Wolverhampton Safeguarding Boards

Joint Learning and Improvement Framework

2017 -2019

"Safeguarding and Promoting the Welfare of Children and adults with care and support needs in Wolverhampton is Everybody's business"

CONTENTS

1 INTRODUCTION

1.1 Professionals and organisations protecting children and adults with care and support needs (hereon referred to as 'vulnerable adults') have to make difficult decisions every day which can have a profound effect on their welfare. To do this job well they need to reflect on the quality of their services and learn from their own practice as well as the practice of others. Good practice should be shared so 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 further harm to children or vulnerable adults. This needs to be an open and transparent learning process so that the public can see where improvements are being made to protect children and vulnerable adults from harm in the future.

1.2 Working Together to Safeguarding Children (2015) requires 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. Furthermore, the Care Act 2014 requires that Local Safeguarding Adult's Boards assure themselves that safeguarding practice is continuously improving and enhancing the quality of life of adults in its area.

1.3 Each 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 and vulnerable adults. Some of these reviews (i.e. Serious Case Reviews, Safeguarding Adult Reviews and child death reviews) are required under legislation. The framework should support the work of the Wolverhampton Safeguarding Boards and their partners so that:

- Reviews are conducted regularly, not only on cases which meet statutory criteria, but also on other cases which can provide useful insights into the way organisations are working together to safeguard and protect the welfare of children/vulnerable adults and that this learning is actively shared with relevant agencies. Although not required by statute these reviews are important for identifying improvements which need to be made to local services. Such reviews are conducted either by a single organisation or by a number of organisations working together.
- Reviews look at what happened in a case, and why, and what action will be taken to learn from the review findings;
- Action results in lasting Improvements to services which safeguard and promote the welfare of children/vulnerable adults and help protect them from harm; and
- There is a transparency about the issues arising from individual cases and the actions which organisations are taking in response to them, including sharing the final reports of Serious Case reviews (SCRs) and Safeguarding Adult Reviews (SARs) with the public.

1.4 Reviews are not an end in themselves, but a method to identify improvements needed and to consolidate good practice. The Wolverhampton Safeguarding Boards and partner organisations will translate the findings from reviews into programmes of action which lead to sustainable improvements.

2 PRINCIPLES FOR LEARNING AND IMPROVEMENT

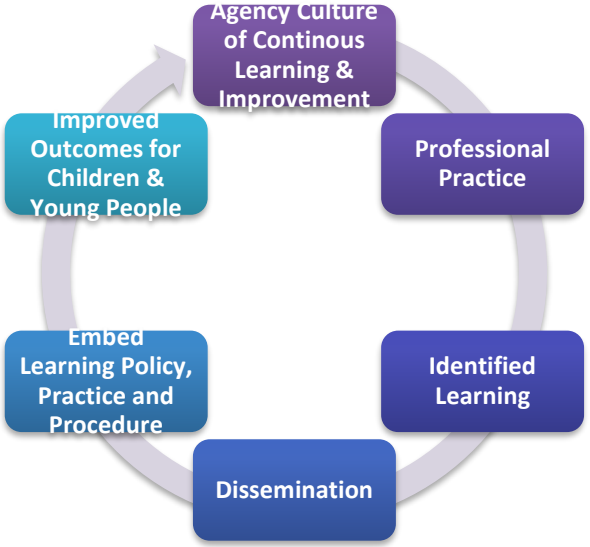
2.1 There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of children/vulnerable adults, so as to identify what works and what promotes good practice.

2.2 Within this culture the principles are:

- A proportionate response: according to the scale and level of complexity of the issues being examined i.e. the scale of the review is not determined by whether or not the circumstances meet statutory criteria;
- Independence: Reviews of serious cases to be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- Involvement of practitioners and clinicians: Professionals should be fully involved in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- Offer of family involvement: Families, including surviving children, should be invited to contribute to reviews and be provided with an understanding of how this will occur;
- The child/adult to be at the centre of the process;
- Transparency achieved by publication of the final reports of Serious Case Reviews and Safeguarding Adult Reviews and the Boards response to the findings. The LSCB/LSAB annual reports will explain the impact of SCRs, SARs and other reviews on improving services to children, adults and families and on reducing the incidence of deaths or serious harm to children/adults. This will also inform inspections;
- Sustainability: 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/adults.

2.3 Wolverhampton Safeguarding Board's learning and improvement Framework is based on a process of continuous improvement. The framework seeks "incremental" improvement over time and our processes will be regularly evaluated and improved in the light of their efficiency, effectiveness and flexibility.

2.4 For the Framework to be effective organisations must adopt a culture of continuous learning and improvement. In practice this means practitioners, managers and organisations taking a reflective, non-blaming, systemic and analytical approach that focuses on achieving improvements and best outcomes for children, young people and adults with care and support needs. A 'Cycle of Learning & Improvement' is illustrated below;



2.5 The most important aspect of the framework is how learning is translated into improvements and it must be acknowledged that this aspect provides the greatest challenge. The WSCB/WSAB Quality Assurance Framework details the roles and functions of the Children's Quality Assurance Committee, Children's Performance Management Committee and Adults Quality and Performance Committee functions as part of the wider quality assurance agenda.

2.6 Professionals need to be empowered to take responsibility and work together so that learning can be embraced. This work needs to be owned throughout the structure and mandated and encouraged through both Boards. All member organisations need to support the culture change necessary for this to happen.

2.6 The framework provides a vehicle for the Safeguarding Boards to meet their statutory requirements and go beyond this to ensure all sources of learning are considered, recognised and used to drive improved outcomes for children, adults and their families.

2.7 The framework will apply to Wolverhampton Safeguarding Boards and all partner agencies in their delivery of workforce development activities. It will inform single agency frameworks to ensure connectivity and compatibility.

3 WOLVERHAMPTON LEARNING AND IMPROVEMENT FRAMEWORK: METHODOLOGY

Wolverhampton Safeguarding Boards assume that practitioners generally act from good intentions and try and act in the best interest of their clients but that organisations systems, processes and 'culture' can lead to poor decision making and poor practice. It is therefore these organisational 'systems' which should be the focus of any review and learning and any scrutiny of practitioners cannot be divorced from these critical variables. It is in the spirit of this approach that the framework should be viewed.

Learning can be obtained through a range of sources and these are detailed below:

Reviews

3.1 **Serious Case Reviews** (SCRs) and **Safeguarding Adult Reviews** (SARs)
The WSCB's functions in relation to SCRs are set out in Regulation 5 of the LSCB Regulations 2006.

3.1.1 Serious Case Reviews (SCRs) are a statutory requirement and key source of learning in helping to understand what happened and why when things go wrong for a child or young person. It is a multi-agency review of a case and looks at how professionals and organisations worked together with the child or young person at the centre of the review. WSCB adopts a systems methodology to conducting SCR's.

3.1.2 Wolverhampton Safeguarding Children Board have developed a SCR toolkit to provide detailed guidance on the management and processes of SCRs; with a specific focus on learning.

3.1.3 Further information into the conduct of SCR's can be found on the WSB website.

3.1.4 The WSAB's functions in relation to SARs are set out in The Care Act 2014. Further information regarding the conduct of SARs can be found on the WSB website.

3.1.5 A Safeguarding Adults Review is a process for all partner agencies to identify the lessons that can be learned from particularly complex or serious safeguarding adults cases, where an adult in vulnerable circumstances has died or been seriously injured and abuse or neglect has been suspected.

3.1.6 Wolverhampton Safeguarding Adults Board are in the process of developing a SAR Toolkit to provide detailed support and guidance.

3.2 Table Top Reviews

3.2.1 These are Multi Agency Reviews which have not reached the statutory requirement for a SCR or a SAR but demand a level of scrutiny and analysis given the significant issues contained within the case. They will equally focus on identifying learning and improvement.

3.3 Child Death Reviews (CDRs)

The WSCB's functions in relation to child deaths are set out in Regulation 6 of the LSCB Regulations 2006.

3.3.1 WSCB is responsible for ensuring that a review of each death of a child normally resident in its area is undertaken by a Child Death Overview Panel (CDOP). WSCB is responsible for collecting and analysing information about each death with a view to identifying:

- any case giving rise to the need for a review mentioned in regulation 5(1)(e);
- any matters of concern affecting the safety and welfare of children in the area of the authority;
- any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area; and
- procedures to be put in place for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

3.3.2 Walsall and Wolverhampton LSCBs share lead responsibility for the CDOP. Its responsibilities are set out in its Terms of Reference and include making recommendations to the LSCBs or other relevant bodies so that action can be taken to prevent future such deaths where possible; and identify patterns or trends in local data and reporting these to the LSCBs.

3.3.3 Further information into the conduct of child death reviews can be found on the WSCB website.

3.4 Inspection & peer reviews

3.4.1 All Local Authorities are subject of Ofsted Inspection with respect of 'services for children in need of help and protection, children looked after and care leavers'. ''These inspections are conducted under s.136 of the Education & Inspections Act 2006. They focus on the effectiveness of the Local Authorities services and arrangements to help and protect children, the experiences and progress of children looked after, including adoption, fostering, the use of residential care and children who return home. The framework also focuses on the arrangement for permanence for children who are looked after and the experiences and progress of care leavers.'' The focus is also on the effectiveness of leadership, management and governance and the impact on children's lives.

3.4.2 Such inspections identify the strengths and challenges within Local authorities and make recommendations for improvement. WSCB has a responsibility to contribute to Ofsted Inspection and hold the Local Authority to account to ensure improvements are embedded in practice and strengths are shared to improve the learning across the children's partnership.

3.4.3 As of December 2013, Local Safeguarding Children's Boards have been brought into the Ofsted inspection regime. The review of the LSCB is conducted under 15(A) of the Children Act 2004. With specific emphasis on the effectiveness of the LSCB in meeting its statutory functions and evaluates and monitors the quality and effectiveness of the Local Authority and statutory partners in protecting and caring for children. The WSCB has a responsibility to learn from this inspection and ensure improvements in safeguarding across Wolverhampton.

3.4.4 The Local Government Association (LGA) has a national agreement to progress safeguarding reviews across the various Local Authorities. The fundamental aim of Peer Reviews is to help councils and their partners to reflect on and improve safeguarding services for children, young people and adults with care and support needs. It is a supportive, but challenging process, to assist councils and their partners in recognising strengths and identify their own areas of improvement. The Wolverhampton Safeguarding Boards have a responsibility to promote learning from the Peer Review and ensure the business priorities take into account any learning achieved via the Peer review process and be clear how this contributes to improved outcomes for children and adults.

Audits

In addition to Serious Case Reviews, Safeguarding Adult Reviews and Child Death Reviews, the WSCB, WSAB and individual organisations undertake a wider range of audit activity to help learn about current practice and influence service improvement. These include:

3.5 Single Agency Audits: Learning from multi-agency audits, SCR and other reviews should be embedded within each partner agency. In order to verify that learning has been embedded, it is expected that each individual partner agency of the WSCB/WSAB undertake single agency audits in order to ensure that organisational change is consolidated, evaluated and it is possible to demonstrate a clear impact on said changes on the outcome of children and adults. Each agency is responsible for determining when to carry out such audits and the methodology by which to undertake these however; audit schedules and audit tools should be shared with the Quality and Performance committees as such audits will support and provide evidence for the section 11 annual audit or assurance statement process each agency is required to undertake.

3.6 Multi Agency Case Audits: Multi Agency Case Audits (MACAs) are a valuable element of the review and quality assurance process for safeguarding and child/adult protection. The Wolverhampton Safeguarding Boards undertake multi-agency audits on a periodic basis. The themes and schedule are based on referrals from across the partnership on areas of concerns where there is a need to reflect up the impact of practice arising from trend analysis of quantitative data. The key themes and trends identified are compiled in a 'Learning from Audit Briefing Note' with an expectation that partners identify the learning that is relevant to their agency and take effective action to make the necessary required improvements.

3.7 Section 11 Audits: Section 11 of the Children Act 2004 requires a range of organisations and individuals to self-evaluate their practice and compliance with procedures. Within Wolverhampton this is achieved through the use of a tool developed by Virtual College.

3.8 Section 175/157 Audits: Section 175 of the Education Act 2002 came into effect on the 1 June 2004. Section 175 requires school governing bodies, local education authorities and further education institutions to make arrangements to safeguard and promote the welfare of children. Such arrangements will have to have regard to any guidance issued by the Secretary of State. Similar requirements are in place for proprietors of Independent Schools under Section 157 of the Education Act 2002.

3.8.1 The WSCB is required to monitor the effectiveness of safeguarding arrangements in schools. With this, the Section 175/157 Audit of Schools will be undertaken on a bi-annual basis via the use of bespoke audit tool developed and agreed in consultation with the Head-teacher's Safeguarding group.

4 DISSEMINATING AND EMBEDDING LEARNING

4.1 Sharing and embedding good practice, what works well and learning from when things go wrong is a crucial part of supporting a culture of continuous learning and improvement. Professionals and organisations should have access to a wide range of learning and this should be disseminated through a range of methods. Embedding learning must be integrated into everyday practice for it to be truly effective.

4.2 Dissemination of learning can take place through:

- Single Agency Training
- WSCB and WSAB Multi Agency Training
- Conferences
- Best Practice Briefings and Forums
- WSCB and WSAB Newsletters
- Awareness Campaigns

4.3 Embedding learning can take place through:

- Policy & Protocol Development
- Reflective Practice and Supervision
- Collaborative joint working arrangements
- Service team meeting structures
- WSCB and WSAB Multi Agency Training Programmes

4.4 The Law Policy and Procedure Committee will take a lead in developing and endorsing policy and procedures in respective of multi-agency activities; in addition to helping organisations develop new procedures and practice guidance.

4.5 The Joint Communication and Engagement Committee through communication with other Strategic groups and committees, share best practice by bringing together expertise in different bodies ensuring learning from experience e.g. from Serious Case Reviews, Safeguarding Adult Reviews etc.

4.6 The Joint Learning and Development committee is responsible for the strategy development, promotion and provision of interagency training to safeguard children and adults with care and support needs. It will ensure:

- That training is effective and complies with best practice and statutory guidance.
- The provision of a multi-agency training programme which brings together a range of professions and organisations to model partnership working in practice.
- Wolverhampton Safeguarding Boards will provide this training themselves or commission a provider to deliver on behalf of the Boards.

4.7 Commissioning of multi-agency training will be the responsibility of the Joint Learning & Development committee and all training that is provided external to the partnership training pool will be subject to procurement rules.

5 MONITORING AND EVALUATION

5.1 The **Performance Management Committee(PMC) and the Quality Assurance Committee** are responsible for performance and quality information on behalf of WSCB. The **Quality and Performance Committee** is responsible for this on behalf of WSAB. This includes ensuring there is a continuous improvement plan for safeguarding practices which is formulated on the basis of:

- Developing a clear understanding of the safeguarding profile of Wolverhampton and how the respective agencies are performing to meet those needs
- Reviewing data, trends, safeguarding key performance indicators and the results of audits that have been carried out
- Quality assuring practice, through multi-agency audits of case files and identifying lessons to be learned

5.2 The work of these committees is central for informing the boards on the activities of partner across the city, using a range of methods for gathering, analysing, translating and reviewing data, trends, local safeguarding key performance indicators which is evaluated, summarised and presented to the board. The board recognises that; effective quality assurance is a critical component to assist in the drive towards continuous improvement. The **Quality Assurance Framework** outlines this in more detail.

5.3 The WSCB and WSAB have a statutory function to monitor and evaluate the effectiveness of training, including multi agency training provision. This Learning & Improvement Framework supports this requirement.

5.4 This is achieved through the Learning and Development committee ensuring:

- Development of quality standards for single agency safeguarding training
- Agency representation at WSCB/WSAB training
- Numbers of staff having completed safeguarding training
- Commissioning training arising through learning from SCR's, CDR's, SARs, audits and implementation of new statutory and non-statutory guidance.

5.5 Evidencing the Impact of Learning Outcomes is crucial to understand and evidence how training is making a positive difference to professional practice and service improvement. The Learning and Development Committee quality assuring single and multiagency safeguarding training measures include:

- Feedback and Evaluation
- Impact measures in terms of improved practice and therefore improved outcomes for children and young people and adults
- Audit

6. EXPECTATIONS OF BOARD MEMBERS

6.1 Each board member has signed a Job Description agreeing to undertake the job purpose and core tasks as identified. This can be found in the Board Constitution.

6.2 Learning and improvement is a core task for all partners and therefore the agency representative has a responsibility for ensuring that learning is taken forward, acted upon and embedded within their own organisation, be that through single agency audits or amendment of policy and procedures, as required.

METHODS OF LEARNING

Appendix A

Method	What we learn	Evaluation methods	Key stakeholders	committees
SCR, SAR and subsequent briefings	Multi agency lessons Single agency lessons Risk assessment	Inspection, peer review, audit	LSCB/LSAB partners Media Service users Ofsted The public	SCR SAR JL&D
Multi agency reviews	Multi agency lessons Single agency lessons	Inspection, peer review, audit Participant feedback	LSCLSAB partners Service users	SCR SAR JL&D
CDOP	Themes and trends Modifiable factors	Participant feedback Annual report	LSCB partners Children and families Ofsted	CDOP JL&D
Quality Assurance and Performance management activities	Views of stakeholders Organisational performance/trend Quality of practice Quantitative information	Outcomes of these activities	LSCB/LSAB partners Service users Ofsted	QA PM Q&P

Audits of single agency training	Quantity and quality of single agency training Compliance with LSCB standards Learning outcomes Training needs provision	Participant feedback, action plan feedback	LSCB/LSAB partners	JL&D
Guidance and policy	Government priorities Practice guidance National perspective Local policies	Compliance with policy	LSCB/LSAB partners Media Central Gov Ofsted	All committees