HSCB Learning and Improvement Framework

(Revised December 2016)

Working Together 2015 outlined that each local LSCB should maintain a 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.

The HSCB's Learning and Improvement Framework informs and responds to its **Quality Assurance Framework.** Both play an integral part in ensuring that the HSCB and its member agencies drive forward improvement and evaluate the impact of actions taken.

Harrow's framework will support the work of the HSCB and its 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 and that this learning is actively shared with relevant agencies;
- Reviews will 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 and help protect them from harm; and
- There is 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 with the public.

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, 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 must be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for action 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, including the LSCB's response to the review findings, in order to achieve transparency. The impact of the 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 the HSCB's annual report and will inform inspections; and

- *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.*

Audits and Inspections:
Reviews and audits of practice in one agency, or across agencies have been undertaken and reported to the HSCB. Harrow has a longstanding history of joint audits, where agencies work together to complete audits across the partnership. Learning from audits is achieved by discussion at the QA and SCR subgroups and disseminated by representatives of organisations in those groups back to their workforce, as well as being part of HSCB's local training.

Since 2015 the HSCB's multi-agency case audits have been constructed to seek evidence of improvement against significant practice themes drawn from previous auditing and case reviews. Wherever possible, multi-agency case audits are used to 'triangulate' evidence from thematic audits and reviews to ensure that the HSCB does not rely solely on one source of scrutiny.

The HSCB also requests findings of all internal and external reviews and audits, such as CQC, Ofsted, HMIC to be provided as a matter of course, if they relate to safeguarding or workforce matters, such as audits into supervision or staff training. This includes any appropriate audits carried out by the HSAB

Section 11 self-evaluations / audits
All statutory partners are required to undertake regular Section 11 (Children Act 2004) evaluations of responsibilities including governance, workforce recruitment, incidents, training, policy and procedures to give these to the LSCB for analysis and support. Agency returns are then submitted by their Board representative to the HSCB's Quality Assurance Scrutiny Panel for a support and challenge interview led by the Chair of the HSCB.

All other agencies are encouraged and supported to carry out Section 11 Audits and schools are provided with a tailored s11 audit for self-evaluation which can be submitted for scrutiny and comment by the Quality Assurance Sub-committee.

Performance Data
The Quality Assurance Subcommittee holds the HSCB Dataset which includes performance data of local agencies. This data is refreshed on a quarterly basis for the HSCB and exceptions are scrutinised.

All LSCB partner agencies are expected to contribute relevant data to this dataset. This data is used to highlight local trends, comparisons with statistical neighbours, and any matters of concern, which may lead to the identification of further action.

LSCB Annual Report
The HSCB's Annual Report will be prepared with involvement of HSCB Board Members, sub committees, to provide a comprehensive picture of safeguarding and early help.

Voice of the child
All agencies and sectors are expected to provide the HSCB with details of user feedback as a matter of course, and in situations where views are relevant to issues of safeguarding and early help. The HSCB in all parts of its work will endeavour with the help of local partners to ensure the experience of children and young people in Harrow is clear.

Learning and Improvement Case Reviews and Action Plans
Each SCR is completed using an appropriate methodology and independent lead reviewer. Training is provided to those who contribute chronologies and to members of the SCR

Review Group, as required.

SCRs and other case reviews should be conducted in a timely way which:
 Recognises the complex circumstances in which professionals work together to safeguard children;
 Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
 Seeks to involve professionals and families fully in reviews without blame;
 Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
 Is transparent about the way data is collected and analysed; and
 Makes use of relevant research and case evidence to inform the findings.

The HSCB will also conduct reviews of cases which do not meet the SCR criteria. It will also review instances of good practice and consider how these can be shared and embedded.

Management reviews of child protection incidents which fall below the threshold of an SCR have been undertaken in Harrow. Learning from these are discussed at the SCR subgroup and disseminated to partners, through training,

Development or amendments to policy or procedures, and in the LSCB's bi-annual learning newsletter.

The HSCB's Review Subcommittee oversees recommendations and action plans arising from these case reviews and their implementation. The HSCB will seek to support improvement, which should be sustained through regular monitoring and follow up.

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CDOP

The Child Death Overview Panel (CDOP) reviews all child deaths up to the age of 18 / school leaving age, and a Rapid Response Meeting is carried out for each unexpected child death, overseen by the Designated Nurse and the Designated Doctor for Safeguarding. Learning is reported to the CDOP, disseminated to local agencies and / or nationally, and in the HSCB's bi-annual learning newsletter.

Learning and Development

The HSCB evaluates its own safeguarding training and its impact on staff both on the day of training and three months after courses to obtain evidence of impact on practice.

The Learning and Development Subcommittee evaluates the performance of its local trainers and acts on feedback by participants. Any learning and development activity should include key lessons/messages from local or national SCR/learning lessons activities or from the annual LADO report. The LSCB will also request details of a single agency's safeguarding training or observe a session in order to evaluate its effectiveness. Each agency is also required to collate details of the effectiveness of its own training and local impact, as part of its quality assurance.