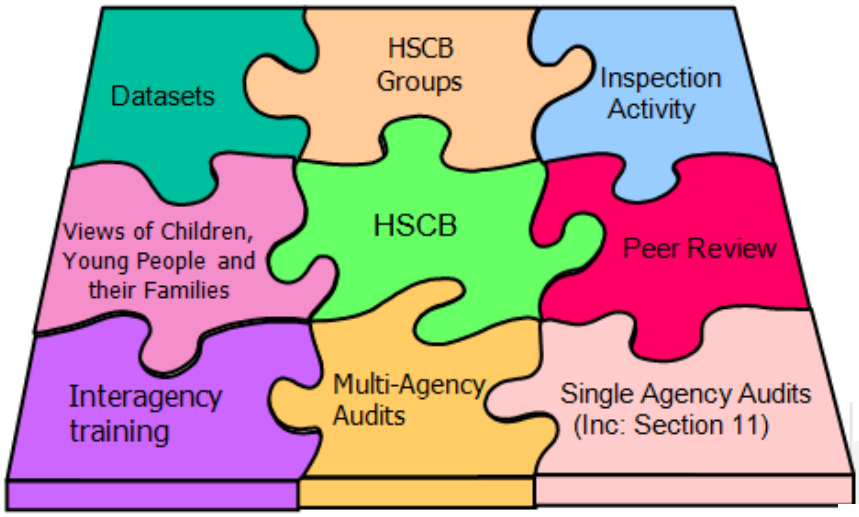
Hartlepool safeguarding children board

Learning and Improvement Framework

Ensuring Quality Assurance



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Context

The overall aim of Hartlepool Safeguarding Children Board (HSCB) is to ensure that all children in Hartlepool are appropriately safeguarded. In order to achieve this, HSCB require an understanding of the quality and effectiveness of safeguarding services and a means to monitor and improve this.

Working Together to Safeguard Children (2015) states that in order to comply with Regulation 5 of the Local Safeguarding Boards Regulations 2006 [2] the LSCB 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 to Safeguard Children (2015);*
- *quality assure practice, including thorough 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.*

It also states that Local Safeguarding Children Boards (LSCBs) should maintain a **learning and improvement framework** to be shared across the local organisations who work with children and families. The aim of such a framework is to enable organisations to be clear of their responsibilities, provide clarity to professionals and organisations around the quality assurance processes and outline a cycle of continuous learning and improvement. This in turn will enable learning and improve services for children and young people.

Purpose

Learning and improvement activities are crucial to any well performing partnership and its member agencies. The **HSCB Learning and Improvement Framework** presents HSCB's approach to quality assurance. It provides guidelines for learning and monitoring activities, outlines how learning is shared and embedded and provides a cycle for learning, improvement and review. It aims to use these to assure itself of the quality and effectiveness of the safeguarding provision for children across Hartlepool.

> '*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."*

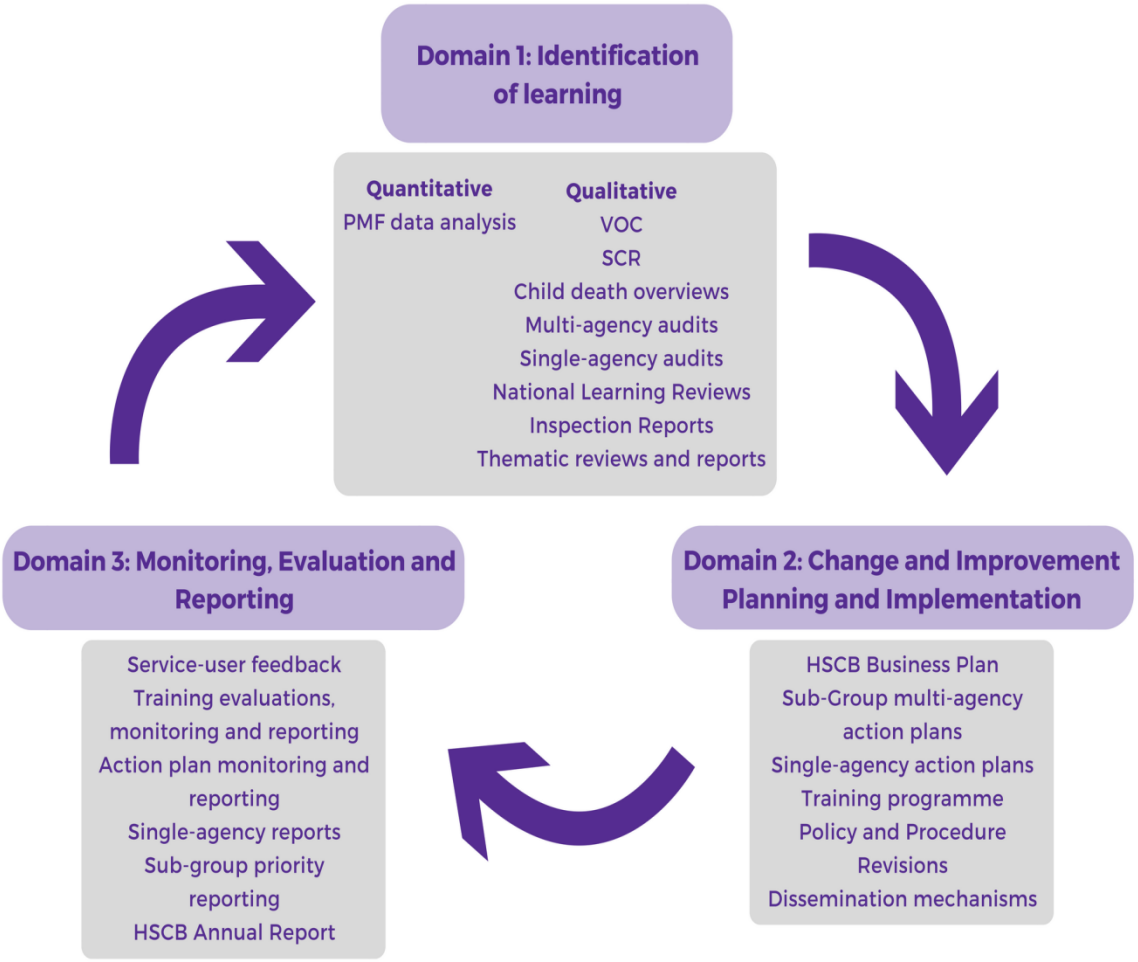
'Working Together to Safeguard Children'[1], 2015 (Chapter 4:1)

The Learning and Improvement Cycle

The vision of the HSCB Learning and Improvement Framework is to drive improvement by establishing a continual cycle of learning to inform best practice and thereby embedding positive outcomes for children, young people and their families in Hartlepool.

This cycle has three key domains. The first aims to clarify what needs to be learnt, based on quantitative and qualitative evidence. The second involves the planning and implementation of changes derived from the learning identified, with the third incorporating the monitoring and evaluative processes.

Diagram 1: The Learning and Improvement Cycle



Domain 1: Identification of Learning

1.1 Quantitative Information

Working Together (2013)[1] states that LSCB's must:

> *'Monitor and evaluate the effectiveness of what is done by the Local Authority and Board partners individually and collectively to safeguard and promote the welfare of children and advise them on ways to improve.'*

1.1.1 Performance Data

Performance data represents a useful tool for monitoring quantitative information and identifying trends. The Teeswide Performance Management Framework (PMF) is a live document which provides HSCB with a dataset for Hartlepool and comparisons across 3 Tees-wide LSCB's as well against local and national averages. It presents data against 55 key indicators which cover three main areas of interest.

These are:

- Enabling children to lead healthy lives.
- Providing the right support for children.
- Ensuring children are safe.

The PMF data is collected and collated from a number of different agencies in relation to these areas with a view to:

- monitor performance against an agreed set of indicators
- identify areas for improvement
- promote understanding of safeguarding activity and trends
- improve monitoring and accountability of all partners to the Board
- improve decision making and prioritisation
- provide efficiency savings in some partners only having to provide information once, instead of numerous times and consistency as to the type of information collected
- improve outcomes for children and young people as a consequence of improved understanding of need and prevalence

The PMF is presented and considered by the Board on a quarterly basis in order to respond to exceptions and trends. This enables the Board to identify new priorities to inform the Board's Business Plan and areas for further investigation and work. Each agency – and indeed each Board member – may have a different interpretation of the story that the data tells and it will be for the Board and the Board's sub-groups to reach a consensus about what is or is not significant and what might require further attention. Where the analysis of data and information has been undertaken by HSCB, recommendations are made to the Board for further enquiry or for challenge and action.

The Board may seek new information and data to be collected for the following purposes:

- To support an understanding of outcomes.
- To quantify achievement through indicators.
- To measure how well a particular service/agency is working – how much, how well, what impact on child/family.

In addition, analysis of the PMF enables the identification of key themes which are to be explored in more depth. This exploration is carried out through annual "Deep Dive" reports (see 1.2.8).

1.2 Qualitative Data

'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.' (WT 2015, p-72)

To fulfil its statutory functions, HSCB is responsible for:

- carrying out serious case reviews (SCRs) where the criteria are met.
- carrying out other reviews of serious incidents where the SCR threshold is not met but lessons remain to be learnt.
- carrying out reviews of all child deaths under the age of 18.
- evaluating the quality and effectiveness of help being provided to children and families, including early help.
- evaluating practice through joint audits to identify good practice as well as to identify priorities that will improve multi-agency working with children and families.
- coordinating what is done by each person or body represented on the Board for the purpose of safeguarding and promoting the welfare of children in the area.

1.2.1 Voice of the Child (VOC) and Family

The Voice of the Child (VOC) or young person merits particular attention for the Board. Feedback from children and young people can inform learning and drive action and service improvement. Children and young people can tell their own agencies and the Board whether services and interventions have made a difference to their lives and whether their lives have improved as a result. They can give feedback on the quality of their relationships with their practitioner.

There are a variety of methods for hearing the voices of children and young people including:

- surveys for children who are in the care of the local authority
- The health and well-being/anti-bullying survey which takes place in schools
- Audits of the 'child's voice' in assessments from early help through to statutory Single Assessments
- Involving young people in interview panels
- Children's Rights and Advocacy Service

There is a variety of media which can be used to engage and involve children and young people in expressing their views. The annual anti-bullying survey gives a good insight into how school age children at Primary and Secondary Schools are feeling, and whether there have been improvements in how safe they are feeling in and about school, relationships and other issues. Case file audits will ascertain where children and young people are being actively involved in assessment and planning for intervention which will impact on them as individuals. The Board must be certain that practitioners across the children's workforce are knowledgeable and equipped to hear the voice of children and young people. The Section 11 Audit and other audits and surveys can ask questions about how agencies are ensuring that this happens and outcomes can inform the commissioning of training or other learning opportunities to enhance this further. Particular attention needs to be given to how agencies are hearing the voices of children who are pre-verbal or who have communication difficulties because of either disability or language.
The Board seeks the best way to engage directly with children and young people and for ways in which children and young people may contribute to the Board's Annual Report.
It collates and monitors what is happening across the workforce to ensure that the voice of children and young people is being heard and is influencing service provision.

1.2.2 Serious Case Review (SCR)

These will be undertaken as defined in Working Together 2015:
A Serious Case Review (SCR) will be undertaken where:
- Abuse or neglect of a child is known or suspected
- 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.

Cases which meet one of these criteria above **must always** trigger an SCR. In addition, an SCR **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. The regulation also includes cases where a child died by suspected suicide and abuse or neglect is known or suspected. The Learning and Improving Practice Sub-Group (LIPSG), is responsible for commissioning such reviews. Findings and learning arising out of these reviews will feed into a SCR action plan in order that lessons to be learned are planned for. The group has published a SCR process and guidance document which gives further details on criteria for SCRs, referrals processes, system methodology and approaches for learning together, including the roles and responsibilities of reviewers, review panels and professionals involved, processes and timelines.

1.2.3 Child Death Reviews

The Child Death Overview Process for HSCB is undertaken by the Tees Child Death Overview Panel (CDOP). The Tees CDOP is a subgroup of each of the 4 Tees LSCB's, including HSCB. By undertaking this function on a Tees-wide basis it affords a greater opportunity to learn from child deaths across Teesside not just the deaths of children normally resident in Hartlepool. The CDOP meets monthly to review all child deaths, and to establish classifications of death and consider whether the causes of death had any modifiable features, i.e. were preventable. The Tees CDOP collates actions and learning from Child Death Reviews into an action plan which is reviewed and updated at each Child Death Overview Panel meeting. This process increases accountability and provides written evidence of progress and completed actions with the facility to monitor deadlines. Key themes and trends are identified and specific work is undertaken where required. The CDOP Chair provides regular updates to the HSCB and an annual report, which includes the panel's recommendations, is submitted to Board.

1.2.4 Multi-Agency Audits

Multi-agency audits are a critical element in learning and improvement to safeguard children. Audit themes and scope are informed by a range of sources which include scrutiny of performance data, and any emerging concerns from one or more partner agencies. Depending on the nature of the scrutiny, a number of cases are selected by using either random or purposive sampling methods. Case files are checked for consistency and effectiveness in multi-agency practice and impact on children and young people and families. Wherever possible, practitioners and managers are involved in these audits. This offers an opportunity to reflect and to discuss the child's journey through the safeguarding system, in order to identify good practice as well as where lessons need to be learnt. Audit reports feed into LIPSG to plan for and implement any changes or improvements to be made.

1.2.5 Single Agency Audits

Under Section 11, there is an expectation that the auditing of child safeguarding standards should not be considered a one off process, rather as a continual process of monitoring and improvement of quality. Consequently, all Section 11 agencies should routinely measure and audit the quality of safeguarding practice and processes. Whilst the responsibility for assuring quality and identifying areas for audit rests with the individual agency, the Board should be informed of all safeguarding audits and receive a copy of the outcome along with actions arising. Those agencies required to undertake Section 11 Audits are expected to complete a yearly online S11 survey which is then digitally collated and the results are presented to Board. Results will then be scrutinised to ensure the quality of child-safeguarding practice.

Internal single-agency audits enhance practice within an agency when the findings are disseminated via supervision and training. Agencies will be asked to present the findings of internal case file audits, which might serve to enhance practice and safeguarding across the wider safeguarding workforce, to LIPSG and the Board. Whilst the responsibility for assuring quality and identifying areas for audit rests with the individual agency, the Board may request specific safeguarding audits are undertaken, and receive a copy of the findings, along with actions arising. At the very least, information in regard to audits undertaken will be provided by individual agencies in their regular assurance reports to the Board.

1.2.6 National and Local Learning Reviews

LIPSG members receive notifications of national and local learning reviews and have a timetabled rota of responsibility for reporting on lessons learned. Quarterly meetings are dedicated to National Learning Review reporting with a designated member presenting their review of findings. The LIPSG work plan is then updated with actions for lead members. The respective agencies and/ or HSCB subgroups are expected to take any improvement actions forward with progress reports presented quarterly.

1.2.7 Inspection Reports

In addition to the Ofsted inspections of "*Services for children in need of help and protection, children looked after and care leavers*" and of the LSCB itself, partners will each experience their own inspection such as Care Quality Commission, Her Majesty's Inspection of Constabulary (HMIC), and Ofsted inspections. In addition, Joint Targeted Area Inspections (JTAIs) will be carried out to assess how local authorities, the Police, health, probation and youth offending services are working together in a given area to identify, support and protect vulnerable children and young people. The outcomes, learning and action plans from these inspections can enhance the Board's capacity for support and challenge in order to improve outcomes for children and young people across the workforce. Partners are asked to inform the Board of any inspection activity and the outcomes of those inspections which will feed into the LIPSG.

1.2.8 Thematic reviews and reports

Throughout the learning and improvement cycle key themes may be identified through PMF data, audits or reviews. In order to provide a detailed exploration of key issues, these themes will be scrutinised through:

- **'Deep-dive' reviews** of a content area as agreed by the Board.
- **Thematic reviews** of a specific area identified either nationally or locally as a priority.

These reviews will always be based on evidence based research. They would be presented to Board for assurance and followed by dissemination of the findings through workforce training and workshops, and at individual agency and practitioner level through team meetings and supervision. A further follow up would then take place through, for example, case file audit or practitioner surveys to ascertain the impact.

Domain 2: Improvement Planning and Implementation

Working Together 2015 (p 73) states, “Reviews are not ends in themselves. The purpose of these reviews is to identify improvements which are needed and to consolidate good practice. LSCBs and their partner organisations should translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children.”

It is therefore essential that learning and improvement work undertaken is not seen in isolation, but as a progression of work to safeguard children and young people for all agencies. It is expected that all agencies will work together to use and disseminate learning and take necessary actions to improve their practice to achieve better outcomes for children and young people.

This will be done in a number of ways:

2.1 HSCB Business Plan

The HSCB Business plan is the overarching work plan for all Board members and partner agencies. All reports, reviews and dataset information gathered, considered and scrutinised will inform the writing of the Board’s business plan. It focuses on what HSCB’s key priorities are in light of all of the information ascertained. It identifies what the Board want to achieve, sets out how this is to be achieved, allocates responsibility for its achievement and outlines expected impact.

2.2 Sub-Group Multi-Agency Action Plans

The Learning and Improving Practice Sub-Group (LIPSG) produces action plans which are written by multi-agency partners. These are informed by the datasets, audits and reviews outlined in domain 1 and are linked to the Board’s business plan priorities. These plans set out in greater detail what actions are to be undertaken, timeframes and the persons or agencies responsible for their completion.

2.3 Single-Agency Action Plans

Single-agency partners produce their own single-agency action plans which **take actions from** and **feed action into** the Boards business plan and/or sub-group action plans.

2.4 Training Programme

The Training and Development group undertake a multi-agency **Training Needs Analysis** with all agencies, in line with local and national policy, to inform development of a multi-agency training provision programme. This training and development plan is informed by needs identified through the processes set out in domain 1. The programme is delivered by a pool of suitably skilled, knowledgeable and experienced practitioners/managers, facilitating the training and development activities on behalf of both HSCB and SLSCB.

2.5 Policy and Procedure Revisions

The Tees Procedures Group (TPG) hold responsibility for co-ordinating a Tees-wide work programme which timetables the procedures for review. The need for a procedure to be reviewed can be identified: via the website or e-mail; from an agency for addition; change or deletion of content; due to the publication of national guidance/directive or from Serious Case Review findings recommending the change. The TPG have produced guidance for the procedural review process. All updated Tees Procedures can be found on the Tees Procedures website: www.teescpp.org.uk/

Other HSCB policies, procedures and guidance which are not held by Tees Procedures are updated yearly by the HSCB business manager.

2.6 Dissemination Mechanisms

Any identified learning will be presented to Board by the LIPSG chair. Board members will then disseminate the key learning points within their respective agencies via line management procedures. This may take different forms depending on the type of learning and the individual agency (e.g. through team meetings, supervisions, briefings, action plans or reports).

Each individual Board member holds responsibility for ensuring learning is disseminated effectively, that any actions or changes are embedded in practice within their agency and for providing assurance of this to the Board.

The HSCB Safeguarding User Group Board members may also disseminate relevant learning points with User Group members for further dissemination within their respective agencies.

Domain 3: Monitoring, Evaluation and Reporting

3.1 Service-User Feedback

Service-user feedback can be sought in a number of ways to evaluate changes made in light of learning and evidence the impact of these changes. Individual agencies collect their respective service-user feedback using their own proformas which can be included in their reports to Board to evidence impact. Multi-agency audits can also capture the views of service-users which will feed into LIPSG and the Learning and Improvement Cycle.

3.2 Training Evaluations, Monitoring and Reports

Training evaluations will be completed by delegates on commencement and completion of training modules, in order to evaluate the impact the training has made upon professional practice. The Joint Training and Development Group will quality assure all training and development activities, monitor course evaluations and produce a yearly report. The report will outline the effectiveness of the Training and Development Strategy and Programme and aims to provide assurance to the Board that any recommendations for improvement are acted upon.

3.3 Action Plan Monitoring and Reporting

Action Plans are monitored by the respective lead member. Six-monthly progress updates are presented to Board and evaluated. Board members are expected to provide challenge and scrutiny on the presentation of progress reports. Any additional support meeting the objectives set out in the action plan can be offered and assurance of impact sought.

3.4 Single-Agency Reports

Each partner agency is expected to submit an individual agency assurance report to the Board at least once per year. The assurance report is submitted on a standard template and covers areas such as:

- Identified improvements.
- Areas for development.
- Key evidence of impact.

3.5 Sub-Group Priority Reporting

Sub-groups will provide six-monthly assurance reports to Board which may form part of thematic meetings for scrutiny, challenge and support.

3.6 HSCB Annual Report

The HSCB business manager holds responsibility for producing an annual report which summarises the key improvements made within the reporting period, what has been done well, what the impact has been and identifies future areas for development.

The three domains outlined in this framework form a continuous cycle of learning and improvement. The table below outlines timeframes for key reporting which feeds into this cycle of learning.

Diagram 2: The Reporting and Monitoring Timetable

January	February	March
Early Help Deep Dive Report NSPCC Learning From National Review/ Local Learning Review S11 Audit Report	Multi-agency Audit Report SCR Update	Domestic Abuse; Mental Health; Substance Abuse Deep Dive Reports
April	**May**	**June**
NSPCC Learning From National Review/ Local Learning Review LIPSG Actions Monitor and Review	CSE and VEMT Deep Dive Reports SCR Update	Multi-agency Audit Report NSPCC Learning From National Review/ Local Learning Review
July	**August**	**September**
Looked-after Children and Care Leavers; Youth Offending Deep Dive Reports LIPSG Actions Monitor and Review	Multi-agency Audit Report SCR Update	Multi-Agency Training Programme Deep Dive Report NSPCC Learning From National Review/ Local Learning Review
October	**November**	**December**
HSCB Annual Report LIPSG Actions Monitor and Review	NSPCC Learning From National Review/ Local Learning Review	Multi-agency Audit Report