Portsmouth Safeguarding Children Board (PSCB)

Learning and Improvement Framework

Updated September 2017

1. Introduction

1.1. The PSCB and its committees' engage in a wide range of activity 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 and updates the earlier PSCB Evaluation Framework (agreed January 2011) and the draft PSCB Learning and Improvement Framework (developed from November 2012) and it incorporates the Working Together guidance (HM Government, 2015).

1.2. **Working Together** states that the objectives of LSCBs are:

1.2.1. 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

1.2.2. 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:

1.3.1. assess the effectiveness of the help being provided to children and families, including early help;

1.3.2. assess whether LSCB partners are fulfilling their statutory obligations;

1.3.3. quality assure practice, including through joint audits of case files involving practitioners and identifying lessons to be learned; and

1.3.4. 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:

1.4.1. “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."

1.5. 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.

1.6. 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.

1.7. 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:

2.1.1. 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;

2.1.2. the approach taken to reviews should be **proportionate** according to the scale and level of complexity of the issues being examined;

2.1.3. 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;

2.1.4. 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;

2.1.5. 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;

2.1.6. 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

2.1.7. 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:

2.2.1. recognises the complex circumstances in which professionals work together to safeguard children;

2.2.2. seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;

2.2.3. seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;

2.2.4. is transparent about the way data is collected and analysed; and

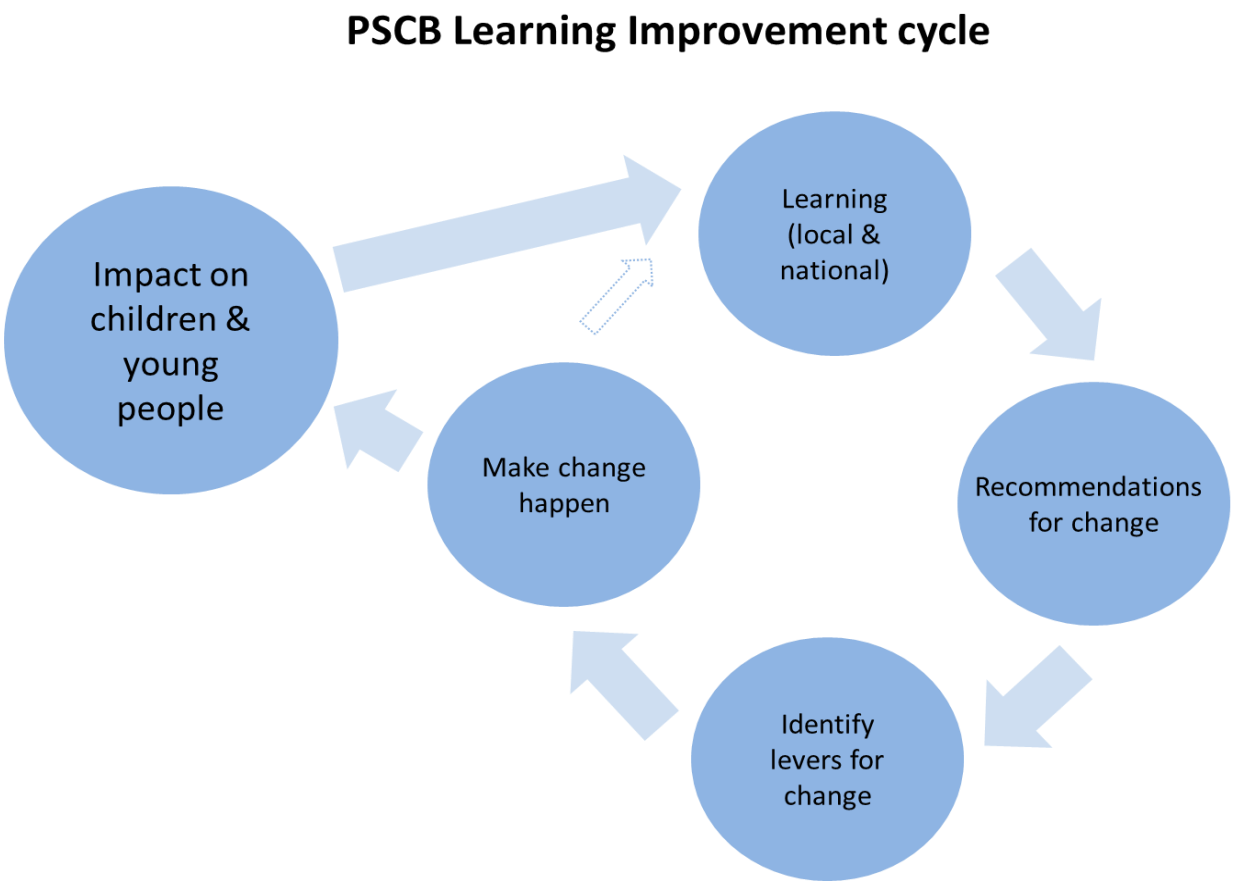
2.2.5. makes use of relevant research and case evidence to inform the findings.

3. How the PSCB supports learning and improvement.

3.1. The PSCB has a committee structure with clear terms of reference for each element of the structure (see Appendix 1). Despite the distinct functions covered by each committee it is vital to effectiveness that they interact with each other. This is achieved through the Chairs of committees meeting with the Independent Chair of the Board and the Business Manager via regular meetings of the PSCB Executive. The Executive therefore plays a vital role in the Learning and Improvement Framework by ensuring there is systematic reporting on the work of committees and clarification of issues for committees to pursue. It also oversees the PSCB scrutiny calendar that ensures a systematic review of aspects of local safeguarding through regular reporting to the Board, Executive or Committees by partner agencies.

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).



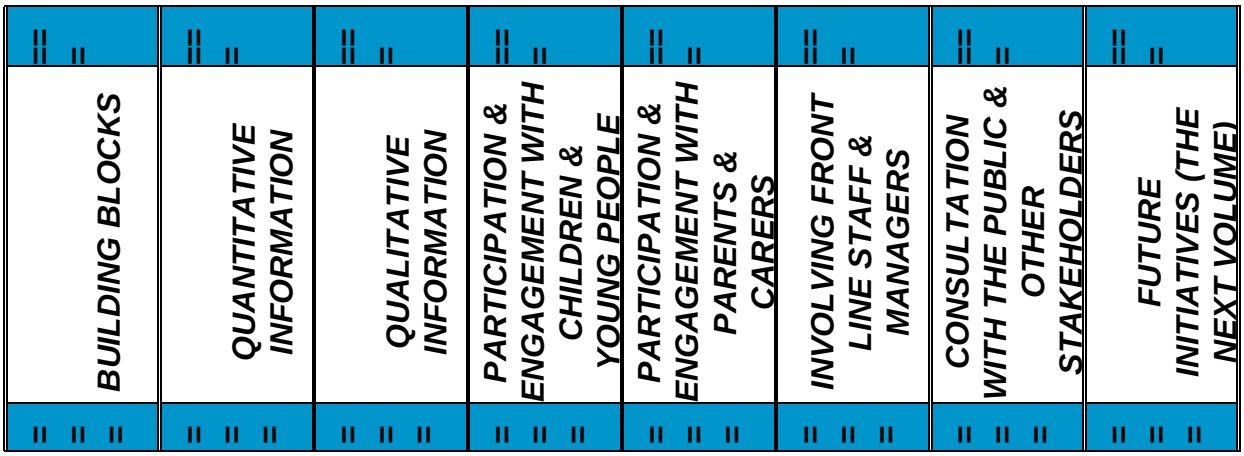
4. The relationship of the LSCB with other bodies

4.1. Learning and improvement is not exclusive to the PSCB and it must be open to importing learning from, and exporting learning to, other bodies, including the Health and Wellbeing Board, the Children's Trust, the Safer Portsmouth Partnership and the Safeguarding Adults Board. The PSCB 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 and coordination of information from a variety of different sources (see Appendix 2). The following description of a 'library' of distinct but inter-related activities and reports is consistent with the Quality Assurance Framework for the SE Region LSCBs:

6. The PSCB Learning & Improvement 'Library'



7. Building Blocks

7.1. It is essential for the PSCB 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:

7.2. Section 11 Audit (known as Compact)

7.2.1. This provides a benchmark of agency activity and issues. Audits are carried out each year. Arrangements are in place to conduct an annual audit of 50% of local services/establishments that work with children, young people and their families. This uses the locally developed self-assessment tool to review their compliance with section 11 of the Children Act 2004 and their progress against the standard in the Portsmouth Early Intervention and Safeguarding Compact. This is managed by the MESC and reported annually to the PSCB.

7.3. Annual Reports

7.3.1. Key agencies will submit specific annual reports to PSCB as part of their statutory responsibility (e.g. Private Fostering, LADO/Managing Allegations Against Staff).

PSCB will also receive annual reports as part of its scrutiny role (e.g. Child Death Overview Panel, Multi Agency Risk Assessment Conference (MARAC), Multi Agency Public Protection Arrangements (MAPPA), Health and Well Being Board). 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.

7.4. Agency Annual Report

7.4.1. 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 PSCB Annual Report.

7.5. Quantitative Information

7.5.1. In order for the PSCB 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 PSCB of patterns, trends and areas that might need a more detailed follow up. The Multi-agency data set includes both key nationally and locally collected multi-agency data. The purpose of this data set is to highlight:

7.5.1.1. progress towards meeting the PSCB Business Plan priorities

7.5.1.2. major changes to performance and quality assurance measures from the PSCB management information report

7.5.1.3. any additional information pertaining to the safeguarding and welfare of children and young people in Portsmouth, and

7.5.1.4. prompt discussions within the Board and Committees on where improvements can take place and successes shared.

7.5.2. The MESC will monitor the PSCB Dataset to analyse the data for trends and comparisons with similar local authority areas and will produce recommendations for the PSCB arising from this analysis.

7.6. Qualitative Information

7.6.1. The PSCB 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 PSCB includes opportunities to analyse and consider outcomes from monitoring the children's social care complaints process and other complaints processes in partner agencies. The PSCB will develop a regular face to face dialogue with representatives of local children and young people's forums. MESC has begun to work on developing processes that will provide the PSCB with answers to the 24 questions in the local information part of the Children's Safeguarding Performance Information Framework (DfE, 2012).

7.6.2. These are the essential tools by which the PSCB 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 on the PSCB website as appropriate.

7.7. Audits

7.7.1. Four multi-agency thematic audits will be carried out each year. These will involve a multi-agency team reviewing case files and holding reflective practice meetings with practitioners where appropriate to review practice in the cases. These are held quarterly and are focused on themes identified by MESC and agreed by the PSCB or Executive.

7.7.2. Bespoke commissioned multi-agency audits are conducted (e.g. the joint Health and Children's Social Care audit of health referrals into children's social care). and, bespoke commissioned single agency audits are carried out (e.g. the Children's Social Care audit of the quality of supervision practice of front line social workers).

7.8. Case reviews

7.8.1. 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: abuse or neglect of a child is known or suspected; and either the child has died; or 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: Abuse or Neglect of a child is known or suspected AND the child has died (including by suicide); OR 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.

7.8.2. 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:

7.8.3. 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)

7.8.4. 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.[1]

7.8.5. 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.[2]

7.8.6. 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'.

7.8.7. 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.

[1] National Patient Safety Agency (NPSA)

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

7.8.8. Management 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 Committee of the PSCB using the case analysis process that it has refined over some time. The Professional Practice Committee 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.

7.9. Other types of qualitative information:

7.9.1. Board Member 'Walkabouts' e.g. visiting frontline practice where child protection referrals are received and decisions made on action.

7.9.2. Planned 'on a day' surveys by Board members or Committee members.

7.10. Learning from research

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

7.10.2. Commissioned local or regional research (e.g. Local Authority Research Consortium[3]).

7.11. The PSCB will receive a report on the LAC survey conducted by Children's Social Care annually and also draw upon the annual survey of secondary students' wellbeing that is conducted by the Health Improvement Development Service.

7.12. The PSCB will also commission surveys from time to time on relevant safeguarding topics where this will support improved outcomes.

7.13. The PSCB and its partners are committed to working closely with the University of Portsmouth (and other academic establishments) to produce research outcomes that will inform service improvement. It also commissions research into relevant safeguarding issues e.g. analysis of a cohort of looked after children. The PSCB has also commissioned professional doctorate level research into early intervention in families where neglect is a concern. We have also commissioned external consultancy research into (a) the experience of families going through child protection processes and (b) to inform the development of supervision standards.

8. Participation & Engagement with Children and Young People

8.1. The PSCB will develop a programme to:

8.1.1. 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);

8.1.2. Develop links and build relationships with existing children and young people's groups and forums;

8.1.3. Raise awareness of safeguarding issues amongst children and young people and equip them with the knowledge to stay safe;

[3] LARC

8.1.4. Promote the direct participation and input of children and young people in the work of the PSCB at a strategic and operational level;

8.1.5. Ensure input from children and young people is communicated outwards; and

8.1.6. Challenge partners to demonstrate how the voice of the child influences their work.

9. Participation & Engagement with Parents and Carers

9.1. The PSCB will develop a programme to:

9.1.1. 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);

9.1.2. Develop links and build relationships with existing parents' and carers' groups and forums;

9.1.3. Raise awareness of safeguarding issues amongst parents and carers and equip them with the knowledge to ensure children stay safe; and

9.1.4. Challenge partners to demonstrate how the voice of parents and carers influences their work.

10. Involving Front Line Staff and Managers

10.1. The current methods being used by the PSCB include:

10.1.1. Multi-agency training
10.1.2. Link to practitioners groups used in reviews
10.1.3. Link to case audits
10.1.4. Link to feedback from training sessions, workshops, conferences
10.1.5. Annual staff survey across PSCB partner agencies

11. Consultation with the Public and Other Stakeholders

11.1. This will involve communicating what the PSCB does and seeking to understand from the public what the key child safety issues are within the Portsmouth community and their preferred solutions. This will include:

11.2. Improving the use of the PSCB webpages as a means of communicating messages and receiving feedback

11.3. Exploring the use of social media as a means of communicating messages and receiving feedback

11.4. Developing the role and responsibilities of Lay Members

11.5. A PSCB Communication Strategy will be developed to clarify and expand the methods of communication both from the Board and to the Board.

12. Future Initiatives

12.1. The PSCB 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 Portsmouth.

13. Evaluating the impact of the Learning and Improvement Framework

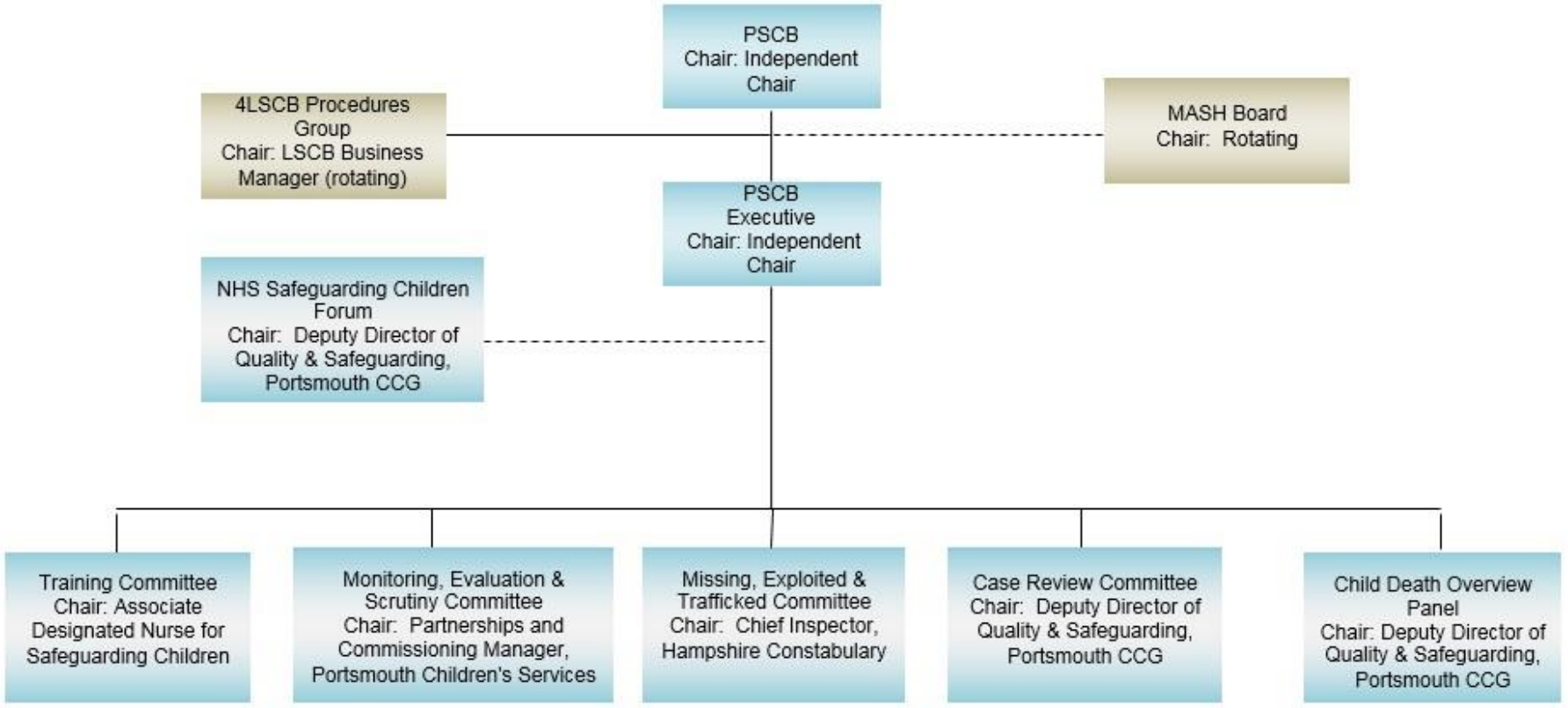
13.1. The effectiveness of the Learning and Improvement Framework is reviewed at each annual development day for the PSCB as part of its own learning about how to improve its ways of working.

13.2. The PSCB will look to the Executive 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 PSCB Annual Report and will provide the evidence base for challenges to the Children's Trust Board, to the Health and Wellbeing Board and to other local partnerships as appropriate. By developing strategies, policies, and protocols; overseeing safeguarding training; and undertaking audits and reviews, the PSCB 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.

Appendix 1:

PSCB
Portsmouth Safeguarding Children Board
Protecting Portsmouth's Children

PSCB Structure 2017



Appendix 2: Sources of Learning