HAMPSHIRE SAFEGUARDING CHILDREN BOARD

LEARNING AND IMPROVEMENT FRAMEWORK

Version	Ratified	Author(s)
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Introduction

Working together to keep children safe is the primary aim of Hampshire Safeguarding Children Board (HSCB) and it is essential that both professionals and organisations learn lessons and share good practice.

Hampshire Safeguarding Children Board (HSCB) is a strategic partnership committed to learning and we review, scrutinise and challenge local safeguarding arrangements and front-line practice in order to improve.

Statutory safeguarding guidance *Working Together to Safeguard Children* (DfE, 2015) states that:

'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'.

This framework underpins our work and describes our overarching approach to quality assurance and improvement.

'HSCB is dynamic and forward thinking' (Joint targeted area inspection of the multi agency response to abuse and neglect in Hampshire, February 2017) and we will ensure that the Board remains responsive to emerging safeguarding issues within our area, adapting our quality assurance and learning processes to maximise opportunities for learning.

Roles and Responsibilities

This framework is for HSCB, partner agencies and all local organisations who work with children and families. HSCB will review and update this framework on an annual basis including its impact on improving outcomes for children.

Partner agencies and all local organisations who work with children and families are expected to endorse and embed this framework into their organisational policies. In addition, partner agencies and local organisations are responsible for:

- Providing staff and other resources to deliver the framework.
- Contributing to reviews of practice undertaken.
- Providing data and analysis to enable trends and emerging safeguarding issues to be identified and acted upon.
- Ensuring lessons from reviews of practice are disseminated widely within their organisation (e.g. internal training, policies/procedures, implementing actions plans).
- Ensuring that lessons from reviews of practice are embedded throughout their organisation, as evidenced via auditing and staff surveys.

Overview

This framework seeks to promote continuous improvement. The building blocks to this framework are:

Learning from Data and Audits

- Overseeing a robust and tightly focussed multi-agency dataset
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Learning from Data and Audits

Overseeing a robust and tightly focussed multi-agency dataset

HSCB oversees an agreed dataset that monitors multi-agency child protection arrangements and enables the Board to support and challenge partners for their performance. Our Quality Assurance Group reviews agency data on a quarterly basis and refreshes the set of indicators annually, ensuring that the Board remains responsive to emerging safeguarding issues and can evidence the impact of the its work.

The multi-agency dataset is aligned to our annual business plan and addresses the following themes:

- Children and families are able to access Early Help and it is effective.
- Thresholds are clear and appropriate; planning and decision making is effective.
- Children in need of protection are identified, safeguarded and supported.
- The Local Authority fulfils its corporate parenting role and looked after children and care leavers have good outcomes.
- Groups of children with particular needs are identified, safeguarded and supported.
- Children in specific circumstances are identified, safeguarded and supported.
- Children receive high quality education and are kept safe.
- Children affected by and / or at risk of neglect are identified, safeguarded and supported.
- We are recognising the needs of children when considering the impact of domestic abuse, substance misuse and mental ill health in adults
- Missing, Exploited and Trafficked Children are identified, safeguarded and supported.
- We have a coordinated multi-agency approach to Elective Home Education
- Unaccompanied Asylum Seeking Children are identified, safeguarded and supported.
- Children at risk of suicide and self-harm are identified, safeguarded and supported.

One of our key priorities is to ensure that the dataset and reporting to the Board meets the following principles:

- **Scope and relevance** - Demonstrates the performance of the partnership in terms of its strategy to improve outcomes for children across all priority areas
- **Integrity** - Timely, accurate and reliable
- **Trends** - Clear explanations of upward or downward trends
- **Targets** - Whether the measures are subject to national/local targets
- **Comparisons** - Relevant comparisons with other areas and/or organisations
- **Confidence** - Whether good performance will be sustained
- **Actions** – Analysis leads to improvement in practice

HSCB's dataset is reported on a quarterly basis to the Quality Assurance Subgroup and the Main Board. This will include an analysis undertaken by the Partnership Support Team of key themes linked to our safeguarding priorities. This enables HSCB members to understand

how their services are performing and highlights any emerging safeguarding issues that require strategic oversight and decision-making.

Undertaking multi-agency audits

HSCB undertakes an annual programme of multi-agency audits focussing on the quality of front-line practice in Hampshire. This work is commissioned by the Quality Assurance Subgroup and managed within the Partnership Support Team. This activity is also informed by feedback from national inspections. Learning is disseminated to front-line professionals via a range of mechanisms including practitioner forums and learning lessons workshops. In undertaking audits and reviews, HSCB is committed to the following principles:

- We will avoid excessive or unnecessary checks. Targeted quality assurance is more effective.
- We will prioritise quality assurance activities that provide opportunities to focus on front-line practice and to encourage professional multi-agency challenge.
- We will adopt a thematic approach to audit and assurance activities aligned to business plan priorities and emerging issues.
- We will be clear about the standard of practice that's required within the Terms of Reference, providing exemplars of good practice where possible.
- We will involve children, families and front-line workers in audits and reviews in an appropriate way.
- We will identify and share both good practice and areas for development and ensure that recommendations are addressed and monitored to deliver improvements to services.

Audit reports are presented to the Quality Assurance Subgroup and Main Board to ensure strategic and operational oversight of front-line practice. Progress against recommendations from audits and assurance activities is overseen by the Quality Assurance Subgroup.

Type of review	**Description**	**Who**	**Reporting**
Multi-agency case audits	Multi-agency case audits compliment single-agency auditing, which occurs in most organisations as part of their assurance of their duties under section 11 of the Children Act 2004. HSCB has an annual programme of multi-agency audits linked with the Business Plan priorities, which enables progress to be evidenced. The primary focus of our multi-agency case audits is to establish the effectiveness of front-line practice, what has worked well and where improvements, both single-agency and multi-agency, are needed. Recommendations are agreed and monitored by the Quality Assurance	Quality Assurance Subgroup	HSCB via Quality Assurance Subgroup.

	Subgroup and reported to the Main Board to evidence impact. Frontline professionals and managers are involved and the 'voice of the child' and their lived experience is a key theme within the audit process. For all audits, consideration is given to how the 'voice of the child' will be included, either through analysis of agency reports or via direct participation where this is deemed appropriate.		
Single-agency audits	Single-agency case audits occur in most organisations as part of their assurance of their duties under section 11 of the Children Act 2004. The outcomes of single-agency audits are reported to the Quality Assurance Subgroup as part of HSCB's remit to seek assurance that child protection arrangements are effective.	Partner agencies	Quality Assurance Subgroup via partner agencies.
Section 11 audits	Section 11 of the Children Act 2004 requires 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. As part of our statutory duty to ensure the effectiveness of safeguarding arrangements, HSCB undertakes annual monitoring of compliance with safeguarding standards. This is undertaken through self-assessment and panel evaluation of an agreed 4LSCB (Hampshire, Isle of Wight, Portsmouth & Southampton) audit tool. The purpose of the audit is to support Board partners in achieving compliance with safeguarding standards through: • Seeking assurance from Board partners that services are compliant with safeguarding standards. • Enabling Board partners to showcase areas of good practice where positive outcomes for children can be evidenced. • Enabling Board partners to reflect on their safeguarding priorities and to identify	Partner agencies	HSCB via Quality Assurance Group.

	areas for improvement. • Providing a feedback mechanism to Boards on progress against areas for improvement including any barriers to partnership working. The Board operates a two-year cycle of self-assessment (year 1) followed by monitoring and tracking of action plans (year 2). Members of HSCB's Quality Assurance Subgroup evaluate each agency's full self-assessment and written feedback is provided via the Independent Chair. The second stage of monitoring action plans is undertaken via a multi-agency discussion led by the Independent Chair of the Board. An overview of the Section 11 results is presented to the Main Board and key themes are included in the Boards' Annual Report and used as evidence in regulatory reviews of the LSCBs. HSCB undertakes site visits as part of its audit and assurance processes to provide visible leadership from the Board together with opportunities to validate agencies' self-assessments.		
Section 175/157 audits	Section 175 of the Education Act 2002 requires school governing bodies, local education authorities and further education institutions to make arrangements to safeguard and promote the welfare of children. Similar requirements are in place for proprietors of Independent Schools under Section 157 of the Education Act 2002. HSCB undertakes annual monitoring of the effectiveness of safeguarding arrangements in schools and post-16 settings. Within Hampshire, this is led by Hampshire County Council's LADO team in collaboration with Education & Inclusion Services. The findings are analysed with suggested improvements made to assist schools who have not yet reached the required standard. Follow-up site visits are undertaken to validate information provided during the audit and to gather evidence of good practice to share.	Schools and Post-16	HSCB via Education Group.

Learning from Experience

Reviews of safeguarding practice including Serious Case Review and non-statutory reviews

'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'.[1]

Learning opportunities from safeguarding practice arise from a variety of sources. This framework sets out the key practice reviews that HSCB, partner agencies and other local organisation undertake.

Type of review	Description	Who	Reporting
Serious case review	Where abuse or neglect is known or suspected and either: 1) a child dies; or 2) a child is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child.	Partner agencies Relevant organisations, Independent Reviewer, HSCB Partnership Support Team.	HSCB via the Learning & Inquiry Group.
Non statutory reviews	Review of a safeguarding incident which falls below the threshold for an SCR in which learning is identified	Partner agencies Relevant organisations, Independent Reviewer, HSCB Partnership Support Team.	HSCB via the Learning & Inquiry Group.
Individual agency or management review	Review of a safeguarding incident which falls below the threshold for an SCR and where there are limited concerns about how organisations or professionals worked together to safeguard the child	Partner agency.	HSCB via the Learning & Inquiry Group.
Child Death Review	A review of all child deaths up the age of 18.	Child Death Overview Panel (CDOP).	HSCB via the CDOP.

[1] DfE (2015) *Working Together to Safeguard Children*.

Principles for conducting reviews

The following principles, outlined in *Working Together to Safeguard Children*, should be applied by the HSCB 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 should 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, unless there are clear, evidenced reasons why not,** 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.
- 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.

Protocols for conducting reviews

Working Together to Safeguard Children outlines the requirements for conducting case reviews, specifically serious case reviews and child death reviews.

www.workingtogetheronline.co.uk

Guidance for commissioning case reviews has been developed and ensures that all partner agencies understand their role in contributing to case reviews. The guidance also provides information on review criteria, governance processes and engagement with professionals and family members.

Identification of Learning

Identification of key learning is achieved through the function of the Learning & Inquiry Group (LIG), a sub group of the HSCB.

Reviews of practice are commissioned by two of the HSCB subgroups: the LIG and the Quality Assurance Group (QAG).

The LIG may commission a Serious Case Review (SCR) or a non-statutory review in order to provide an analysis, lessons from the case and recommendations for any changes in policy or practice.

The LIG has a responsibility for monitoring recommendations made following completion of a Serious Case Review or non-statutory review and ensuring that the learning is cascaded to front-line professionals and informs service improvement and development. This is undertaken via a range of mechanisms including learning lessons workshops, practitioner forums, staff briefings and multi-agency training.

The chair of the Quality Assurance Group, or nominated member of the Partnership Support Team, also attends the LIG at least annually to discuss learning identified through quality assurance activity including audits.

Improving Services

Embedding learning

In order to improve safeguarding practice, learning identified from reviews of practice must be embedded into current practice. This is achieved by:

How	What	Who	Reporting
Dissemination of learning	Multi-agency training programme.	Partner agencies Relevant organisations, HCC Workforce Development Team, HSCB Partnership Support Team.	HSCB via Workforce Development Group.
	HSCB multi-agency 'learning lessons' workshops and 'practitioner forums'.	Partner agencies Relevant organisations, HCC Workforce Development Team, HSCB Partnership Support Team.	HSCB via Workforce Development Group.
	HSCB briefings and communication strategy.	Partner agencies Relevant organisations, HSCB Partnership Support Team.	HSCB via LIG and Quality Assurance Group.
	Publication of serious case review final reports.	HSCB, Partnership Support Team.	HSCB via the Learning & Inquiry Group.
	Single-agency training.	Partner agencies.	HSCB via Workforce Development Group.
	Single-agency briefings and other communication strategies.	Partner agencies.	HSCB via LIG and Quality Assurance Group.
Actions to improve practice	Single and multi-agency actions plans from case reviews.	Partner agencies, relevant organisations, HSCB Partnership Support Team.	HSCB via the Learning & Inquiry Group.
	Single and multi-agency actions plans from case audits.	Partner agencies, relevant organisations, HSCB	HSCB via Quality Assurance

		Partnership Support Team.	Group.
	Single and multi-agency action plans from Section 11 audits.	Partner agencies, relevant organisations, HSCB Partnership Support Team.	HSCB via Quality Assurance Group.
	Actions arising from reporting to HSCB and Quality Assurance Group.	Partner agencies, relevant organisations, HSCB Partnership Support Team.	HSCB via Quality Assurance Group.

Evaluation of learning

The aim of the activity outlined in this framework is to make a positive impact on frontline practice and in turn improve outcomes for children in Hampshire.

As part of its quality assurance activity, HSCB evaluates the impact of lessons learnt from reviews of practice. Evaluation includes:

How	Who	Reporting
Single and multi-agency audits of front-line practice	Partner agencies, relevant organisations, HSCB Partnership Support Team.	HSCB via Quality Assurance Group.
Case reviews	Partner agencies, relevant organisations, HSCB Partnership Support Team.	HSCB via the Learning & Inquiry Group.
Reporting on action plans arising from audits and reviews	Partner agencies, relevant organisations, HSCB Partnership Support Team.	HSCB via the Learning & Inquiry Group.
Evaluation of training including post-course feedback and follow-up surveys / interviews to ensure learning has been embedded	Partner agencies, relevant organisations, HSCB Partnership Support Team.	HSCB via Workforce Development Group.

This evaluation process identifies whether or not lessons have been learnt and can identify new issues.

Front-line Intelligence

HSCB front-line visits / listening events

The Chair and Board members undertake visits as part of the Board's quality assurance programme, enabling front-line staff from agencies to discuss safeguarding issues and barriers to partnership working. HSCB also hosts annual 'practitioner forums' to provide front-line staff with visible leadership from the Board together with opportunities to share their perspectives on what is working well and what isn't.

Training feedback

HSCB commissions and delivers multi-agency training to complement single agency training and support partner agencies in meeting their statutory responsibilities with regards to safeguarding training.

Feedback from delegates is captured through formal feedback and reported to our Workforce Development Group. The impact of our training on practice is also monitored at three and six months from date of attendance. This feedback is used to inform the annual Learning Needs Analysis, which enables our training programme to be responsive to feedback from front-line professionals.

HSCB staff surveys

HSCB undertakes a range of staff surveys to support the delivery of the annual business plan and to inform future work of the Board. Themes for the surveys are informed by Board priorities, learning from audits and recommendations from both local and national Serious Case Reviews. Findings as reported to relevant HSCB subgroups and where appropriate, recommendations for further work are made.

Independent Reviewing Service feedback

The Independent Reviewing Service provides intelligence to the Quality Assurance Subgroup in respect of its independent view as to how the safeguarding system operates.

External Learning

HSCB will take account of learning from national reviews, research etc. and ensure it is shared or included in related action plans targeting service improvement.

National Research and Serious Case Reviews

HSCB uses learning from national research and published Serious Case Reviews to assist in improving local safeguarding arrangements. Key learning is shared with the Learning and Inquiry Group to identify further opportunities for improving practice and to support the Board with disseminating examples of best practice.

Strategic Partnership Feedback

HSCB works closely with a number of other strategic partnerships including the Children's Trust, Safeguarding Adults Board, Health and Wellbeing Board, Care Matters etc. through defined protocols that enable challenge, scrutiny and feedback to be given to the HSCB on its priorities and performance.

Feedback from Board members is obtained via an annual evaluation process led by the Independent Chair. These discussions help to strengthen the existing partnership arrangements and to identify further learning opportunities.

Inspection Feedback

The safeguarding system receives regular scrutiny and challenge from national inspectorates including Ofsted, CQC, HMIC, HMIP etc. These inspections generate both single and multi-agency action plans and are an important source of learning for the Board's Joint Targeted Area Inspection Group and the Quality Assurance Group.

Themed Reports

During the course of each year, relevant reports will be produced for HSCB providing a narrative account of the work being undertaken in particular areas. These reports will be expected to identify any relevant learning that has been identified in respect of their specific safeguarding themes.

The following list is not exhaustive and HSCB may request additional reporting on specific areas based on its analysis of what areas require focus.

- Restraint/Physical Intervention within Secure Children's Homes
- Strategic MAPPA Board
- Multi-Agency Risk Assessment Conferences (MARAC)
- Management of Allegations against Professionals and Volunteers working with children
- Private Fostering
- Language Schools

Monitoring and Review of this Framework

This framework will be monitored via the Learning and Inquiry and Quality Assurance Groups. It will be reviewed on an annual basis or sooner in response to delivery of this framework, governmental guidance and national agendas.