Somerset Safeguarding Children Board

Learning and Improvement Framework

Note on Transitional Arrangements

Following the publication of Working Together 2018, Somerset has begun its transition from LSCB to safeguarding partner and child death review partner arrangements. The transition must be completed by 29th September 2019.

Introduction

This document has been updated to outline how the transitional arrangements described above will be applied in Somerset, and how Somerset Safeguarding Children Board (SSCB) meets its duties to create, maintain and measure a framework of continuous learning and improvement. The SSCB is formed of partner agencies including healthcare providers and commissioners, police, probation, social care and education.

The SSCB is committed to continual improvement of the way it works and the outcomes for safeguarding practice. This framework outlines the method by which lessons are learned from the different activities of the Board and how they can best be disseminated and embedded in practice. The aim is to meet the challenges of a changing environment and to continue to improve safeguarding practice across the partnership. The framework is flexible, responsive to changes and integral to the creation of the business plan.

The Board is committed to continuing to work with other LSCBs, and Boards such as the Somerset Safeguarding Adult Board, Health and Wellbeing Board, Somerset Community Safety Partnership and Clinical Commissioning Group, to share practice and learn from others.

Methods and tools for learning

The framework covers all opportunities for learning. For the SSCB these include:

- Learning and development supported by the SSCB learning and development strategy
- Serious Case Reviews and multi-agency Learning reviews
- Multi-agency case audits
- Attendance at practitioner forums (i.e MAPIGS) by the SSCB Independent Chair (or Board members)
- Consultation with young people
- Section 11 audits
- Learning and Development Audit
- SSCB Quality & Performance dataset
- Child Death Overview Panel
- Safeguarding Conversations

Learning and Development

The SSCB has an annual learning and development programme which is agreed via the Training and Development Subgroup. The programme is varied and incorporates courses, workshops, conferences and e-learning.

The programme is adapted through the year as needs dictate and covers issues arising from Serious Case Reviews and other reviews as well as priorities set as part of the business plan. It is also based on research and latest training and development practice incorporating reflective practice, sharing of practice and the facilitation of learning events.

The learning and development strategy outlines how the programme is developed, as well as an evaluation framework and incorporating the learning into supervision and one to ones.

Serious Case Reviews and multi-agency Learning Reviews

From 29 June 2018, local authorities are required, under a new statutory duty, to notify the National Child Safeguarding Practice Review Panel of incidents where they know or suspect that a child has been abused or neglected and the child has died or been seriously harmed.

Until the new arrangements begin to operate in Somerset, the SSCB will continue with Serious Case Reviews (SCRs) and multi-agency Learning Reviews (MLRs) in line with statutory guidance overseen by the Learning and Improvement Subgroup. All SCRs and MLRs use a systems approach and one that is proportionate to the case.

Learning from SCRs and MLRs locally and nationally is cascaded via briefings, learning bulletins and Practitioner workshops and promoted on the SSCB website.

Action plans arising from local cases or ones the SSCB has been involved in are monitored and followed up and implemented across different agencies as appropriate.

Child Death Overview Panel

Until the new Child Death Review Partnership arrangements have been published, the SSCB will continue to carry out Child Death Reviews as set out in Working Together 2015 and giving due regard to the Transitional Guidance from the existing Child Death Overview Panel to the Child Death Review Panel. The transitional arrangements require all deaths notified prior to implementation of the new partnership arrangements to be completed within four months:

> *"Where any child death reviews have not been completed at the point the new child death review arrangements begin to operate, the LSCB has up to four additional months to complete those reviews. Where it has not completed a review it must pass the information to the child death review partners. The latest date for completion is 29 January 2020. Any CDOP set up under LSCB arrangements may not undertake any new child death reviews during this four-month period.*
> *If any child death reviews remain incomplete by the end of the four-month period, the LSCB must ensure that all relevant information is provided to the child death review partners."* (Transitional Guidance)

Lessons and trends arising from these reviews are compiled and reported to the main Board. Campaigns are carried out as appropriate – e.g. guidance on dangers of co-sleeping.

Multi-agency case audits

Multi-agency case audits look at themes aligned to the Board meetings. Participants attend the multi-agency case audit meetings and share practice and thoughts on the case and any learning is drawn out. Any multi-agency issues arising from audits are passed to the SSCB Quality and Performance Subgroup for action. The findings of such reviews are made to the Board as part of the overall reporting of data and audits. Collating and analysing audits and data from all agencies form the key area of work of the Quality and Performance Subgroup and themes and trends are highlighted and reported to the Board as part of an improvement plan.

Practitioner forums

A representative of the Board regularly attends multi-agency practitioner forums (MAPIGS). These enable front line practitioners to discuss any issues or areas where improvements can be made so that the work of the Board can also reflect issues raised at the 'front line'.

Section 11 Audit

The Section 11 audit considers safeguarding practice across all agencies. These are undertaken using an online audit tool. Lessons from the audit and gaps are addressed directly by the agency through an action plan and also form part of wider learning where needed including changes to practice.

The audit also allows the identification of additional support for agencies to take place and highlights areas where improvements can be made. The audit also serves as a measurement of impact of safeguarding practice across the partnership.

Learning and Development Audit

The learning and development audit is carried out annually with all agencies and this highlights what training is being carried out, how it is evaluated and crucially how the impact on practice is measured. This is then reviewed by the Training and Development subgroup and a report made to the Board.

The audit allows the Board to identify any gaps in the provision of training and to challenge and support agencies as required to address these to meet their statutory requirements around safeguarding. Additionally, the audit also highlights any gaps in the provision of multi-agency training and thus contributes to the SSCB learning and development plan.

SSCB Dataset

The SSCB dataset consists of a number of multi-agency indicators, identified and agreed by the Quality and Performance (Q&P) subgroup. The dataset is monitored and reviewed by the Q&P subgroup and members are tasked with actions as appropriate. An overview of the dataset and any areas of concern are reported at each full Board. These areas of concern will then be discussed at the Board and the relevant agencies asked to address as appropriate.

Information from other sources

The SSCB will also use information and patterns/trends from other areas of work, such as complaints and referrals to the Local Authority Designated Officer, to highlight any areas where improvements in practice could be addressed.

On-going dissemination and cascade of learning

All of the learning and findings from these tools are disseminated and incorporated into the day to the day business of the Board and its partner agencies. This takes various forms and includes:

- Specific learning interventions such as training
- Briefing notes and practice workshops
- Development and updating of protocols and procedures
- Development and ongoing review of the Business Plan
- Discussions, debate and challenge at Board level using evidence from these tools to hold agencies to account
- Information on the website
- Cascade of information via all members of the Board and its subgroups
- Linkages to communication channels in other agencies, e.g. newsletters, to ensure key messages are disseminated
- Monitoring and evaluation of impact is ongoing utilising the learning and improvement tools in this framework.

Review and taking forward the framework

The learning and improvement framework will be incorporated into the SSCB Business Plan and will be reviewed on an annual basis.

References

Working Together to Safeguard Children – guide to inter agency working to safeguard and promote the welfare of children. HM Government July 2018.

Working Together: transitional guidance. HM Government July 2018

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(This SSCB framework has been adapted and based upon good practice from Essex Safeguarding Children Board's Learning and Improvement framework 2016)

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