St. Helens Safeguarding Children Partnership

Learning and Improvement Framework

St Helens
Safeguarding Children
Partnership

Review date: 01.10.21
Date of ratification_____

Introduction

Working Together to Safeguard Children 2018 states that “Good practice should be shared so that there is a growing understanding of what works well to safeguard and promote the welfare of children and their families. Equally, when things go wrong there needs to be an understanding not only of what happened but also why things happened as they did, including analysis of the context such as workload, staff capacity, and other external events.”

Key themes emerging from multi and single agency Audits, Practice Learning Reviews, Critical Incidents, Root Cause Analysis, CDOP (Child Death Overview Panel), evaluations of the impact of training and the Safeguarding Practice Review process will be disseminated into the Audit, Review and Learning Forum as well as the Safeguarding Children Partnership Forum via a number of channels. This will inform future training programmes and briefing sessions to ensure that practitioners and organisations reflect on the quality of their services and learn from their own practice and that of others.

The Safeguarding Partnership and its partner agencies have a responsibility to ensure that all sources of learning are considered, recognised, and used to drive improved outcomes for children and families.

> *“The role of independent scrutiny is to provide assurance in judging the effectiveness of multi-agency arrangements to safeguard and promote the welfare of all children in a local area, including arrangements to identify and review serious child safeguarding cases. This independent scrutiny will be part of a wider system which includes the independent inspectorates’ single assessment of the individual safeguarding partners and the Joint Targeted Area Inspections. Whilst the decision on how best to implement a robust system of independent scrutiny is to be made locally, safeguarding partners should ensure that the scrutiny is objective, acts as a constructive critical friend and promotes reflection to drive continuous improvement. The independent scrutineer should consider how effectively the arrangements are working for children and families as well as for practitioners, and how well the safeguarding partners are providing strong leadership and agree with the safeguarding partners how this will be reported.”*

Purpose of the Learning Improvement Framework

This framework is intended to fulfil the following objectives:

- Ensure that the multi-agency partnership fulfils its statutory obligations.
- Ensure there is a culture of continuous learning and improvement.
- Ensure that learning is a shared responsibility between those who commission and provide training, organisations/managers responsible for staff and the staff themselves.
- Ensure that services are clear about their responsibilities, to learn from experience and improve services as a result.

Stakeholders

It is important to highlight the key stakeholders who will influence and be influenced by multi-agency learning and improvement. These are illustrated below showing the key needs of each group.

The key point to note here is that any learning and recommendations identified by the Partnership Board or its member agencies will need to meet different expectations and requirements specific to the whole stakeholder group. It should also be noted that some learning will be much wider than the Safeguarding Partnership and its

member agencies and consideration should be given as to what measures can be taken to influence change regionally or nationally.

Methods of Learning

The Safeguarding Children Partnership Board is a learning organisation and through its provision, scrutiny and challenge functions contributes to a significant amount of multi and single agency learning. Key themes for learning arise from several methods and they need to be embedded into programmes of learning, governance, and workforce development.

Method of Review/Source of Learning	Description	Learning	Method of Learning	Key Stakeholders	Points of Dissemination
Safeguarding Practice Learning Reviews	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.	Multi-agency & single agency lessons National implications Changes to governance & legislation	Briefings Feedback to Safeguarding Partnership Board Implemented in relevant multi-agency Training Courses	Safeguarding Partnership Board Partner Agencies Children and Families Media Ofsted General public	Safeguarding Partnership Board Audit, Review and Learning Forum Safeguarding Children Partnership Forum Task and Finish Groups
Multi-agency Practice Learning Reviews	Review of a safeguarding incident which falls below the threshold for an SCR or where a complex case has identified good outcomes for the child and there are lessons to be learnt for multi-agency working.	Local learning - multi agency & single agency lessons	Briefings Feedback to Safeguarding Partnership Board Implemented in relevant multi-agency Training Courses	Safeguarding Partnership Board Partner Agencies Children and Families	Safeguarding Partnership Board Audit, Review and Learning Forum Safeguarding Children Partnership Forum
Critical Incident Reviews	Review of a safeguarding incident which falls below the threshold for an SCR	Local learning	Briefings Feedback to Safeguarding Partnership Board	Safeguarding Partnership Board Partner Agencies	Safeguarding Partnership Board Audit, Review and Learning Forum Safeguarding Children Partnership Forum
Child Death Reviews	A review of all child deaths up to	Themes and trends	Briefings	Safeguarding Partnership	Merseyside Child Death

Merseyside CDOP – Local Child Death Reviews and Briefings	the age of 18 years. Local review of all child deaths up to the age of 18 years.	Modifiable factors	Feedback to Safeguarding Partnership Board Press Release/ Website	Board Partner Agencies Families Media	Overview Panel (CDOP)
Best Practice Panel	Panel to review good practice. This should be shared so there is an understanding of what works well.	Multi agency and single agency lessons	Feedback to Safeguarding Partnership Board to be cascaded to professionals	Safeguarding Partnership Board Partner Agencies Children and Families	Audit, Review and Learning Forum Safeguarding Children Partnership Forum
Single Agency Reviews	Review of a safeguarding incident that falls below the threshold for an SCR and where there are limited concerns about how organisations or professionals worked together to safeguard the child.	Single agency lessons Changes to governance	Feedback to Safeguarding Partnership Board to be cascaded to professionals	Safeguarding Partnership Board Partner Agencies Children and Families	Audit, Review and Learning Forum
Multi-agency case audits and thematic audits	Audit of practice relating to a child's journey through the safeguarding system (case sample), highlighting where things go well as well as opportunities to improve.	Multi agency and single agency lessons Changes to governance Themes and trends	Feedback to Safeguarding Partnership Board to be cascaded to professionals	Safeguarding Partnership Board Partner Agencies Children and Families	Audit, Review and Learning Forum
Single agency audits	Audit of practice (case sample) Highlighting good practice and opportunities to improve, and sharing findings with the partnership	Single agency lessons Changes to governance Themes and trends	Feedback to Safeguarding Partnership Board to be cascaded to professionals	Partner Agencies Children and Families	Audit, Review and Learning Forum
Section 11 audits	Self- and partnership assessment of an organisation's safeguarding arrangements and	Themes and trends Changes to governance	Feedback to Safeguarding Partnership Board to be cascaded to professionals	Safeguarding Partnership Board Partner Agencies	Audit, Review and Learning Forum Executive

	practice against Section 11 of the Children Act 2004, highlighting good practice as well as opportunities for improvement.			Children and Families	Safeguarding Partnership Board
Section 157/175 audits	Self- and partnership assessment of a school's safeguarding arrangements and practice against S175/157 of the Education Act 2002.	Themes and trends Changes to governance	Feedback to Safeguarding Partnership Board to be cascaded to professionals	Safeguarding Partnership Board Partner Agencies Children and Families	Audit, Review and Learning Forum Safeguarding Partnership Forum Safeguarding Partnership Board
Quality Assurance & Performance Management activities (audits, surveys, data analysis, performance indicators)	Variety of methods using Quality Assurance Framework	Themes and Trends	Feedback to Safeguarding Partnership Board to be cascaded to professionals	Safeguarding Partnership Board Partner Agencies Children and Families	Audit, Review and Learning Forum Children at Risk of Exploitation Group Safeguarding Partnership Forum Safeguarding Partnership Board
Evaluation of the impact of Training	Evaluation process to understand the impact of training on outcomes for service users	Increase of knowledge, skills, and confidence Changes in practice Improved outcomes for children	Feedback to Safeguarding Partnership Board to be cascaded to professionals	Safeguarding Partnership Board Partner Agencies Children and Families	Audit, Review and Learning Forum Safeguarding Partnership Board

Principles for learning and improvement:

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

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 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 to be at the centre of the process**.
- **Transparency**: Achieved by publication of the final reports of Safeguarding Practice Learning Reviews and the Safeguarding partnership's response to the findings. The Partnership Board's annual reports will explain the impact of Safeguarding Practice Learning Reviews and other reviews on improving services to children and families and on reducing the incidence of deaths or serious harm to children. 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.

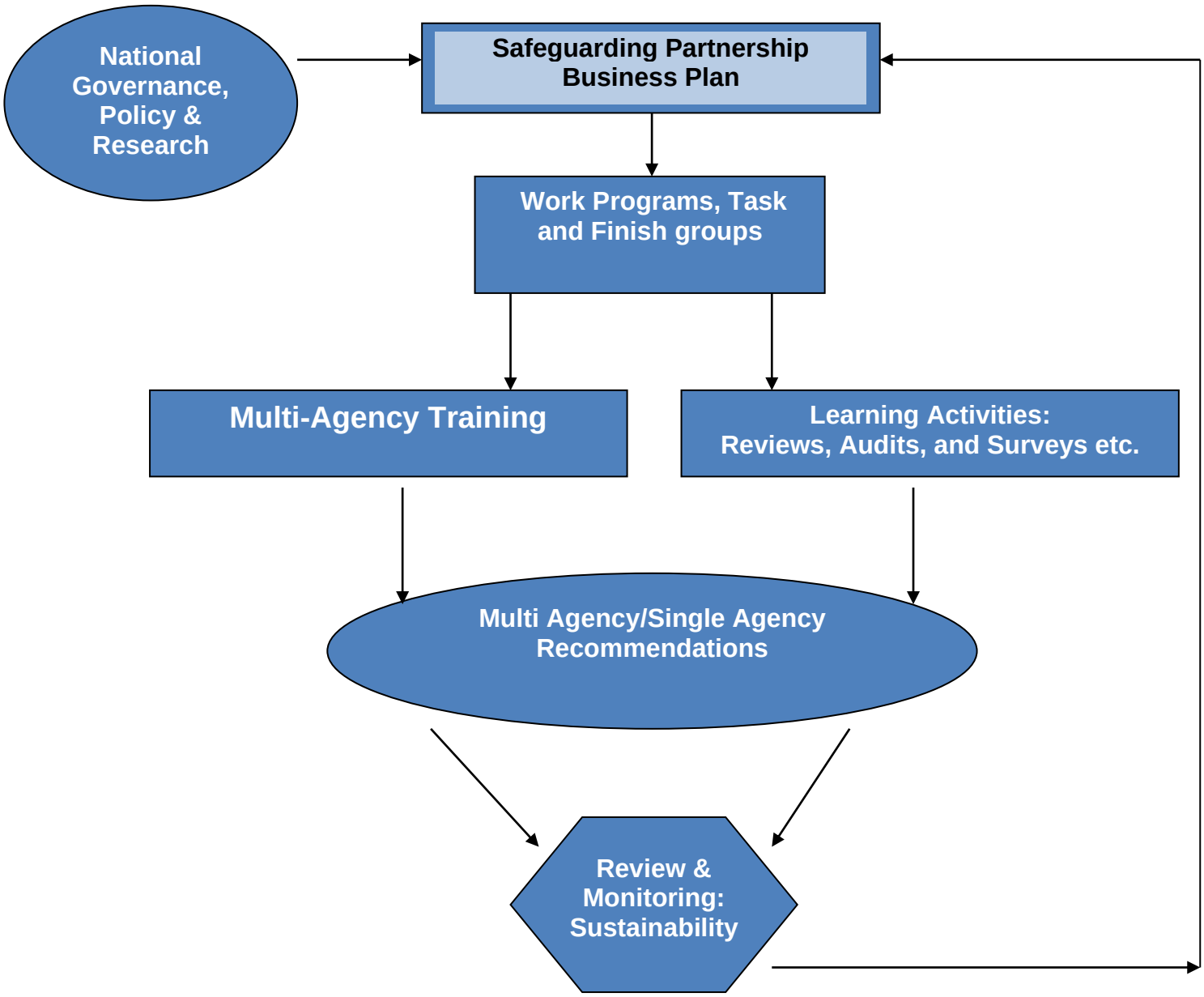
There is an understandable focus on Safeguarding Practice Learning Reviews given the profile of this type of review, however it should be remembered that they are not the only process that should drive learning and improvement. The Safeguarding Children Partnership should pay equal or greater attention to the dissemination processes for learning giving consideration to:

- The need to reach a multi-agency audience.
- An understanding of adult learning.
- The on-going training and development needs of certain professional groups.

Clearly one approach will not be suitable for all learning and every agency; a range of learning opportunities should be provided that could include: inter-professional discussion forums, specific dissemination events, thematic presentations (combining the learning from several different reviews) and the uses of the Partnership Board's newsletters to produce factsheets on specific topics.

Translating learning into continuous improvement

As a learning organisation it is important to be clear how the learning from this wide variety of review activity (as outlined above) is used to drive improvement in practice, policy, and procedure. It is therefore important that organisational learning is seen as a dynamic, cyclical, and multi-layered process that informs the Partnership's wider strategic planning framework that determines current and future priorities and resource allocation.



Expectations of Single Agencies

- Agencies are responsible for ensuring that their workforce is suitably recruited, qualified, and enabled to safeguard children.

- Agencies are responsible for providing appropriate supervision and support for staff, including access to safeguarding training appropriate to their role.

- Agencies are responsible for ensuring that their staff are competent to carry out their responsibilities for safeguarding and promoting the welfare of children and creating an environment where staff feel able to raise concerns and feel supported in their safeguarding role.

- Agencies are responsible for offering their staff a mandatory induction, which includes familiarisation with child protection responsibilities, procedures, and thresholds to be followed if anyone has any concerns about a child's safety or welfare; and

- Agencies are responsible for ensuring that all professionals have regular reviews of their own practice to ensure they improve over time.

- Agencies are responsible for releasing staff to assist in delivering multi-agency learning activity as well as attending multi-agency learning.

- Agencies are responsible for ensuring that all staff have evidence of suitable basic safeguarding training, refreshed in the appropriate timescales set out in national and/or the Partnership Board's guidance.

- Agencies are responsible for responding to audits under section 11 of the Children Act 2004.

- Agencies are responsible for reporting on their compliance and quality of single agency work.

Expectations of the Multi-Agency Safeguarding Partnership

Safeguarding partners should agree on ways to co-ordinate their safeguarding services; act as a strategic leadership group in supporting and engaging others; and implement local and national learning including from serious child safeguarding incidents.

The purpose of these local arrangements is to support and enable local organisations and agencies to work together in a system where:

- Children are safeguarded and their welfare promoted.
- Partner organisations and agencies collaborate, share, and co-own the vision for how to achieve improved outcomes for vulnerable children.
- Organisations and agencies demonstrate professional curiosity and challenge appropriately, holding one another to account effectively.
- There is early identification and analysis of new safeguarding issues and emerging threats.
- Learning is promoted and embedded in a way that local services for children and families can become more reflective and implement changes to practice.
- Information is shared effectively to facilitate more accurate and timely decision-making for children and families.

To work together effectively, the safeguarding partners with other local organisations and agencies should develop processes that:

- Reflect a strength-based approach towards children and families and sits under the Signs of Safety model of practice.
- Facilitate and drive action beyond usual institutional and agency constraints and boundaries.
- Ensure the effective protection of children is founded on practitioners developing lasting and trusting relationships with children and their families.

To be effective, these arrangements should link to other strategic partnership work happening locally to support children and families. This will include other public boards including:

Health and Wellbeing Boards; Adult Safeguarding Boards: Channel Panels; Improvement Boards; Community Safety Partnerships; the Local Family Justice Board; and MAPPAs.

It is the responsibility of those who commission and provide training, organisations, and managers responsible and the staff themselves to facilitate an environment that empowers the workforce to embed their learning into practice.