## North Yorkshire Safeguarding Children Board

### Learning and Improvement Framework

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<td>2.1</td>
<td>22/05/2015</td>
<td>Haydn Rees Jones, NYSCB Policy and Development Officer&lt;br&gt;Dallas Frank, NYSCB Business Unit Manager</td>
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#### Update and Approval Process

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### Issue Date

21 September 2015

### Review Date

20 July 2017

### Reviewing Officer

NYSCB Policy and Development Officer
Learning and Improvement Framework

1.0 Purpose of the Document

1.1 This document outlines the Learning and Improvement Framework for the North Yorkshire Safeguarding Children Board (NYSCB). The framework identifies the full range of learning experiences in which the NYSCB and its partners will engage and demonstrates how this information will be communicated, used both to drive service improvement and to inform the wider national community of learning identified.

1.2 The revised statutory guidance “Working Together” (2015) places a requirement on all Local Safeguarding Children Boards (LSCBs) to introduce learning and improvement framework.

‘Local Safeguarding Children Boards 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” (Working Together 2015).

1.3 In order to improve quality of service and drive change, it is important that professionals and partners working with children have opportunity to reflect on the quality of their services both from their own practice and that of others. Through its Learning and Improvement Framework NYSCB will work with partners to identify good practice and challenge any practice requiring improvement and use learning to drive practice development and to establish a multi-agency understanding of safeguarding practice across the county.

2.0 Scope & Objectives

2.1 The NYSCB ‘Learning and Improvement framework’ provides the mechanism by which the NYSCB will meet its statutory requirements and will also go beyond these requirements to ensure that all sources of learning are considered, recognised and used to drive change and improve the outcomes.
for children and their families. Through use of its Learning and Improvement Framework NYSCB will:

- Improve services to children and their families by developing the Children’s workforce.
- Ensure that the NYSCB fulfils its statutory obligations
- Ensure that the outcomes form reviews and other learning opportunities are used to influence practice development.
- Ensure the Children’s workforce is suitably skilled
- Ensure that pathways are in place which identify the link between learning outcomes and improved services
- Ensure that single and multi-agency training and learning is consistently audited and reviewed to ensure best quality and that learning form this is used to develop training programmes accordingly.

3.0 **Core Principles**

3.1 Reviews, such as Serious Case Reviews (SCRs) and Child Death Reviews (CDRs) are legislative requirement. The NYSCB will strictly observe the criteria for SCRs and CDRs to ensure that statutory reviews are undertaken when necessary.

3.2 Working Together (2015) introduces the category of “notifiable incidents”. These are incidents involving the care of a child which meets any of the following criteria:

- A child has died (including cases of suspected suicide), and abuse or neglect is known or suspected;
- A child has been seriously harmed and abuse or neglect is known or suspected
- A looked after child has died (including cases where abuse or neglect is not known or suspected); or
- A child in a regulated setting or service has died (including cases where abuse or neglect is not known or suspected)

3.3 If an incident meets the criteria for a Serious Case Review then it will also meet the criteria for a notifiable incident.

3.4 Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the functions of LSCBs. This includes the requirement for LSCBs to undertake reviews of serious cases in specified circumstances. Regulation 5(1)(e) and (2) set out an LSCB’s function in relation to serious case reviews, namely:
• 5(1)(e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.
• (2) For the purposes of paragraph (1) (e) a serious case is one where:
  (a) abuse or neglect of a child is known or suspected; and
  (b) either —
    (i) the child has died; or
    (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

3.5 A child is “Seriously harmed” where the child has sustained, as a result of abuse or neglect, any or all of the following:

• A potentially life-threatening injury;
• Serious and/or likely long-term impairment of physical or mental health or physical, intellectual, emotional, social or behavioural development.

3.6 This definition is not exhaustive. In addition, even if a child recovers, this does not mean that serious harm cannot have occurred.

3.7 Cases which meet one of the above criteria (i.e. regulation 5(2)(a) and (b)(i) or 5(2)(a) and (b)(ii)) will always trigger an SCR. It should be noted that Regulation 5(2)(b)(i) also includes cases where a child died by suspected suicide.

3.8 Where a case is being considered under regulation 5(2)(b)(ii), unless there is definitive evidence that there are no concerns about inter-agency working, the NYSCB will commission an SCR. In addition, even if one of the criteria is not met, an SCR will be carried out when a child dies in custody, in police custody, on remand or following sentencing, in a Young Offender Institution, in a secure training centre or secure children’s home. The same applies when a child dies who was detained under the Mental Health Act 1983 or where a child aged 16 or 17 was the subject of a deprivation of liberty order under the Mental Capacity Act 2005.

3.9 In cases which do not meet the threshold for SCR but it is believed could provide valuable lessons about how organisations work together to safeguard and promote the welfare of children, the NYSCB will identify appropriate methodologies to carry out a review of the case. These cases may be either notifiable incidents or examples of practice proposed to the NYSCB by
agencies. Reviews not meeting the criteria of an SCR will be proportionate and may be conducted either by a single organisation or by a number of organisations working together. All reviews will follow the principles in the NYSCB Learning and Improvement Framework.

3.10 The NYSCB and its partners will translate the findings from reviews into programmes of action which will lead to sustainable improvements and the prevention of death, serious injury or harm to children. The following principles will be applied by the NYSCB and its partners for all reviews:

- A culture of continuous learning and improvement across the organisations will be adopted that works 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 fully.
- Participation of families provides an important insight into cases. Families 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. Unless in exceptionally compelling circumstances, the final reports of SCRs and other reviews will be published, including the NYSCB’s response to the findings, in order to achieve transparency.
- The impact of SCRs and other reviews on improving services to children and families and on reducing incidences of deaths or serious harm to children will be described in the NYSCB Annual Reports as well as informing inspections, and

3.11 The diagram below outlines how the NYSCB will translate learning into improved outcomes for children and Young people in North Yorkshire.
3.12 The NYSCB will also develop learning from external sources. For example, the publication of the results of serious case reviews and other information published by LSCBs nationally. Similarly, learning can be derived from a number of other areas, including (but not limited to):

- The publication of national guidance
- Information obtained at conferences
- Focussed studies and research carried out externally to the NYSCB
- The Media
- Publications from other LSCBs
- Government initiatives and legislation.
- Ofsted inspections of NY and other SCB’s
- Feedback from children, young people and their families

3.13 Learning and understanding will be supported by a greater general understanding of developing issues, for example the identification of trends which reveal themselves over a period of time through the analysis of datasets. Learning will be generated through direct feedback from NYSCB partners, children, young people and their families, for example, through the complaints, comments and commendations process.
4.0 **Improvement**

4.1 The methods through which learning is analysed will depend on the learning points being raised. The level of analysis engaged by the Board will vary greatly and must be:

- Proportionate to the seriousness of any potential learning incident
- Proportionate to the risk to the on-going safeguarding and welfare of children and young people
- Appropriate to the specific issues relating to a case or situation

4.2 The NYSCB will facilitate, practitioner learning events to enable colleagues to come together to consider learning points identified through the various methods outlined in this framework. These will include:

- Development Days – Facilitated events arranged to bring partners together to discuss and analyse issues and identify specific ways forward
- Thematic Peer Review Panels – Specific events designed to bring professionals involved in specific cases together to discuss and analyse issues, identify learning and challenge practice
- Facilitated Learning Events – to consider National and Local developments regarding safeguarding children in line with the NYSCB business plan.
- Class room training developed within the NYSCB training strategy to reflect partners identified needs and reflect National and Local issues.
- On line learning opportunities
- Briefings – delivered to practitioners as a result of issues which arise as a result of National or local learning from reviews or new legislation.
- NYSCB research and findings from audits

4.3 Analysis will be used to:

- Identify where systems, policies, procedures and practice can be modified and enhanced
- Challenge colleagues regarding single agency practice or policy developments
- Develop an LSCB understanding and view of safeguarding activity within partner agencies and the safety of children and young people in North Yorkshire.

5.0 **Responsibility/accountability**

5.1 The final decision on whether to conduct an SCR rests with the NYSCB Independent Chair. If a SCR is carried out by the NYSCB, this will normally be
completed within six months of initiating the SCR. However, if this is not possible (e.g. because of potential prejudice to related court proceedings), every effort will be made while the SCR is in progress to:

- Capture points from the case about improvements needed; and
- Take corrective action to implement improvements and disseminate learning.

5.2 When compiling and preparing to publish reports, the NYSCB will consider how best to manage the impact of publication on children, family members and others affected by the case. However, unless there exceptionally compelling reasons not to publish an SCR the NYSCB will normally publish result in a report which is accessible via the NYSCB website for a minimum of 12 months. The NYSCB will also publish either as part of the SCR report or in a separate document, information about: actions which have already been taken in response to the review findings; the impact these actions have had on improving services; and what more will be done.

5.3 Where recommendations from SCRs or Reviews impact on the policies, procedures and practice of the Board, these must be reported to the NYSCB Executive for approval and provided to the NYSCB Board for information.

6.0 Learning and Implementation

6.1 The communication of learning is essential in order to improve practice and drive change within the NYSCB and its partner agencies. This drive for change must be focused on developing services and improving outcomes for children, young people and their families. The table on the next page identifies the core methods by which the NYSCB will learn, evaluate, include, monitor and disseminate learning.
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The flowchart on the next page identifies the pathways through which learning will impact on the strategies, policies, procedures, and practice of the NYSCB and its partners, driving service development and improving outcomes for children.