LEARNING AND IMPROVEMENT FRAMEWORK

16th June 2017 (Final)

Version	Date	Author	Changes	Next stage
V0.3	23.06.2016	C Tew/H Pearson	Published as updated L&R doc only.	Awaiting City agreement
V0.4	07.02.2017	Janet Russell	Clarifications and confirmation of information	Consultation
V0.5	18.04.2017	Janet Russell	LLR LSCB/SAB combined LIF	Consultation and approval
V0.6	17.05.17	Beverley Czyz	Update following feedback after SIRG 27.04.2017	Final Sign off
V1	16.06.17	Beverley Czyz	Final Version	Dissemination

Contents

Appendices

1. Introduction

1.1 The Leicester City and the Leicestershire & Rutland Safeguarding Children and Safeguarding Adult Boards are committed to developing a shared Learning and Improvement Framework locally across both children and adult safeguarding, which will support a consistent approach across the sub-region.

1.2 This approach relies upon local statutory and non-statutory agencies engaging with a continuous cycle of learning and improvement, under the established Local Safeguarding Board(s) arrangements. This document describes the Learning and Improvement Framework adopted by the Safeguarding Boards and its member agencies.

1.3 The responsibility of the Local Safeguarding Boards is to seek assurance of effectiveness of the inter-agency arrangements to keep children and adults safe.

1.4 This Framework describes the processes by which the Safeguarding Boards review the effectiveness of our local safeguarding partnerships and individual agencies by using a comprehensive range of local information to evaluate the quality of local activity and outcomes against agreed practice standards. The Safeguarding Boards oversee any areas where single or multi-agency improvement has been identified within safeguarding reviews, audit or safeguarding performance review activity.

1.5 The Learning and Improvement Framework consists of four quadrants:

- Embedding learning from review processes
- Performance Framework
- Using audits to improves practice and outcomes
- LSCB/LSAB effectiveness

1.6 No one quadrant in isolation can represent, or drive, the learning and improvements in local safeguarding practice. Effective partnership working underpins all areas of activity.

1.7 The LLR Children and Adults Local Safeguarding Boards has its own structure of groups that manage reviews and other learning and improvement processes.

1.8 In Leicester City, the Safeguarding Adults Board subgroup is called the Adult Review and Learning Group (ARLG) and the Children's Safeguarding Board group is called the Serious Incident Review Group (SIRG).

1.9 In Leicestershire & Rutland, the group for both the Adults and Children is called the Safeguarding Case Review (SCR) Subgroup.

1.10 For clarity and consistency throughout this document, these groups are referred to as the Serious Case Review Group.

1.11 Our Safeguarding Boards are committed to ensuring that learning arising from reviews and audit processes are shared with staff working across local agencies and that, locally, we demonstrate continual improvement across our safeguarding activities, which improves the safety and outcomes for children, families and adults at risk.

1.12 The Safeguarding Boards have an Information Sharing Agreement (ISA) which supports all kinds of review processes and audit work. The agreement details when information can be shared lawfully by agencies for the purposes of safeguarding children and adults at risk.

1.13 The ISA can be found on **http://lrsb.org.uk/uploads/safeguarding-children-isa-(information-sharing-agreement)-2015---16.pdf**

2. Our Learning and Improvement Principles

This framework derives from the principles for learning and improvement as set out in Working Together 2015. The LLR LSCB and LSAB agree to the following:

- The child, vulnerable person and their family are at the centre of the process.
- There is a **culture of continuous learning and improvement**
- Reviews of serious cases should be led by individuals who are **independent**
- **Practitioners and managers** are fully involved in Serious Case Reviews or learning reviews
- Families, including surviving children and adults, should be invited to contribute to reviews. This is important for ensuring that the child's voice and lived experience is at the centre of the process.
- Case reviews should be **proportionate**
- **Improvements must be sustained, monitored and reviewed** so findings make a real impact
- Learning must contribute **to improved services and outcomes for children and young people and vulnerable adults.**
- **Local partnerships** are clear about where services and practice needs improvement and how resulting action plans will lead to sustainable improvements
- Partners are effective at challenging each other and holding each other to account
- We are honest and transparent in our appraisal of practice
- We will learn from experience, both good and problematic

2.1 The framework operates as a "feedback loop" and is explicit in describing how learning and areas for practice improvement are:

- **IDENTIFIED**
- **DISSEMINATED**
- **EMBEDDED**; and
- **EVALUATED** for direct **IMPACT** on outcomes for children and young people and vulnerable adults.

3. Identifying Learning

3.1 **"The local framework should cover the full range of reviews and audits which are aimed at driving improvements to safeguard and promote the welfare of children."** *(Working Together 2015)*

3.2 This learning and improvement framework has been developed on the understanding that learning about multi-agency safeguarding does not only happen in the context of a formal review process, but from a much broader set of complex systems and processes across a range of agencies.

3.3 LLR LSCBs and LSAB foster a learning culture across all of its work; an effective learning and improvement framework will bring together in a joined up way performance data, assurance activity and the various views and experiences of children, young people, vulnerable adults and their families and that of frontline practitioners as illustrated below. The aim is to use the sources of information to look at what is working well, what is not and what needs to happen to improve practice.

3.4 At the forefront of all of these mechanisms will be a focus on ensuring the **child's and vulnerable adult's experience** is captured (including views of parents and family members) and this informing what could be improved from their perspective to influence better practice and service delivery in the future.

3.5 Single and multi-agency reviews play an important part in the Learning and Improvement framework for the safeguarding Boards and well-functioning Boards are able to evidence that all staff are aware of the outcomes of local reviews and take account of these in their practice. In those circumstances where more formal review is required; there is a suite of review options that can be tailored to the individual case. (Please refer to section 4 for more details)

4. Reviews of Practice

4.1 Reviews are undertaken to learn from past events. The LLR Safeguarding Boards will use this learning to improve practice and services for vulnerable children, adults and their families.

4.2 Reviews consolidate learning about what is working well and what presents challenges to organisations (both child and adult-facing) within Leicester, Leicestershire and Rutland. Paramount to all review processes will be a focus on trying to understand events from a child/adult's perspective.

4.3 **Local Safeguarding Children Boards (LSCB)** and partner agencies are required under Chapter 4 of *Working Together to Safeguard Children* (HM, 2015) to apply the following principles to all reviews:

- There should be a culture of continuous learning and improvement across organisations
- The approach taken with 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 or being blamed for actions they took in good faith
- Families including children should be invited to contribute to these reviews.

4.4 The Social Care Institute for Excellence (SCIE) has developed and piloted the systems approach as a methodology for conducting safeguarding reviews. Professor Eileen Munro, in her review of safeguarding in 2012, spoke positively about the systems methodology, alongside root cause analysis to support learning in reviews. *Working Together to Safeguard Children* (HM, 2015) positively supports alternative processes of learning alongside the Serious Case Review statutory framework.

4.5 It states:

"LSCBs may use any learning model which is consistent with the principles in this guidance, including the systems methodology recommended by Professor Munro."

4.6 The Care Act 2014 requires **Safeguarding Adults Boards (SABs)** to undertake Safeguarding Adults Reviews (SARs) for cases in its area where an adult, with needs for care and support, has died or experienced serious abuse or neglect and there is reasonable cause for concern about how the SAB, member agencies or other persons worked together to safeguard the adult.

4.7 The Care Act does not introduce a specific method that has to be used to undertake SARs giving SABs freedom to conduct them in the most appropriate manner.

4.8 The Leicester, Leicestershire & Rutland Learning and Improvement Framework provides an overview of the different types of proportionate enquiry used locally to support learning that will be disseminated and embedded to improve safeguarding practice across local agencies.

5. How do we review practice?

By undertaking statutory and non-statutory reviews of serious incidents!
See appendix (a) and (b)
Detailed below is a snapshot of the type of **single and multi-agency reviews** undertaken.

- Children's - Serious Case Reviews
- Child Death Reviews
- Safeguarding Adults Reviews (SARs)
- Adults - Domestic Homicide Reviews
- Multi-agency Public Protection Arrangements Serious Case Review
- Non-statutory
- Multi-Agency Learning Reviews
- Single Agency Learning Reviews/Serious Incident Investigations
- Peer Reviews
- Complaints, compliments, professional disputes and whistleblowing

5.1 Children's - Serious Case Reviews (SCRs)

Serious Case Reviews are described within *Working Together to Safeguard Children* (HM, 2015); these are statutory reviews undertaken by Local Safeguarding Children Boards (LSCBs) for cases where abuse or neglect is known or suspected and either:

- A child dies; or
- A child is seriously harmed and there are concerns as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

5.1.1 Additionally, LSCBs are required under Regulation 5 of the Local Safeguarding Children Board Regulations 2006 to undertake a SCR 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 unit; where the child is detained under the Mental Health Act 2005; or where a child aged 16 or 17 was the subject of a deprivation of liberty order under the Mental Capacity Act 2005.

5.1.2 Regulation 5 (2) (b) (i) includes cases where a child dies with suspected suicide. A SCR should be considered whenever a child has been seriously harmed in any of these situations unless there is definitive evidence that there are no concerns about inter-agency working. The LSCB must commission a SCR.

5.1.3 Working Together 2015 introduced for the first time a definition of "Seriously harmed"; it includes, but is not limited to, cases 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.

5.1.4 This definition is not exhaustive. In addition, even if a child recovers, this does not mean that serious harm cannot have occurred. LSCBs should ensure that their considerations on whether serious harm has occurred are informed by available research evidence.

5.1.5 There are a variety of methodologies that can now be utilised to support the review process – see Appendix C for an overview of these.

5.1.6 Leicester LSCB has a separate framework for the Process for the Management of Notifications of Serious Incidents and Serious Case Review.

5.2 Child Death Reviews

Chapter 5 of *Working Together to Safeguard Children* (HM, 2015) sets out the procedures to be followed when a child dies. There are two inter-related processes for reviewing child deaths (either of which can trigger a Serious Case Review):

- A rapid response by a group of key professionals who come together for the purpose of enquiring into, and evaluating, each unexpected death of a child

- An overview of all child deaths (under 18 years) in the local safeguarding children board (LSCB) area(s), undertaken by a panel.

5.2.1 Child Death Overview Panels (CDOPs) are responsible for reviewing information on all child deaths, and are accountable to the LSCB Chair. Child death review processes became mandatory in April 2008; however, LSCBs have been able to implement these functions since April 2006. The learning from these reviews is received by the LSCB Boards in an Annual Report. Lessons learnt from local review including early learning from CDOP are disseminated through safeguarding briefings.

5.2.2 The responsibility for determining the cause of death rests with the coroner or the doctor who signs the medical certificate of the cause of death (and therefore is not the responsibility of the Child Death Overview Panel).

5.2.3 Click the link for further details regarding **Child Death Reviews.**

5.3 Safeguarding Adult Reviews (SARs)

The Care Act 2014 introduced mandatory Safeguarding Adult Reviews for the first time.

5.3.1 It states a Safeguarding Adults Board (SAB) must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if:

- There is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and condition 1 or 2 is met.

- Condition 1 is met if —
    a) The adult has died, and
    b) The SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

- Condition 2 is met if —
    a) The adult is still alive, and
    b) The SAB knows or suspects that the adult has experienced serious abuse or neglect.

5.3.2 A SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

5.3.3 The Care Act 2014 goes onto say that each member of the SAB must co-operate and contribute to the carrying out of a review under this section with a view to identifying the lessons to be learnt from the adult's case, and applying those lessons to future cases.

5.3.4 No one model is prescribed, SAB must determine locally the process for undertaking a SAR. There are a variety of methodologies that can now be utilised to support the investigation process – see section 4 for an overview of these methods.

5.3.5 Further details can be found on the link regarding the **Safeguarding Adult Review**.

5.4 Domestic Homicide Reviews (DHRs)

Domestic Homicide Reviews (DHRs) are statutory reviews under section 9 of the Domestic Violence, Crime and Victims Act (2004), which came into force in April 2011. These reviews enquire if agencies locally are responding appropriately to victims of domestic violence by offering and/or putting in place suitable support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and violence.

5.4.1 The DHR will also assess whether agencies have sufficient procedures and protocols in place, which were understood and followed by their staff and where there may be a need to improve these procedures.

5.4.2 Potential DHR cases are discussed within the Safeguarding Boards SCR Groups and commissioned on behalf of the Community Safety Partnerships who maintain statutory responsibility to:

a) establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

b) identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

d) prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

e) contribute to a better understanding of the nature of domestic violence and abuse; and

f) highlight good practice.

5.4.3 Learning from the DHR is fed back to staff within safeguarding briefings or workshop events.

5.4.4 Click on the link for further details regarding **Domestic Homicide Reviews.**

5.5 Multi-agency Public Protection Arrangements (MAPPA) - Serious Case Reviews

The work of the Multi-Agency Public Protection Arrangements (MAPPA) is overseen and managed by the Strategic Management Board (SMB). A case may be considered for a statutory MAPPA Serious Case Review where there are concerns about multi-agency failures to manage a serious offender in the community, or a further serious offence takes place. The SCR Group will support scoping across agencies. A panel is established and terms of reference (ToR) agreed. An Independent Author produces an overview report and identifies learning from the case. The Report is received by the MAPPA SMB who oversees the progression of the actions. Relevant multi-agency learning is shared with the relevant Safeguarding Boards Serious Case Review Group.

5.5.1 Click on the link for further details regarding **MAPPA SCRs**.

5.6 Non-statutory Reviews

LSCB/LSABs should also (where appropriate) conduct reviews of cases which do not meet the criteria for a statutory review, but which can provide valuable lessons about how organisations/agencies are working together to safeguard and promote the welfare of children and adults. Although not required by statute these reviews are important for highlighting good practice as well as identifying improvements which need to be made to local services. Such reviews may be conducted either by a single organisation/agencies or by a number of organisations/agencies working together.

5.6.1 Reviews are not ends in themselves. The purpose of reviews is to identify improvements which are needed and to consolidate good practice. LSCBs/LSABs and their partner agencies should translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of deaths, serious injury or harm to children and vulnerable adults.

5.6.2 Partner agencies should give serious consideration to notifying the LSCB/LSAB of cases which may not meet the criterion for a statutory review but there remains particular concern about inter-agency safeguarding practices. If in doubt discuss the

circumstances with the safeguarding board manager who will take advice from the Chair of learning review subgroup.

5.7 Multi-Agency Learning Reviews

This is a meeting of key professionals or managers across agencies to discuss a single or a cluster of cases where there are concerns about: the multi-agency management of the case, and where it is recognised there was a "near miss" or the events could have led to more serious outcomes that do not meet statutory review criteria. The SCR Group will agree the terms of reference for this type of reflective review, which is chaired independently by a Senior Manager from an agency not involved in the case. The aim of the multi-agency case discussion is to take remedial action across agencies to prevent the likelihood of this happening again. This type of review is particularly useful where a system/process needs a timely review to prevent further risk. A summary report and recommendations/actions are received back to the commissioning SCR Group.

5.7.1 It is recommended this approach is only used on cases where there is a single episode or cluster of similar key practice episode that took place over a brief period.

5.7.2 A brief summary of the key practice episode would be written up (anonymised) with agreed recommendations/actions agreed. Progression of the action plan is overseen by the serious case review group.

5.8 Single Agency Learning Reviews

A Single Agency identifies a Serious Incident requiring investigation/review that meets the agency's threshold to conduct a review.

5.8.1 The incident clearly only involves this agency, but safeguarding is a significant feature of the review and learning would benefit learning to be shared with member agencies. Agencies need to determine that, if other agencies are involved, they ensure their contribution is built into the review process.

5.8.2 Even where there is no other agency feature in a single agency learning review if the finding suggest there are implications for the inter-agency response to safeguarding children or adult then the findings must be shared with the LSCB and LSAB partners.

5.8.3 The Serious Case Review group receives a brief summary of learning and the action plan being taken forward by the agency.

5.9 Peer Reviews

A peer review is undertaken by an appropriate "peer": for example, one Board may undertake a review of another Board's effectiveness, or a provider agency may review another provider. Peer Review methods are also employed across agencies to enable comparisons on performance across a range of standards, or used to focus on particular activity. An analytical report using qualitative data or quantitative data would be received drawing comparisons and conclusions.

5.9.1 There are various methodologies that can be used to support a learning review process; some of these are shown at **appendix (a)** however this is not an exhaustive list. What has become common practice is the use of elements from a number of

approaches to create a bespoke model to ensure each review is managed proportionately.

5.10 **Complaints, Compliments, Professional Disputes and Whistleblowing**

The LSCB inter-agency procedures provide that key messages from complaints, compliments, professional disputes, escalations and whistleblowing should be used to inform learning and improvement activity including development of procedures. Any learning and improvement activity required will be addressed through the relevant Executive Group and delivered by the appropriate Sub group under the auspices of their delivery plan.

6. Why audit?

6.1 Having a systematic auditing process in place allows the Boards to monitor the quality of practice and judge where there is a need to target areas for development.

6.1.1 The auditing process provides one of the best learning opportunities for both workers and organisations. Auditing will assess and measure the quality of professional practice and test:

- Whether the adults, child, young person's voice has been heard through intervention.
- Whether multi-agency practice is making a difference for children, young people adults and their families – captured in large part by involving them in the audit process.
- Whether or not what is happening ought to be happening
- Whether current practice meets required standards, procedures and published
- Guidelines
- Whether current evidence about good practice is being applied

In addition to review processes the **LSCB/LSAB has a programme of audits** to review single and multi-agency practice. They include:

- Single-agency case file audits
- Multi-agency case file audits (including LLR LSCB Joint audits)
- Section 11 audits
- Safeguarding Adult Assessment Framework (SAAF)

6.2 Single Agency Case File Audits

The Chair of the Safeguarding Effectiveness Group (SEG) makes a formal request to colleagues in partner agencies for a schedule of reporting of their own agency/ organisation's safeguarding case file audits, where these exist.

6.3 Multi-Agency Case File Audits (MACFAs)

The purpose of MACFAs including LLR LSCB audits is to provide regular and effective monitoring and evaluation of frontline practice and the quality of management oversight. However, it is not enough merely to gather the findings; these must be used to improve practice.

6.3.1 The theme of a particular MACFA can be determined by:

- A recommendation by a statutory inspectorate that audit activity should inform practice and judgements about effectiveness
- A recommendation arising from a review process conducted by the Board
- Practice to support a particular priority group of service users, such as Looked After Children (LAC)
- Trends in data and performance monitoring that require further investigation.

6.3.2 Guidance for participants in the MACFA process is made available to practitioners prior to the event.

6.3.3 The safeguarding performance and assurance groups receive reports on the findings of each MACFA and monitors progress on an action plan arising from each of the various audits.

6.4 Section 11 Audits

A Section 11 Audit enables the relevant Safeguarding Children Board to assess whether statutory partners are fulfilling their statutory responsibilities to help, protect and care for children and young people. Leicester Safeguarding Children Board works with colleagues in the Leicestershire & Rutland Board Office to conduct a joint annual Section 11 audit of partner agencies.

6.4.1 The findings from the audit are reported to the Executive Group and/or SEG on a regular basis.

6.5 Audits under Section 175 and 157 of the Education Act 2002

Section 175 of the Education Act 2002 came into effect on the 1 June 2004. Section 175 requires school governing bodies, local education authorities and further education institutions to make arrangements to safeguard and promote the welfare of children. Similar requirements are in place for proprietors of Independent Schools under Section 157 of the Education Act 2002.

6.5.1 The LLR LSCBs is required to monitor the effectiveness of safeguarding arrangements in schools and undertakes an audit cycle consistent with the Section 11 audit process. The findings are analysed with suggested improvements made to assist schools who have not yet reached the required standard.

6.6 Safeguarding Adult Assessment Framework (SAAF)

The SAAF is the Adults Safeguarding Boards equivalent of the Section 11 audit. It is managed in the same way and the results are regularly reported to the Executive Group and /or SEG in the same way.

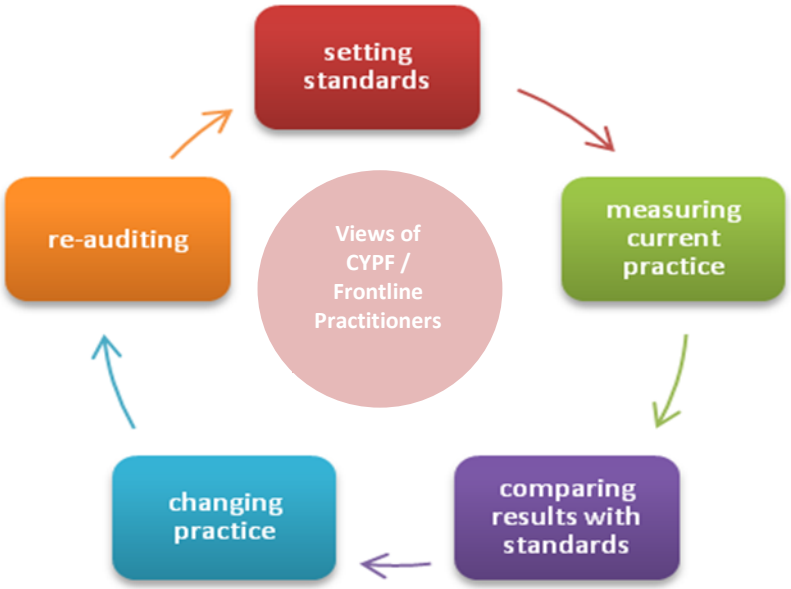
6.7 External Lessons

Opportunities for learning from national reviews, feedback from corporate structures and other forums external to the Boards are equally relevant to how our safeguarding systems improve. The Boards will take account of such learning and ensure it is appropriately disseminated or included in related action plans targeting service improvement. For example by sharing Executive Summaries of the learning for dissemination across Leicester, Leicestershire and Rutland

7. The Local Safeguarding Boards Performance and Assurance Cycle

7.1 Outside of learning reviews the local safeguarding boards have other methods of seeking assurance on compliance with multi-agency safeguarding procedures and quality of practice. These include a range of activity detailed below.

7.1 The Local Safeguarding Boards performance and assurance cycle is shown in diagram form below:



7.2 Performance Management Information – LLR LSCB/LSAB Datasets

The Boards assurance and effectiveness groups manage the collection and analysis of performance data information in relation to defined aspects of safeguarding practice in accordance with the Boards business plan and core datasets.

7.3 The datasets are designed to provide quantitative information to monitor key points in the child/adults journey through safeguarding systems in order to provide evidence for the support or challenge to partners of their individual and multiagency response to the LLR safeguarding arrangements.

7.4 The Boards respective sub-groups will oversee and agree the dataset and regularly review the merit of the indicators for their relevance. The dataset is scrutinised alongside qualitative information (reviews, audits and specific assurance questionnaires) as part of the quality assurance and performance management framework and in turn for learning and improvement.

8. Single and Multi-agency Front-line Practitioner Intelligence

8.1 Engagement with front-line staff, first-line managers, Child Protection Chairs and Independent Reviewing Officers to understand their experiences of what is working well and what is not, is key to the Boards in gaining a transparent understanding of the realities of front-line child and adult protection and safeguarding work. Critically the examination of practitioner feedback in respect of the knowledge, skills, experience and opportunities they have for direct work and engagement with children, young people and vulnerable adults.

9. Engagement of families and service users

9.1 The Safeguarding Boards are committed to approaches to strengthen family and service user engagement and participation in safeguarding processes. This will also improve feedback on experiences following a safeguarding process. The information gathered by all agencies from adults/carers/families who interface with services (plaudits, complaints) provides organisations with a valuable insight into service delivery.

10. The Boards' Risk Register

10.1 The risk register is an important element in the business of the Safeguarding Boards as it identifies risks to the delivery of safeguarding practice across the partnership and its impact on children, vulnerable adults and their families. The risk register is manged by the Safeguarding Boards.

11. Annual Reports

11.1 The requirement for the Annual Report is to "provide a rigorous and transparent assessment of the performance and effectiveness of local services" and should be informed by evidence gathered from agencies. The Report should therefore be a reflection of the assurances (or concerns) raised by the Boards over the course of the preceding financial year.

12. Sharing the Learning

12.1 An important part of supporting a culture of continuous learning and improvement is to disseminate and embed good practice from what information tells us about what works well and learning from when things go wrong. Integral to the success of this framework will be the sharing of learning across organisations to ensure transparency, accountability and consistent improvement to practice.

12.2 Senior Officers across all organisations will be expected to drive a culture whereby learning is effectively disseminated and embedded into the day to day practice of front-line staff and volunteers.

How the Boards **shares its lessons**

- Board's Training Programme and Strategy
- Large scale multiagency safeguarding conferences
- Single Agency Training
- Multi-agency thematic briefing notes
- Single Agency Briefings
- Campaigns and promotional material
- Communications through Board and partner agency web / Twitter
- Publication of SCRs and Case Reviews
- Annual Reports
- Website

12.3 For any review undertaken by the Board, the dissemination of the learning is achieved by a number of means:

- The key messages are shared with partners at Board meetings, with the expectation that Safeguarding Leads will then disseminate these messages within their own agencies/organisations. Briefing presentations are made available to Safeguarding Leads to assist in the sharing of key messages

- Learning from reviews is incorporated to inform the development and content of single and multi-agency training and learning content. A formal system of reporting learning outcomes is fed into commissioning group

- Half-day workshops for multi-agency groups take place as soon as possible after the Board has been briefed on the review outcomes (timing is subject to legal and publication considerations)

- Key learning is featured in the Safeguarding Boards newsletters of the safeguarding messages that are most relevant to the range of disciplines covered by the Boards

- The learning is shared with other Board colleagues at a range of joint business meetings (SCR Media Planning meetings, LLR Procedures and Development Subgroup, the Joint City and County Executive Groups, etc.)

- The learning is shared with colleagues in Children's Services via the mutual attendance on each other's ARLG or Children SCR Groups and Board meetings

- The Board's website features any published review.

12.4 In terms of embedding learning, culture outweigh strategy every time, and together with strong leadership, this can be achieved through:

- Policy and Procedure Development
- Reflective Practice and Supervision
- Collaborative Joint Working Arrangements
- Agency/Service Team Meeting structures that focus strongly on how identified improvements will be implemented and make sense for individual staff on the front-line.

13. Monitoring and Evaluating the Effectiveness of Safeguarding Training

13.1 The aim of the activity outlined in this framework is to make a positive impact on frontline practice and in turn improve outcomes for children and young people and adults in Leicester, Leicestershire and Rutland.

13.2 Our most frequent question will be **"what difference have we made** to adult/children's safety and wellbeing as a result of identifying learning, disseminating lessons and embedding those lessons in day to day practice."

13.3 There will be a variety of mechanisms by which we will achieve this, using new and existing approaches, however the most important evaluation will be the targeted tracking of individual children/adults and being clear about the difference that any learning would have made if applied at the time of intervention.

13.4 One main conceptual framework for assessing the effectiveness of training ("McKendrick's Four Stage Model"). This is issued as the basis on which to gather evidence to support a judgement on effectiveness. It is intended that the evidence gathered under this framework will identify areas of weakness, the causes of those weaknesses and enable the partnership training strategy to adapt and address these.

13.5 The system has two elements:

a) Evidence on the amount, quality and effectiveness of single agency safeguarding training will be provided by workforce leads in statutory partner agencies.

b) Evidence on the amount and effectiveness of safeguarding training provided as part of the Section 11 and SAAF performance framework, Provider Annual Safeguarding Reports and audit processes.

Appendix (A): Summary - Types of statutory review processes

TYPE	REVIEW PROCESS
CHILD SERIOUS CASE REVIEW	• Meets Working Together 2015 statutory guidance • Significant harm abuse or neglect & omissions in management case across agencies identified in initial scoping • Independent Chair agrees with recommendation • Independent Author / Panel established / Terms of Reference agreed • Methodology for conducting review is agreed – this may include the requirement for a single agency review • Overview report identifies key practice episodes, learning and actions
CHILD DEATH REVIEW	• Unexpected Child Death – meets definition Working Together 2015 for statutory review within CDOP process • Abuse or neglect of child not suspected • Likely public health learning – prevention focused • CDOP panel established, investigation progressed to agreed TOR • Overview Report identifies key learning and actions • Learning from CDOP reported into LSCB Safeguarding Effectiveness Group (SEG) & Annual Report
SAFEGUARDING ADULT REVIEW	• Care Act 2014 criteria for adult Serious Case Review met • Independent Chair agrees with recommendation • Independent Author / Panel established / Terms of Reference agreed • Methodology agreed for conducting review • Overview report identifies learning and improvement • Actions progressed and overseen by SCR Group
DOMESTIC HOMICIDE REVIEWS	• Commissioned by Community Safety Partnerships • Coordinated through SCR Group of relevant Board area • Independent Author Commissioned and DHR panel established • Terms of Reference for the review agreed. IMR reports requested from involved agencies • Overview report agreed by panel and actions • Actions progressed

TYPE	REVIEW PROCESS
MAPPA SERIOUS CASE REVIEWS	• Case meets criteria for statutory MAPPA Serious Case Review • Management of serious offender has failed around public protection and number of agencies are involved • SCR Group assists scoping of case across Board agencies • MAPPA panel agree Terms of Reference. • Report identifies findings and agreed actions, received by SMB MAPPA who oversee progress
MENTAL HEALTH HOMICIDE REVIEWS	• In April 2013 NHS England became responsible for commissioning independent investigations into homicides (sometimes referred to as mental health homicide reviews) that are committed by patients being treated for mental illness. The purpose of an independent investigation is to review thoroughly the care and treatment received by the patient so that the NHS can: ○ Be clear about what – if anything – went wrong with the care of the patient ○ Minimise the possibility of a reoccurrence of similar events ○ Make recommendations for the delivery of health services in the future • An independent investigation is carried out separately from any police, legal and Coroner's proceedings. It is done by an independent, expert organisation, which is given access to all the information and reports about the individual patient's care and treatment (within the usual patient confidentiality rules), and who can also request interviews with any NHS staff involved.
SERIOUS FURTHER OFFENCES	• Serious Further Offences (SFOs) were introduced in December 2008. The SFO Notification and Review procedure is intended to ensure rigorous scrutiny of those cases where specified offenders under the supervision of the Probation Provision have been charged with a violent or sexual offence. • The review process for all eligible offenders charged with a SFO who have been assessed as low risk of serious harm and are subject to either a community order or a suspended sentence order, even where the qualifying offence attracts a mandatory review. In these cases, the SFO Review will focus chiefly, but not exclusively, on the area of risk assessment.

Appendix (B): Summary -Types of non-statutory review processes

PEER REVIEW	• LSCB / SAB / agency initiated. Peer review process within safeguarding where data is compared across key performance areas • Findings reported back to Safeguarding Effectiveness Group (SEG) • Analytical report looking at national, regional and local best practice areas and comparisons made • Report formulates conclusions and any recommendations
MULTI-AGENCY CASE REVIEW	• Initial scoping of the case identifies number of agencies involved in an "assessment / procedures / process" system management of case • Terms of Reference agreed for the MACR • Timeframe for the review is short; agencies asked to review records, identify key practice episodes against ToR prior to meeting • Managers of services meet to review case management • Brief summary report identifies learning and recommendations / actions
SINGLE AGENCY CASE REVIEW	• Safeguarding is a significant feature of the investigation • Independent Investigator appointed by agency and leads review • SI report provides summary of findings and learning arising from review • Brief summary of incident and learning reported into the SCR Group • Learning shared with other agencies when learning could improve practice

Appendix (C): Types of Review methodologies

METHOD	FEATURES OF THIS METHODOLOGY
MULTI-AGENCY SYSTEMS APPROACH WITHIN SERIOUS CASE REVIEWS	• The 'systems' model helps identify which factors in the work environment support good practice, and which create unsafe conditions in which poor safeguarding practice is more likely. • It provides a way of thinking about frontline practice and a method for conducting case reviews. • It produces organisational learning that is vital to improving the quality of work with families and the ability of services to keep children safe. • It supports an analysis that goes beyond identifying what happened to explain why it did so – recognising that actions or decisions will usually have seemed sensible at the time they were taken. • It involves moving beyond the basic facts of a case and appreciating the views of people from different agencies and professions. • It is a collaborative model for case reviews – those directly involved in the case are centrally and actively involved in the analysis and development of recommendations. • Examples of this approach include the SCIE model http://www.scie.org.uk/publications/guides/guide24/index.asp and SILPs http://www.reviewconsulting.co.uk/ however, there are other suppliers and models for this type of review.
SINGLE AGENCY ASSURANCE REPORT	• Can be provided by agencies or requested by the SCR Groups • The focus of the report is identifying gaps or strengths in practice and providing assurance as to how practice has improved, what we need to do more of and any control measures now in place or further actions required. • Reports are presented at SIRG meetings

ROOT CAUSE ANALYSIS	• Looks at causation / is a systematic enquiry
	• Can use a variety of different methods to identify root cause:
	  ◦ 5 "why" techniques
	  ◦ Cause and effect (fishbone)
	  ◦ Brainstorming
	  ◦ Timelines and chronologies
	• Cause of the incident identifies the actions to be taken forward
	• Provides learning at a number of levels from individual to agency

METHOD	FEATURES OF THIS METHODOLOGY
ACTION LEARNING METHOD	• Action Learning involves working on real problems, focusing on learning and actually implementing solutions. It is a form of learning by doing. • The process integrates: research (into what is obscure); learning (about what is unknown); and action (to resolve a problem) into a single activity and develops an attitude of questioning and reflection to help individuals and organisations change themselves • Embedded within the SILP review process as a key methodology for learning
INDEPENDENT MANAGEMENT REVIEW	• Based loosely on the guidance for reviews as issued by the 2010 version of Working Together • Information gathering through IMRs • Systems review process is added by format of IMR template • No need for a separate chair and author
APPECIATIVE INQUIRY	• Appreciative Inquiry (AI) is a change management approach that focuses on identifying what is working well, analysing why it is working well and then doing more of it. • The basic tenet of AI is that an organisation will grow in whichever direction that people in the organisation focus their attention. • If all the attention is focused on problems, then identifying problems and dealing with them is what the organisation will do best. • If all the attention is focused on strengths, however, then identifying strengths and building on those strengths is what the organisation will do best. • It is designed to provide safe environment for staff to come together to examine a case and look at what went well and what didn't go so well in safeguarding • Best used in non-critical reviews.
CASE MAPPING EXERCISE	• Case mapping is useful in bringing practitioners and managers together to consider a case(s) to identify and understanding similar features or factors in cases particularly where outcomes for children have not been met and the case does not meet the criteria for a statutory review.