious case reviews which is made available on its website www.bromleysafeguarding.org. This sets out how reviews should be conducted and expectations in terms of ensuring a blame free approach which supports a culture of learning. Children and young people should have the opportunity to contribute to the review so that their experiences can guide the review and actions. It is crucial that the learning is shared and the Serious Case Review Committee takes responsibility for the communication of the report and its findings. The Board adhere to the requirement for the publication of the review and shared findings through holding briefings, publishing an executive summary and through the use of its newsletter and embedding learning in training courses and materials.

Child Death Reviews

10. Local Safeguarding Children Boards have specific responsibilities in relation to the death of a child. They are required to conduct Child Death Reviews (a statutory requirement). LSCB's responsibilities are set out under Regulation 6 of the Local Safeguarding Children Boards Regulations 2006 and include:
    a)Collecting and analysing information about each death to determine if a Serious Case Review is appropriate; any matters of concerns affecting the safety and welfare of children in the area; any wider public health or safety concerns from a particular death or pattern of deaths.

    b) Putting in place procedures for ensuring that there is a co-ordinated response by partners and other relevant persons to an unexpected death.

11. In Bromley a Child Death Overview Panel, a multi-agency group established by the Board, reviews all child deaths. It reports findings annually to the Board. The panel has adopted

Multi Agency Reviews

12. Multi agency reviews may be conducted for cases which do not meet the statutory threshold for an SCR, but which require a level of analysis and scrutiny due to the significant issues which arise within the case. The review will be undertaken where it is thought to provide valuable information on how agencies are working to safeguard children and young people and focus on the learning and improvement. Professionals and children and young people are invited to contribute to the process. The Quality Assurance and Performance Monitoring Committee would establish a group comprising members to lead on this type of review. They would set out the terms of reference for the reviews and agree an appropriate timescale.

AUDITS

13. LSCBs and individual agencies undertake a wider range of case auditing to learn about current practice and to help improve services and in particular how agencies work together. These audits include:
    - Multi-agency case audits
    - Section 11 Audits
    - Section 175/157 Audits of Education Establishments
    - Early Years Audit of Day care providers
    - Single Agency Audits

Multi Agency Audits

14. Multi-agency audits play an important role in reviewing and quality assuring child protection and safeguarding practices. Current cases are typically chosen for audit and they are typically based on a safeguarding or child protection theme which are linked to priority areas for the Board. Lead practitioners with audit experience and who are not directly involved in the case are brought together to discuss the child's experience in the safeguarding system. Professionals and children and young people should be invited to contribute their views and the experiences they encountered to the audit panel. The audit will place in the foreground the child's experience and seek to understand the effectiveness of services from this viewpoint. The focus is to identify lessons for service improvement and professional practice across and between organisations. Highlighting examples of good practice in partnership work will show how effective outcomes can be achieved with a positive impact on children

and young people. A report and action plan is made to the Quality Assurance and Performance Monitoring Committee, which then monitors actions ensuring their implementation. Practice guidance is prepared and published to ensure learning and best practice is disseminated, including being embedded in training case scenarios and briefings.

15. A minimum of three audits or reviews are to be undertaken each year. Multi-Agency Audits (MAAs) are co-ordinated by BSCB's Performance Improvement Officer, drawing on a small multi-agency audit group to establish the audit terms of reference, including scope and sample size and to review and evaluate practice, arrangements and impact against criteria.

Section 11 Audit

16. Under Section 11 of the Children Act 2004 specific types of organisations and individuals are required to evaluate their compliance with safeguarding and child protection practice and procedures and their overall practice in this regard. In Bromley this is undertaken on a two year rolling programme and presented to the Quality Assurance and Performance Monitoring Committee. It comprises:

- An audit tool to be completed by the agency and submitted in advance
- An oral presentation to the Board identifying strengths and challenges and the agency's contribution to the Board's priorities.

17. The sharing of practice and systems provides an opportunity for agencies to learn from each other. Through feedback from partners on how systems and process impact on joint working agencies develop insight into where practice can be enhanced or changed. An issues and actions log is maintained to track progress and where necessary to agree if risks need to escalated to the Board for monitoring.

Section 175/157 Audits

18. Section 175 of the Education Act 2002 requires school governing bodies, local education authorities and further education institutions to make arrangements to safeguard and promote the welfare of children. They are required to pay due regard to guidance by the Secretary of State. A similar requirement is made of independent schools under Section 157 of the Education Act 2002.

Early Years Audit

19. The London Borough of Bromley Early Years' Service has developed a self-audit for the range of early years providers in the borough. The majority of providers fall into the category of private or voluntary institutions and therefore does not have the same statutory requirement as for schools. The audit is being conducted for the first time 2013-14 and it is planned that this will be undertaken on a bi-ennial basis.

Single Agency Audits

20. There is considerable learning to be obtained from specific safeguarding and child protection audits conducted by agencies. Individual agencies present an annual audit plan to the Board so that relevant audits may be requested for further exploration by the Board. The aim of sharing findings is to be able to both identify and show case best practice and improve practice across agencies. It also fosters inter-agency challenge on practice as well as enabling agencies to obtain the support of partners to address problems. On an annual basis agencies will be required to share a summary of their audits, recommendations and the outcome of actions taken.

21. In summary:

- Agencies to present their annual audit schedule to the BSCB's QA & PM Committee
- Audits are managed internally by the agency and where remedial action is required this will be taken by the agency.
- Should the board note concerns with practice, this will be notified to the agency through the Board representative and action monitored.
- Opportunities to disseminate good practice will be identified.
- Audit reports should reflect the views of children and young people.

22. The Board will maintain an issues and risk log in relation to audit findings and actions. The key questions for Board members to address in the audit validation process include:

i. How effective is the agency audit process in assessing the quality of practice?
ii. How well are audit reports used by managers?
iii. What action is taken in response to audit reports?
iv. How do they contribute to safety of children, young people and their families?

Analyse Data and Information

Dataset and Performance Measures

23. Regular quarterly reporting on selected measures of performance from across the safeguarding system enables members to understand how Bromley is performing. The BSCB safeguarding dataset considered the key measures related to child protection priorities. It is supported by an analysis of the data and where available comparative data is provided which helps to differentiate service standards and outcomes.

24. Performance data draws on the government guidance set out in Children Safeguarding Performance Information System (DFE October 2012) as well as locally agreed indicators.

25. Accompanying this joint dataset is agency reporting on their critical safeguarding measures. These safeguarding scorecards are reviewed on a six monthly basis, and allow agencies to reflect on areas ranging from as the impact of staffing levels on inter-agency networks to whether there is compliance with the required level of safeguarding training.

26. Data alone cannot assure the Board that its efforts to foster consistent of practice and partnership working impact is having a positive impact on outcomes for children and young people. However, when taken together with audit findings and case reviews a greater understanding emerges.

Inspections and Annual Reports

27. When agencies are inspected, the inspection findings and agreed actions plans should be presented to the Board highlight safeguarding issues to be addressed. Implications for local practice and safeguarding partnership should be clearly identified and shared with partner agencies. The Board will keep action plans under review and seek to draw on the support of the partnership to make improvements. Good practice in partnership work should be shared by all agencies and where possible this should enhance training programmes, briefings and communication between agencies.

28. The BSCB Annual Report provides for a transparent assessment of the performance and achievements of and challenges faced by local services. It ‘s objective and rigorous analysis of safeguarding arrangements and practice will provide a basis for agencies to make

improvements to partnership work. It will contain the lessons learned from multi-agency reviews and audits as well as using the analysis of local information to support conclusions about safeguarding in the borough.

29. Agency Annual reports on safeguarding should be shared with the Board as an opportunity for learning and to make improvements in practice.

Evaluations

30. The BSCB and its partners engage in specific projects and programmes which aim to improve the wellbeing of children and young people. The evaluation of these can provide valuable information about a safeguarding interventions and may have implications for improving services.

31. Evaluation reports, their recommendations and actions should be reviewed by the BSCB in order to disseminate the learning more widely or in a targeted way.

Dissemination & Communication

32. A co-ordinated approach to communication of learning from its case reviews, audits and evaluations and key reports will be fostered by the Board. The Board is committed to a communication strategy for all its work which will be reviewed as part of the programme of work. It is a requirement that serious case reviews are published and the website is used for this purpose alongside briefings and other methods outlined below.

33. The *Safeguarding Network* comprising practitioners from across a wide range of agencies will have opportunities to learn from audit and review findings and contribute to the process of improving outcomes. Typically this is done through briefings and distributing reports and guidance to them. These may include national as well as local reviews and reports. A *Safeguarding Network Forum* will take place twice a year, it will not only share information and key messages on safeguarding but invite professionals to be involved in development.

34. To aid transparency around sharing the findings of reviews and audits, the BSCB will issue *Practice Guidance* which identifies highlights in local joint working as well as setting out areas for action. These will be based on the full audit reports and case review which will have been scrutinised by Board Members.

35. The *Safeguarding Newsletter* is a termly digest of key messages and information in safeguarding. It remains an important way to share a wide range of information on safeguarding in an easily digestible format. It signposts readers to other resources and provides a forum for celebrating success and achievement

36. *BSCB Bulletin* is an ad-hoc e-briefing sent by email that shares important information and resources, such as policy changes, new procedures and upcoming events, with the safeguarding network.

Views of Children, Young People and their Families

37. Understanding the impact of our interventions on the lives of young people will lead to better, more effective outcomes for them. Improved provision comes from listening to their views about the services they have received; hearing how their experiences of the processes and the professionals impacted on their lives; and acknowledging how they think it could improve.

38. The voice and experience of children and young people should be embedded throughout our work, every audit and case review will be expected to track the child's experience . This means that agency records should be able to clearly demonstrate that their views have been recorded. Appropriate to their age, they will be invited to contribute their views and experience to audits and case reviews. Professionals working most closely with the child will be asked to support them to complete a questionnaire.

39. There are opportunities to draw on key messages from the survey material already being collected by agencies. Agencies are to report the findings from user feedback whether this comprises surveys or audits to the Board on an annual basis. This is in addition to any feedback obtained in the course of conducting a specific audit.

40. All case reviews and audits should include the views of children and young people. In addition, the BSCB will obtain views of young people through their work with the Living in Care Council and the Youth Council, where safeguarding will appear as items on their agenda.

Voice of Frontline Practitioners

41. The voice of practitioners and how they experience safeguarding processes and arrangements is also important to capture. They have an important contribution to make to improving services and the child's experience. Safeguarding Network Forum events not only provide an opportunity to disseminate information to professionals, but to obtain their direct input into shaping the direction of our work. It is proposed that there will be two Forums each year, with a key aim being opportunities to gain practitioner feedback on a range of key issues including Board priorities, service developments, policy & procedure and implementation issues.

42. An anonymised *Practitioner Survey* is also proposed. As an on-line open survey it provides an opportunity to gain a snapshot of professionals' views on how well safeguarding processes are working locally and what would support them to undertake this difficult and complex role. The Board believes that a confident, well trained and supported workforce leads to better outcomes for children and their families.

Embedding Learning

Training

43. BSCB considers training to be the bedrock for developing a culture and shared understanding of working together. It also provides a key resource for embedding lessons learned through multi-agency practice reviews and audits. Training fosters communication within the safeguarding network which in turn enhances knowledge, skill and understanding of safeguarding requirements among professionals.

44. The BSCB has in place arrangements to monitor and evaluate the multi-agency training programme which includes both formal training and briefings. An assessment of the impact of the BSCB's core safeguarding training therefore forms a part of this improvement and performance framework. The impact of the core training programme will be systematically evaluated through follow-up surveys taken 3 months after completion of the training. This will enable some exploration of the impact of training on professional's practice as reported by them. A further survey to managers could be undertaken to establish if an impact for the team or service is noticed.

Policy & Procedure

45. When policies and procedures are approved a date for review is provided, usually 3 years for multi-agency policies. This provides time for the policies or procedures to be communicated and embedded in practice. Where reviews indicate the need for change this are immediately communicated and a review of the policy may be undertaken to ensure it remains relevant, robust and clear. In this way lessons from practice reviews and performance data must be taken into account when reviewing procedure and policy.

Annex
Confidentiality

The following principles must be understood by the Board and its members in relation to performance monitoring and improvement in safeguarding and adhered to.

Each party shall keep confidential all children and family identifying details and confidential information belonging to other parties disclosed or obtained as a result of the relationship of the parties under the safeguarding performance and improvement framework aspects and shall not use nor disclose the same save for the purposes of the proper performance of the framework or with the prior written consent of the other party.

Data protection

The Board and its partners, and safeguarding audit team members agree that data (including personal data) as defined in the Data Protection Act 1998, relating to the processing of the challenge, to the extent that it is reasonably necessary in connection with the challenge, may:

(a) be collected and held (in hard copy and computer readable form) and processed by the audit team and;

(b) may be disclosed or transferred:
   i. to the audit team members and/or
   ii. as otherwise required or permitted by law.