Gloucestershire Safeguarding Children Board

Learning and Improvement Framework

November 2013 (Reviewed November 2016)

"Professionals and organisations protecting children need to reflect on the quality of their services and learn from their own practice and that of others, so that important lessons can be learnt and services improved to reduce the risk of future harm to children." (Working Together, 2015)

1.0 Introduction and Principles

Learning and improvement is a priority for the Gloucestershire Safeguarding Children Board. The GSCB has had a Quality Assurance framework in place since June 2011. This framework was reviewed and updated in November 2013 in line with the *Working Together to Safeguard Children* 2013 requirements to produce the Learning and Improvement Framework. This requirement is retained in Working Together to Safeguard Children 2015.

There are always lessons to be learnt and improvements that can be made to ensure that we are meeting the needs of the most vulnerable children and families in Gloucestershire.

The framework provides a range of ways to help organisations represented on the GSCB answer the question "how effective are we at safeguarding children and young people?" It is only through assessing the quality of work that we do and understanding its impact that we can understand effectiveness in helping to keep children and young people safe.

This will help shape our learning about what works well and those areas where practice needs to be improved.

The Board discussed the principles for learning and improvement set out in Working Together 2013 and in line with those principles agreed that all our learning and improvement activity will:

- Recognise the **complex circumstances** in which professionals work together to safeguard children
- Support a culture of continuous **learning and improvement** across organisations in Gloucestershire, identifying opportunities to draw on what works and promote good practice;
- Be **proportionate** in our approach to learning, according to the scale and level of complexity of the issues being examined;
- **Keep professionals fully involved** in further communications and learning;
- **Be published**, in order to achieve transparency**;** and be included in the GSCB annual report, describing the impact of SCRs and other reviews on improving services to children and families and on reducing the incidence of deaths or serious harm
- Make sure improvement is sustained through regular GSCB **monitoring and follow up**, so that the findings make a real impact on improving outcomes for children and young people in Gloucestershire.

2.0 Learning and Improvement Framework

Safeguarding children and young people is complex. It is important that we find ways to learn about the impact of what we do in terms of the quality of our practice and whether or not it makes a difference. The GSCB does this through the following ways:

2.1 – Quality Assurance Programme

The GSCB has a robust quality assurance framework and programme in place. The programme focuses on cross and inter-agency safeguarding themes and issues through:

- In depth analysis of one or two priority areas each year ('Deep-dive')
- 'Light touch' reviews across two or more agencies
- Analysis of safeguarding self-assessments
- Quarterly performance data and 'spotlight' focus.

The content of the quality assurance programme is determined by the priorities for the GSCB, which are identified through the annual Business Planning Day and informed by lessons and action plans arising from case reviews.

As well as the planned activity outlined above, there are a range of reviews that are done about individual cases, to provide valuable lessons about practice and systems in Gloucestershire, and how organisations are working together to safeguard and promote the welfare of children and young people. These are Serious Case Reviews, Child Death Reviews, Critical Learning Reviews (YJB) and reviews of child protection incidents that don't reach the criteria for a Serious Case Review.

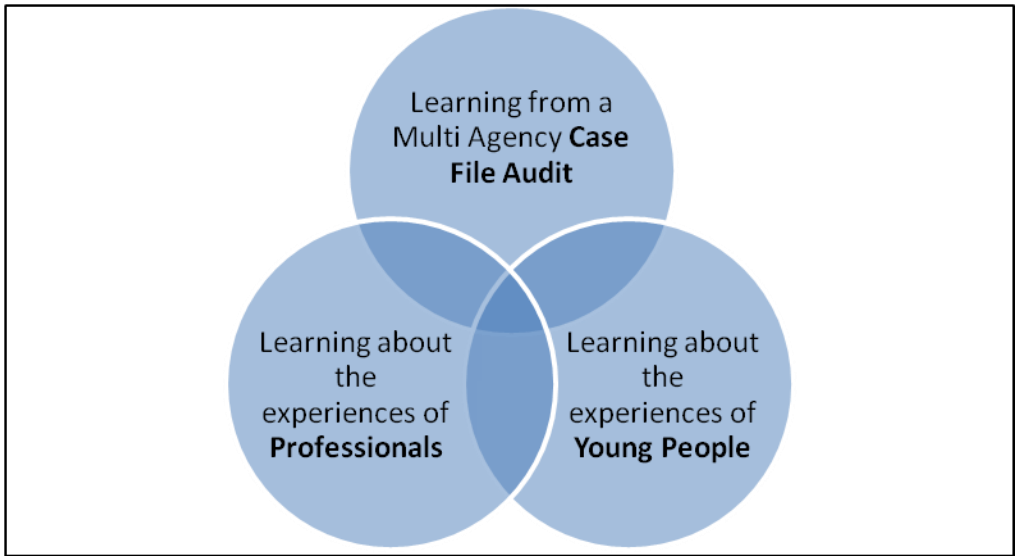
2.2 – Light Touch Reviews

The GSCB plans "light touch" reviews where it wants to check what is happening in a particular area of safeguarding, and there is a bit of local research needed in order to inform further improvements. For example, if the GSCB has a high degree of confidence about the quality of safeguarding supervision but wanted to check whether all the right professionals were benefiting, they might check this through a "light touch" survey, to learn whether deeper investigation or specific action is needed.

A "light touch" learning process does not mean one-size-fits-all. It means making best use of time by identifying the most important question about the topic being explored, but the results might be gained in a range of ways, for example reviewing policy documents, or doing an audit of a large sample of cases, or speaking to a number of professionals.

2.3 – Deep Dive Reviews

The GSCB plans "deep dive" reviews where it needs to learn from a range of sources in a more in depth way. Examples of deep dive reviews that have been undertaken to date are; Children Missing from Home or Care, children at risk of Child Sexual Exploitation, Children in Need and Domestic Abuse. A "deep dive" includes the following:



2.4 – Analysis of Safeguarding Self-Assessment

Safeguarding self-assessment is an essential part of the Learning and Improvement Framework. Organisations critically evaluate how well they are meeting their statutory safeguarding responsibilities under Section11 of the Children Act 2004 and Section 175 (and 157) of the Education Act 2002. These single agency responses are then analysed and tested at a strategic level to identify areas of good practice to build on, and weaker areas for development.

2.5 – Performance Information

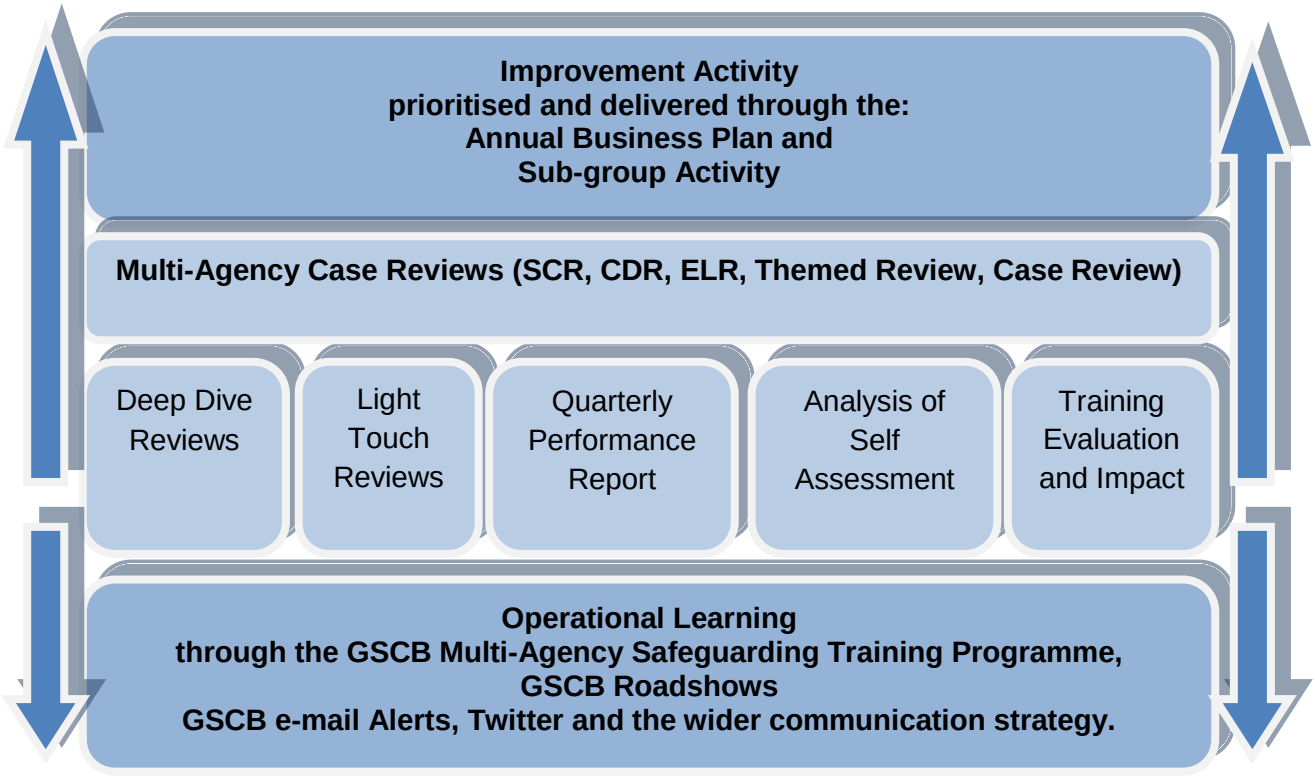
Performance information that the GSCB uses as part of the learning and improvement framework is of 3 types: quantitative information (how much), qualitative information (how well), and outcome information (what difference did it make). The challenge is to increase the focus on outcome information as that is what really matters, supported by qualitative and quantitative information. Examples are given below:

Quantitative Information "How much, how many?"	• Number of children subject of a CP Plan • Number of children missing appointments
Qualitative Information "How well did we do?"	• % of CP Plan children visited and seen at required minimum times • % of those children attending appointments regularly following proactive action
Outcome Information "Is anyone better off?",	• % of CP Cases in which most important safety outcomes are achieved at point of closure • % of children resuming appointments whose health outcomes are achieved

The quarterly performance report used by the GSCB will continue to be developed as part of the GSCB's commitment to continuous improvement.

2.6 – Learning and Improvement: How It All Connects

The following diagram shows the relationship between the learning activity described above, doing something about it, and feeding the learning back into training and staff development, both operationally and strategically.

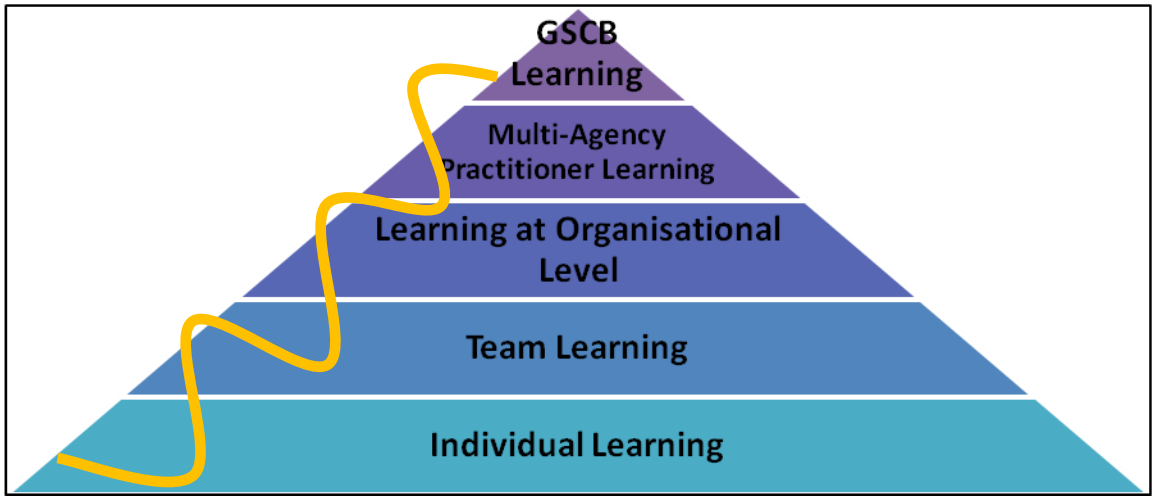


2.7 – Elements of Learning

Whilst this framework brings together the different sources of learning and how the GSCB uses what is learnt to shape improvement activity, it is important to acknowledge that the GSCB provides through a shared learning cycle one element of the wider safeguarding learning and improvement activity that takes place in Gloucestershire.

In some cases the learning is at individual agency level, and it will be incumbent on the individual agency to consider how the learning can best be implemented and in turn provide assurance to the GSCB that this has been achieved effectively.

The diagram below illustrates the elements of learning that take place at strategic, operational and individual level. The golden thread that the GSCB expects represented organisations to deliver at all levels of learning and improvement is the voice of the child. Learning from the views and experiences of children and young people is fundamental to making sure that we are child-focussed in our approach to service design and delivery and are able to meet the needs of the children of Gloucestershire.



Learning at Organisational Level

Employing agencies are responsible for ensuring that

- staff receive induction learning that includes appropriate information about child protection responsibilities and procedures to be followed
- staff have appropriate access to information about GSCB safeguarding training, findings from case reviews and safeguarding alerts
- staff are adequately released to take part in single and multi agency safeguarding learning related to their role
- staff are provided with appropriate reflective safeguarding supervision and support including safeguarding training
- there is an environment where staff feel supported and able to raise concerns about safeguarding where they feel there are lessons to learn.

Representatives from the voluntary and community sector will check the extent to which volunteers are supported in the above, through membership of the Safe Network.

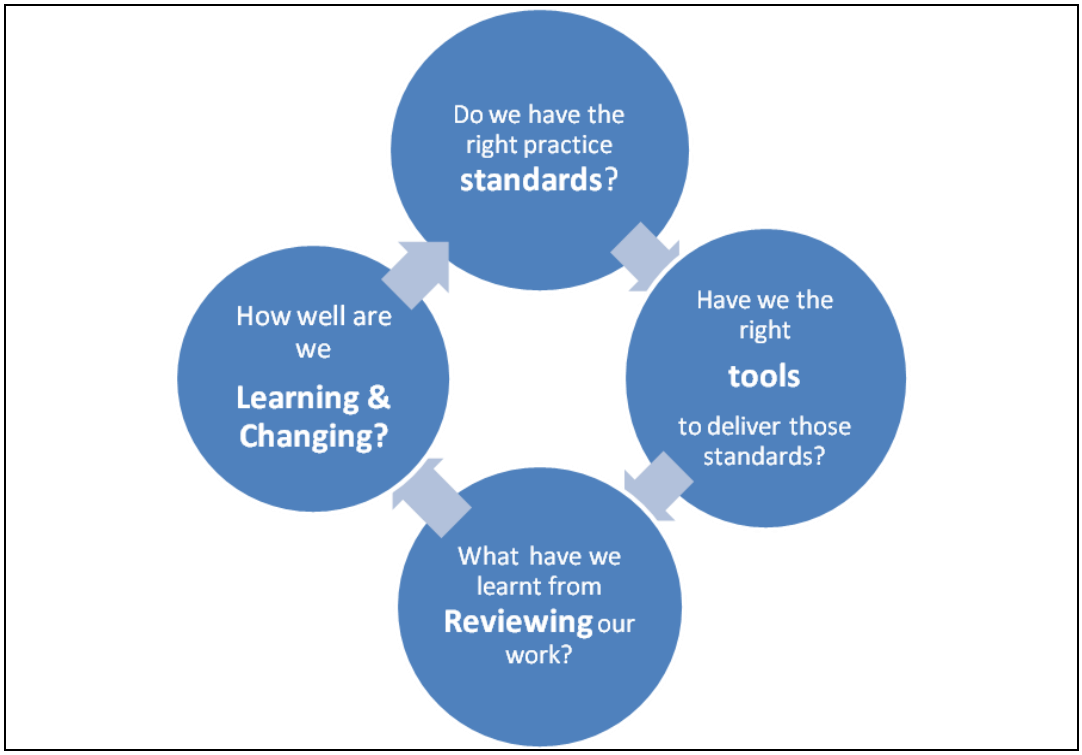
3.0 – Taking Stock: Making sure the Framework delivers on the Principles

3.1 - Recognising complex circumstances in which professionals work

All our case reviews, findings and reports now have ‘systems learning’ at the heart of it. This means understanding frontline practice in context. It means moving beyond the basic facts of what happened when, and appreciating the different perspectives of different workers, striving to go beyond identifying ‘what’ happened, towards explaining why it happened. The aim is to identify underlying factors in the work environment that support good practice or create unsafe conditions in which poor practice is more likely. This kind of learning is vital to improving the quality of services and the GSCB is committed to seeing it applied to every day safeguarding work, not just when tragedies happen.

3.2 - A culture of continuous improvement

In Gloucestershire, the culture of continuous improvement is supported through connecting up four key stages in the learning and improvement cycle:



3.3 – Proportionate approach to learning

Working Together 2013 gave far more flexibility to Local Safeguarding Children Boards to allow for a more proportionate approach to learning. The GSCB used this to develop a "menu" of tried and tested methods to apply according to the learning need. For example, the GSCB might require a Serious Case Review, but when it plans *how* this will be done it refers to the menu of learning methods to make sure that the learning process is proportionate to the scale and complexity of the issues being explored. This is set out in more detail in Appendix One.

3.4 – Keeping professionals involved

There are a number of well established mechanisms in place in Gloucestershire which ensure that professionals are involved at different stages in the learning and improvement cycle. Examples include:

Mechanism	Who/What
GSCB Multi-agency Reflective Learning Circle	Front-line practitioners are invited to meet GSCB representatives who form a learning circle to discuss their experiences of working with children and young people who have been subject of a Child Protection Plan for a second or subsequent time. The Group help overcome barriers and feed the learning back to the Board and to GSCB learning events.
GSCB Safeguarding Roadshows	All front line practitioners working with children, young people and their families are invited every year to attend an interactive learning and improvement Roadshow that is held in each of the six Districts.
Inter-Agency Safeguarding Training	This provides an interactive meeting point for professionals from across agencies: their feedback informs sub group activity, they learn from each other and the learning from case reviews or thematic reviews is embedded in relevant safeguarding training. The GSCB will also learn from training participants about what impact the learning has had on their practice. Learning from case reviews, Sub Group deep dive and light touch reviews is embedded in relevant GSCB multi-agency training programmes.
GSCB Alerts	GSCB Alerts are regularly sent out across all organisations represented on the Board, to help professionals keep up to date about learning opportunities and findings from reviews, both locally and nationally.
Links between Board members and staff	Findings from Sub Group activity is cascaded through GSCB representatives to front-line teams within their own agencies
Systems Reviews	The systems approach to learning includes learning from frontline practitioners from far earlier on in the process.
Twitter	Twitter is used as a mechanism to help professionals keep up to date with the latest news from the GSCB

3.5 – Transparency

Final reports from case reviews are published, unless to do so is not in the best interests of the children or public.

The systems approach to case reviews has meant that the reports have a real focus on how the system is functioning more broadly rather than purely focussing on the lessons that are learnt from the particular case.

The table below highlights the ways in which a system review differs from a traditional SCR.

Traditional learning method for a Serious Case Review	**Systems Approach to learning from a Serious Case Review(ref. SCIE)**
Reports focussed on ensuring lessons are learnt from the particular case	We still focus on learning about the case, but the emphasis is more on how that case gives us insights about how well the safeguarding system is functioning more broadly.
Organisations interview their own staff to produce Individual Management Reports (IMRs) that are then drawn together for the final learning report and recommendations	Staff are brought together far earlier on, as active contributors to the analysis. Meeting with practitioners as a group takes place in more depth so that the learning is better informed by their opportunity to correct, challenge or amplify the emerging analysis.
Compliance with policies and procedures plays a large role in the judgement of professional practice in the case	Professional practice is still judged in terms of its adequacy, but the systems approach seeks to avoid hindsight bias or judging practice in a vacuum.
Authors 'translate' findings into 'SMART' recommendations for action	Rather than just 'recommendations' , 'Findings' are also provided to the GSCB and these act as insights that highlight underlying influence on performance…these result in 'challenges'' put to the GSCB for them to respond to and drive forward improvements.

3.6 - Sustained Improvement

The learning and improvement framework takes a three year perspective, rather than having a yearly 'list' of issues to check, audit and report on this protects more time to also check that previous findings and recommendations are being acted on in a way that will make a more sustained difference. We check progress through:

- Performance reports that provide indicators of direction of travel
- Themed Audits
- S11 and S175 audits that build in a check on whether improvements on the previous year or areas for development identified in year are being delivered
- Peer Reviews that check the robustness and accuracy of our own assessment of how affective the safeguarding system is in Gloucestershire and what needs to improve.

4.0 - How Will we Know that the Learning and Improvement Framework is Making a Difference?

Through year on year improvements to the framework, the GSCB plans to increasingly be able to demonstrate and evidence impact through outcome statements and measures that check the extent to which:

- Quality early help is provided to children and families, from a range of organisations
- The right children are receiving statutory services from Children's Social Care
- Parents are reporting that contact with a service has made a positive difference to their and their children's lives
- Partnership working is delivering positive outcomes for children and their families.

5.0 Implementing and Reviewing the Framework

For this framework to be embedded and effective,

a) All GSCB members will make sure that the Learning and Improvement Framework is widely understood within their own setting; provide strategic leadership to their own settings and to GSCB sub-groups for learning and improvement priorities; endorse provision of the resources needed to deliver learning outcomes; seek assurance and evidence that learning is effective and embedded.

b) GSCB sub groups will routinely report on learning needs and findings

c) The GSCB Workforce Development Sub Group will make sure the training strategy compliments this framework and

d) The Framework will be reviewed and updated annually following a learning stock take as part of the GSCB Annual Business Planning Day.

Appendix One: Learning from Serious Cases and Significant Incidents

WHAT kind of learning	WHY is the learning important	WHO decides	HOW do we do the learning
Serious Case Review	*Learning when a child dies or has been seriously harmed, when we need to check the way organisations worked together to safeguard the child*	The SCR Sub-group makes a recommendation to the Independent Chair of the Safeguarding Children Board.	Traditional method for doing a Serious Case Review, with each organisation interviewing their staff and providing an Independent Management Review, with an Independent Review Author collating an overview report and recommendations. *Or* Systems approach to a Serious Case Review, or other Case Review: • SCIE 'Learning Together' • SILP • Various 'hybrid' models
Case Review	*a) Learning from cases that do not meet the criteria for an SCR, but can provide lessons about how organisations are working together b) learning from good practice and considering how it could be more widely embedded*	Decision by SCR Sub-group	Systems approach as described above
Child Death Review	*To understand themes, patterns and contributory factors in child deaths, to inform local action and national research and analyses of causes*	This is a statutory requirement overseen by the Child Death Overview Panel (CDOP)	Themed learning looking at all child deaths, with a focus on unexpected deaths
Extended Learning Review	*To learn from incidents involving a young person known to the Youth Offending Team, where there is potential learning across partner agencies.*	Youth Support Service reporting to the Youth Justice Board.	Systems method for case reviews, applying the principles of the learning & improvement framework. This learning is overseen by the GSCB to ensure transparency, challenge and independence.
Themed Review	*To learn across cases: where children or young people are vulnerable because of a common theme), to explore common areas of good practice or areas for improvement in professional practice.*	GSCB	Taking a sample of cases, examining files and discussing experiences with practitioners and young people