Brighton & Hove Local Safeguarding Children Board

Learning & Improvement Framework

November 2015

Brighton & Hove LSCB local safeguarding children board

Learning Together to Safeguard the City

www.brightonandhovelscb.org.uk

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1 Introduction

1.1 The Learning and Improvement Framework is intended to strengthen and support a learning culture across partner agencies in Brighton & Hove to continuously improve services to safeguard and promote the welfare of children and young people. To achieve this end, the Board will create a culture of openness and facilitate effective and regular challenge to all partner agencies.

1.2 The Brighton & Hove LSCB is required to:

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

1.3 An LSCB should use data, and 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 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 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 2015)

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 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 The inter- connectedness of the Board and its Subcommittees for learning and improvement

3.1 The Board operates with a Subcommittee and network group structure to manage the functional tasks of the Board. The terms of reference of each element of the Board structure necessarily compartmentalises aspects of the Board's work, with the Board itself having overall responsibility for all aspects of learning and improvement within that structure. However, the effectiveness and thoroughness of the Board requires that the work of each Subcommittee interacts with the work of the others, whereby the output of one Subcommittee informs the input to another. This in turn creates the opportunity for the Board to evaluate the effectiveness of agencies' services to safeguard and promote the welfare of children.

3.2 The LSCB Independent Chairperson will meet with the Subcommittees Chairpersons to drive the LSCB's Business Plan and manage the interface between the work of the Subcommittees. This group has a pivotal role in developing the learning and improvement framework.

4 The relationship of the LSCB with other bodies

4.1 Learning and improvement is not exclusive to the LSCB and it must be open to importing learning from, and exporting learning to, other bodies, including the Health and Wellbeing Board, the Children's Partnership Board, the Community Safety Partnership, Corporate Parenting Board, Prevent Board and the Safeguarding Adults Board. The annual report of the Board will be an important means of communicating Board learning.

4.2 A LSCB Communication Strategy clarifies and expands the methods of communication both from the Board and to the Board.

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. The following description of a 'library' of distinct but inter-related activities and reports is consistent with the Quality Assurance Framework for the South East Region LSCBs:

Brighton & Hove LSCB LEARNING & IMPROVEMENT 'LIBRARY'							
BUILDING BLOCKS	QUANTITATIVE INFORMATION (data sets)	QUALITATIVE INFORMATION (quality assurance)	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)*

Building Blocks

5.2 It is essential for Brighton & Hove 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 LSCB's work and related functions. These reports provide that foundation:

- **Section 11 Audit**
  This provides a benchmark of agency activity and issues. The most recent full audit and Challenge Event was conducted in 2014. Agencies were asked to update on progress against their action plans in March 2015. The next full audit will be undertaken in 2016.

- **Multi-Agency Audit**
  The LSCB has a Quality Assurance Framework (QAF). The framework is based on an 'Outcomes Based Accountability' (OBA)1. Alongside the QAF the LSCB has a yearly multi-agency quality assurance programme.

- **Annual Reports**
  Key agencies will submit specific annual reports to Brighton & Hove LSCB as part of their statutory responsibility (e.g. Private Fostering, LADO/Managing Allegations Against Staff). Brighton & Hove LSCB 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). These reports should include 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.

[1] Mark Friedman, Trying Hard is Not Good Enough, 2005, Trafford Publishing

- **Agency Reports**
  Agencies should contribute to the quarterly Management Information Report; this includes a detailed analysis of data. Each agency should take responsibility for its own analysis which will be scrutinised by Brighton & Hove LSCB. Agencies also submit an annual report for inclusion within the Brighton & Hove LSCB Annual Report.

Quantitative Information

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

- Multi-agency Part A data set: this includes both key nationally and locally collected multi-agency data. The purpose of this data set is to highlight:

  - Progress towards meeting the Brighton & Hove LSCB Business Plan priorities
  - Major changes to performance and quality assurance measures from the Brighton & Hove LSCB quarterly report
  - Any additional information pertaining to the safeguarding and welfare of children and young people in Brighton & Hove, and
  - Prompt discussions within the Subcommittee on where improvements can take place and successes shared.

- Multi-agency Part B data set is thematic; this will contain key performance information (or evidence), both qualitative and quantitative to inform the areas for review and development as identified in the LSCB Business Plan e.g. DV&A, CSE, CSA. This information will be used to tell the story about children, their families, services provided to them and their outcomes and as such it will be closely linked to the quality assurance activity undertaken by the LSCB Monitoring & Evaluation Subcommittee. Agencies across the partnership will be contacted for information depending on the theme/area under review.

5.4 Part A and B data is scrutinised quarterly by the Monitoring & Evaluation Subcommittee and tabled for discussion at every Board meeting.

Qualitative Information

5.5 These are the essential tools by which the Brighton & Hove LSCB scrutinises the work of agencies and holds them to account. By using this 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. Findings and actions from reviews are disseminated to frontline staff via Managers Briefings and published on the Brighton & Hove LSCB website.

- Case reviews

<table>
<tr><th>Review Type</th><th>Criteria</th></tr>
<tr><td>Serious Case Reviews</td><td>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.</td></tr>
<tr><td>Learning Review</td><td>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.

This can include a Themed Learning Together Review (the term used to describe applying the SCIE Learning Together methodology to a group of cases as opposed to one case)</td></tr>
<tr><td>Best Practice Reviews</td><td>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 Subcommittee for consideration of a good practice review.</td></tr>
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5.6 Working Together 2015 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. (Reference: www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/)

- **Child Practice Reviews** replaced the Serious Case Review system as the statutory guidance in Wales on 01.01.13, 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 an Extended review which involves an additional level of scrutiny of the work of the statutory agencies. (Reference: Protecting Children in Wales. Guidance for Arrangements for Multi-Agency Child Practice Reviews. 2013)

- **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.

5.6 Other types of qualitative information:

- Case Audits
  - Multi-agency – The Board has produced an annual audit programme. These may be themed audits in line with issues highlighted from Serious and other Case Reviews, topics under the Brighton & Hove LSCB Business Plan priorities and areas for specific follow up scrutiny identified from other audits/reviews.

  - 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 Brighton & Hove LSCB to assist in building a wider picture of safeguarding activity and effectiveness. The Local Authority conduct an audit of 12 multi-agency child protection and Children in Need cases every quarter and the Monitoring & Evaluation Subcommittee are afforded an opportunity to scrutinise this audit annually during the single agency audit update.

- Executive Walkabouts.

- Planned 'on a day' surveys by Board members or Subcommittee members.

- Learning from research
  - Drawing on lessons from other Serious Case Reviews, national studies of Serious Case Reviews and other 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.

Participation & Engagement with Children and Young People

- The LSCB has a Participation & Engagement Strategy which aims to:

  - Receive and act upon information about the views and experiences of children and young people (utilising quantitative and qualitative data from single and multi-agency performance reporting and audits, serious case reviews and other 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 Brighton & Hove 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

- The LSCB has a Participation & Engagement Strategy which aims 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

The current methods being used by Brighton & Hove LSCB include:

- Multi-agency training
- Involvement for front line staff and managers in Brighton & Hove LSCB Serious Case and Learning reviews
- Involvement of front line staff and managers in multi-agency audits
- Link to feedback from training sessions, workshops, conferences
- Annual staff survey across LSCB partner agencies

Consultation with the Public and Other Stakeholders

This involves communicating what the LSCB does and seeking to understand from the public what the key child safety issues are within the Brighton & Hove community and their preferred solutions. This includes:

- LSCB webpages as a means of communicating messages and receiving feedback
- Twitter as a means of communicating messages and receiving feedback
- Lay Members
- Board Briefings
- LSCB Participation & Engagement Strategy to clarify and expand the methods of communication both from the Board and to the Board.

Future Initiatives

The 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 Brighton & Hove.

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