Croydon Safeguarding Children Board (CSCB)

Framework for Learning and Improvement

(Revised March 2016)

1. Introduction

1.1 The CSCB and its Executive and Sub Groups engage in a wide range of activities to identify what is working well and what needs improving in local safeguarding children arrangements and practice. The Framework for Learning and Improvement informs the Board to make the links between what needs improving and the mechanisms available to achieve these improvements. The framework builds on and updates the earlier CSCB Framework for Learning & Improvement (November 2013) and it incorporates the latest Working Together guidance (HM Government, 2015).

1.2 Section 14 of the Children Act 2004 sets out the statutory obligations of Local Safeguarding Children Boards (LSCBs) as follows:

(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 In order to fulfil its statutory functions under Regulation 5 (Local Safeguarding Children Boards Regulations 2006), an LSCB should use data and, as a minimum, should:

- assess the effectiveness of the help being provided to children and families, including early help;
- assess whether LSCB partners are fulfilling their statutory obligations set out in Chapter 2 of Working Together;
- 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 Chapter 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."

And, "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 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 CSCB supports learning and improvement

3.1 The Board has overall responsibility for ensuring there is continuous learning and improvement and that it is making a difference to the safety and wellbeing of children in Croydon. The CSCB has a committee structure with clear terms of reference for each part of the structure (see Appendix 1). Despite the distinct functions covered by each committee, it is vital to effectiveness that these groups communicate and interact with each other. This is primarily achieved through the Chairs of the Sub Groups attending the CSCB Executive meetings – and having regular meetings with the Independent Chair and the Business Manager. The Executive therefore plays a vital role in the Framework for Learning and Improvement by ensuring there is systematic reporting on all work streams and clarifying issues for committees to pursue. It also oversees the CSCB scrutiny calendar that ensures a systematic review of aspects of local safeguarding through regular reporting to the Board, Executive or Sub Groups by partner agencies.

3.2 Our approach focuses on ensuring what we do (our effort in terms of quantity and quality) makes a positive difference to children's lives and reduces the risk of harm to children (the effect in terms of impact).

3.3 Our See the CSCB Strategic Performance & Quality Assurance Framework is currently under review.

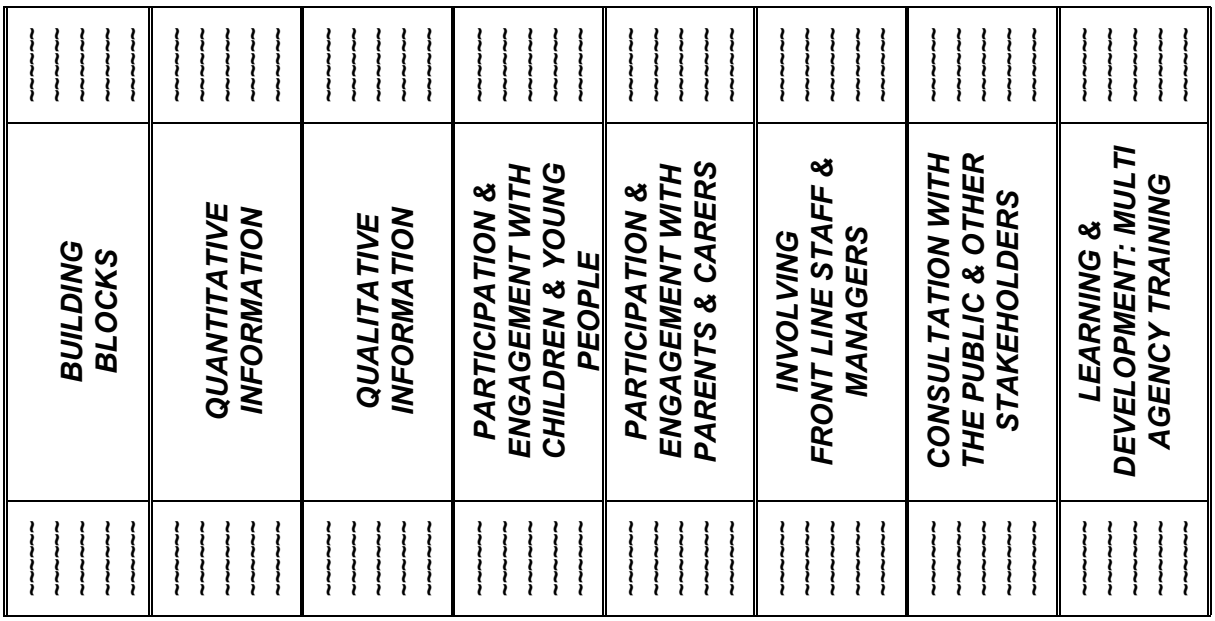
4. The relationship of the LSCB with other bodies

4.1 Learning and improvement is not exclusive to the CSCB and it must be open to importing learning from, and exporting learning to, other bodies, including the Croydon Health & Wellbeing Board, Croydon Children and Families Partnership, the Safer Croydon Partnership and the Croydon Safeguarding Adults Board. The CSCB Annual Report will be an important means of communicating the Board's learning.

5. Scrutiny and Challenge

5.1 The process by which scrutiny and challenge is informed is through the collation, coordination and presentation of information from a variety of different sources. These distinct but inter-related activities and reports can be described as similar to volumes in a library:

The CSCB Learning & Improvement 'Library'



Building Blocks

5.2 It is essential for the CSCB to have a structure underpinning its challenge and scrutiny role. In order to progress this there needs to be a way of understanding the Board's work and related functions. These reports provide that foundation:

Section 11 Audit

- Section 11 of the Children Act 2004 places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children. The CSCB Section 11 Panel scrutinises partner agency arrangements on an annual basis and gives feedback to individual agencies and the Board on the effectiveness of those arrangements, areas for improvement and lessons learnt.

Annual Reports

- Key agencies will submit specific annual reports to CSCB as part of their statutory responsibility, such as, on Looked After Children, Missing Children from Home & Care, Child Sexual Exploitation, Private Fostering and LADO/Managing Allegations Against Staff). CSCB will also receive annual reports as part of its scrutiny role, such as, the Child Death Overview Panel, Multi Agency Risk Assessment Conference (MARAC) and the Multi Agency Public Protection Arrangements (MAPPA). 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.

Agency Annual Reports

- Key agencies should provide 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. These reports will contribute to the CSCB Annual Report.

Quantitative Information

5.3 In order for the CSCB 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 CSCB of patterns, trends and areas that might need more detailed follow up. The Multi-agency data set includes both key nationally and locally collected multi-agency data. The purpose of the dataset is to inform the Board on:

- progress towards meeting the CSCB Business Plan priorities
- risks in the local safeguarding system
- prompts on where improvements are needed, and
- successes in safeguarding children.

5.4 The Quality Assurance, Practice & Performance Sub Group (QAPP) will monitor the CSCB dataset; analyse the data for trends and comparisons with other local authority areas and will produce recommendations for the CSCB arising from this analysis.

Qualitative Information

5.4 The CSCB recognises the importance of information that may be less straightforward to quantify, but is nevertheless vital to understanding the 'whole picture' about safeguarding locally. These are the essential tools by which the CSCB 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. Audits and reviews, together with the findings and actions will be published in the CSCB newsletter or other Board communications as appropriate.

5.5 The work stream of the CSCB includes opportunities to analyse and consider outcomes from monitoring the children's social care complaints process and other complaints processes in partner agencies. The CSCB will develop a regular face to face dialogue with representatives of local children and young people's forums.

- Audits

5.6 Multi agency case audits a year will be carried out involving a team reviewing case files, conducting focus groups of professionals and meeting with service users to hear of their experiences. Bespoke commissioned multi-agency audits and single agency audits are conducted.

- Case reviews

5.7 Working Together Chapter 5 sets out the criteria for initiating a serious case review or other learning reviews. Working Together 2015 does not prescribe any particular methodology to use - except that whatever model is used it must be consistent with the five principles for learning and improvement (see 2.1 & 2.2 above). See Appendix 2 for examples of models for consideration.

5.8 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 CSCB Serious Case Review Sub Group. As above, the methodology agreed should be consistent with the five principles for learning and improvement.

- Other types of qualitative information:

5.9 The CSCB will commission research and surveys from time to time on relevant safeguarding topics where this will support improved outcomes. Other approaches may include:
  - 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 Committee members.

5.10 The CSCB will use learning from research, such as, drawing on lessons from other Serious Case Reviews, national studies of Serious Case Reviews and other safeguarding children research.

Participation & Engagement with Children and Young People

5.10 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 CSCB 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 (e.g. through Section 11 Audits).

Participation & Engagement with Parents and Carers

5.12 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

5.13 The current methods being used by the CSCB include:

- Multi-agency training programme
- Link to practitioners’ groups used in serious case reviews and learning reviews
- Link to case audits
- Link to feedback from training sessions, workshops, conferences.

Communications and consultation with the Public and Other Stakeholders

5.14 This will involve communicating what the CSCB does and seeking to understand from the public what the key child safety issues are within the Croydon community and their preferred solutions. This will involve:

- Improving the use of the CSCB webpages as a means of communicating messages and exploring the use of social media as a means of communicating messages and receiving feedback
- Developing the role and responsibilities of Lay Members
- Developing the CSCB Communication Plan to clarify and expand the methods of communication both from the Board and to the Board.

6. Learning & Development: CSCB Multi Agency Training

6.1 As part of our culture of continuous learning and improvement amongst all partners is the development and delivery of quality training based on the lessons from serious case reviews, learning reviews and frontline practice. The Board's safeguarding training should also complement single agency skills based and agency specific training.

6.2 As part of the Board's learning and development activity, each training course will be evaluated through surveys to assess the impact of the training. Practitioners will bring their experiences of frontline work and their implementation of local policies and practice guidance into the training events. This learning environment will give a further opportunity to provide feedback to the Board on what is working well and where improvements need to be made in practice.

6.3 For further information see the CSCB Learning and Development Strategy.

6.4 For information on the local offer of multi-agency training go to the CSCB Learning & Development webpage.

7. Evaluating the impact of the Learning and Improvement Framework

7.1 The effectiveness of the Learning and Improvement Framework will be reviewed at each annual development day for the CSCB as part of its own learning about how to improve its ways of working.

7.2 The QAPP on behalf of the Board will continue to implement this framework and use it to identify areas requiring improvement that partner agencies can work on individually and together. It will form the focus of the CSCB Annual Report and will provide the evidence base for challenges to local partnerships as appropriate.

7.3 By developing strategies, policies, and protocols; overseeing safeguarding training; and undertaking audits and reviews, the CSCB will seek to develop a learning culture where the Board and each of its partners play an active part in achieving good and improving outcomes for children and young people.

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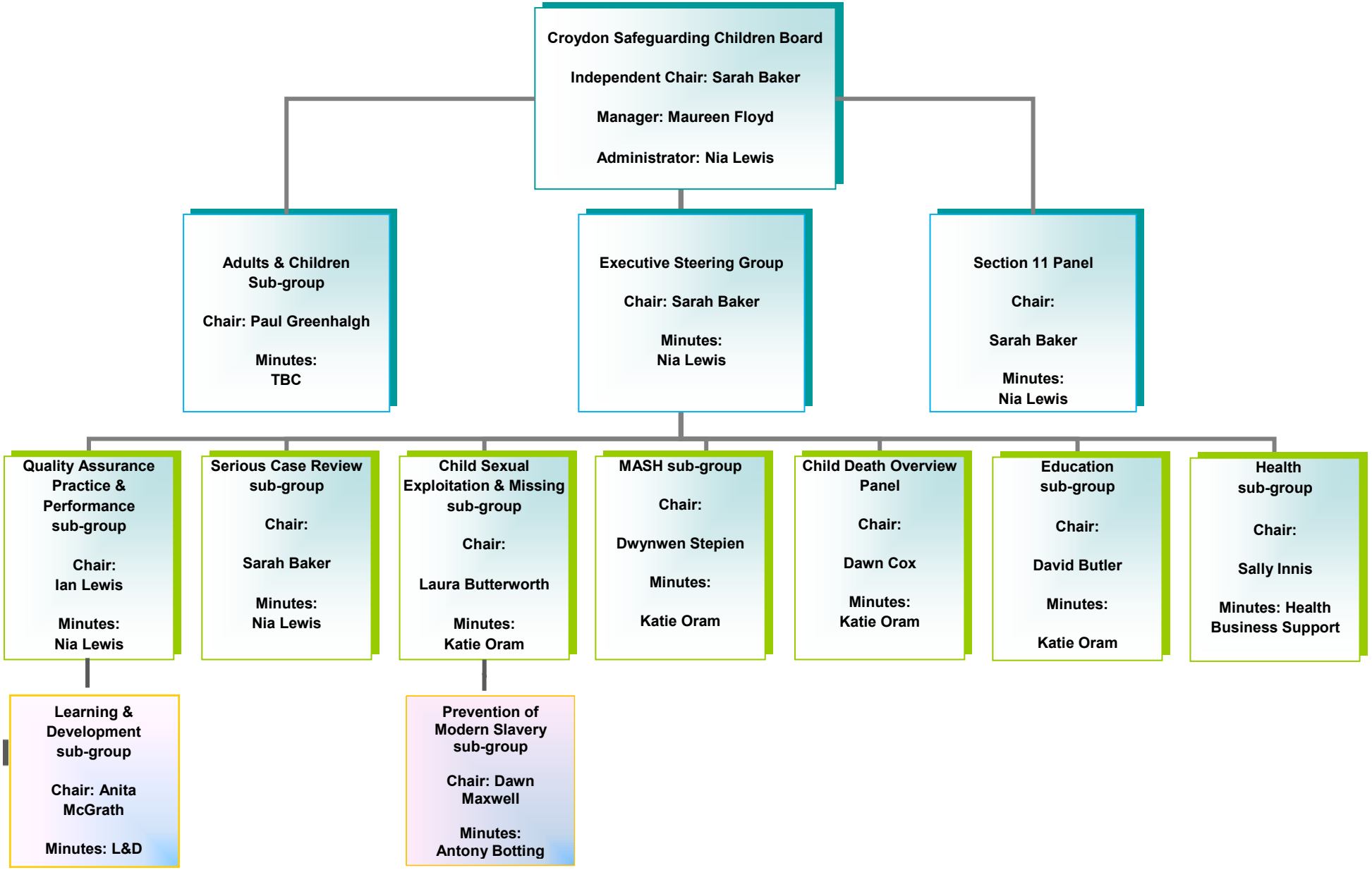
Appendix 1 Croydon Safeguarding Children Board Structure (March 2016)



APPENDIX 2

Methodologies for Serious Case Reviews and Learning Reviews
There are several competing methodologies mainly developed for other purposes and now adapted for serious case reviews. These follow a similar model of exploring what happened and why. The following are examples of possible methodologies that could be considered for a Serious Case Review or a Learning Review.

1. SILP (Significant Incident Learning process)

- SILP is a learning model which engages frontline staff and their managers in reviewing cases, focusing on why those involved acted in a certain way. It follows a systems methodology, looking at those factors in the system which influenced the way events unfolded. SILP also highlights what is working well and patterns of good practice.

- The key principle of SILP is the engagement of frontline staff and first line managers in conjunction with the LSCB SCR Sub Committee or Panel, as well as designated and specialist safeguarding staff. This approach gives a greater degree of ownership and commitment to learning and dissemination. SILP is intended to be a collaborative and analytical process with the main focus to extract learning from a detailed study of a set of circumstances. For example, it takes account of a practitioner's view point by asking:

  - Your view of what was going on in and around the case
  - How you understood your role or the part you were playing
  - Your thinking and your context at the time
  - Your perspective on what aspects of the whole system influenced you as a worker, and
  - The tools you were using.

- By taking account of these issues, the process focuses on understanding why someone acted in a certain way. It highlights what factors in the system contributed to any actions making sense at the time. This process is not about blame – but about an open and transparent learning from practice. The aim is to improve single and multi agency practice. The model importantly highlights what is working well and patterns of good practice.

- The review process includes a learning event for practitioners and managers involved in the case and a 'recall day'.

- There are costs involved as SILP is a registered trademark.

- For more information go to: Review Consulting

2. SCIE

- Adapted from the 'systems approach' used in other high risk areas of work, including aviation and health, the model helps identify which factors in the work environment support good practice, and which create unsafe conditions in which poor safeguarding practice is more likely.
- It provides a way of thinking about front-line practice and a method for conducting case reviews.
- It produces organisational learning that is vital to improving the quality of work with families and the ability of services to keep children safe.
- The model has been adapted from the systems approach used in other high risk areas of work, including aviation and health.
- It supports an analysis that goes beyond identifying what happened to explain why it did so – recognising that actions or decisions will usually have seemed sensible at the time they were taken.
- It involves moving beyond the basic facts of a case and appreciating the views of people from different agencies and professions.
- It is a collaborative model for case reviews – those directly involved in the case are centrally and actively involved in the analysis and development of recommendations.
- There are costs involved as lead reviewers must be accredited by SCIE.
- For more information go to: SCIE – SCRs

3. Protecting children in Wales: guidance for arrangements for multi-agency child practice reviews

- In summary, the framework consists of several inter-related parts; multi-agency professional forums and concise or extended child practice reviews.
- Multi-Agency Professional Forums are a key part of a continuous programme for learning together of multi-professional facilitated events for practitioners and managers. These are held primarily to examine case practice and provide opportunity for consultation, supervision and reflection, and to disseminate findings from child protection audits, inspections and reviews, in order to improve local knowledge and practice and to inform the Board's future audit and training priorities. LSCBs will decide whether to undertake a Concise Review or an Extended Review on a particular case following the criteria set by the Local Safeguarding Children Boards (Wales) Regulations.

- The Concise Review is managed by a Review Panel and a reviewer is appointed to work with the Panel. The review engages directly with children and family members, as they wish and is appropriate, so their perspectives are included. It also involves practitioners and their managers who have been working with the child and family. A planned and facilitated practitioner focused learning event is a key element of the review, conducted by a reviewer independent of the case management, to examine current case practice within a limited timeline and using a systems approach.

- An Extended Review follows the same process and timescale as a concise review, engaging directly with children and families, in so far as they wish and is appropriate, and involving practitioners, managers and senior officers throughout. There is an additional level of scrutiny of the work of the statutory agencies and the statutory plan(s) which were in place for the child or young person. The review is undertaken by two reviewers working closely together, appointed by the Review Panel. They will have responsibility for examining how the statutory duties of all relevant agencies were fulfilled, and reporting on this to the Review Panel and the LSCB.

- For more information see the full guidance.

4. Root Cause Analysis (RCA)

- Developed following catastrophic problems in 1960s NASA programme.

- Focuses on systems explanations with a questioning approach - to ask what happened and why?

- Wide ranging techniques used, such as,"fishbone diagram" promoted by NHS

- "RCA is viewed as a tool of continuous improvement. It can be used a 'whole review approach' or as a 'set of techniques' within other serious case review methodologies" (DFE RCA training workshop)

5. Appreciative Inquiry (AI)

- Developed from work of Cooperrider and colleagues the model uses generative open questions to create change. There is a strong basis for searching for understanding of what works and why. Single agency chronologies are still used. Issues need to be agreed that will be explored during a 'whole system session' or meeting.