Warrington Safeguarding Children Board Learning and Improvement Framework



"Every child and young person in Warrington should be able to grow up safe from maltreatment, neglect, bullying, discrimination and crime -receiving help when they need it in a timely and effective manner"

Our Vision: "To ensure that every child and young person in Warrington is safe and has the opportunity to reach their potential."

1. Introduction

As a partnership we are concerned to deliver the highest quality services and interventions when working with children and young people, that will reduce risk of potential, actual or future harm. In order to do this we recognise that all partners and professionals who work with families must be clear about their responsibility to reflect on the quality of their own services and to learn from their own and from others (locally, regionally and nationally) practice about what works well and also why things can go wrong. Good practice should be shared but also we must continue to learn from

- new research evidence,
- national learning including from Serious Case Reviews
- our experiences when we recognise that we could have done things better
- listening to what children and young people tell us about their experiences and
- from the progress of children and young people who receive help.

To support this process we are pleased to present the **Warrington Safeguarding Children Board (WSCB) Learning and Improvement Framework**, in compliance with Working Together to Safeguard Children 2013. This framework is shared with and accepted by all our partners. The framework supports the promotion of a learning culture that values professional expertise when working to protect children and young people, ensuring that services are based on sound professional knowledge and evidence based outcomes.

The Pilot Joint Inspection of Multi Agency Arrangements for the Protection of Children – Warrington in January 2013 judged that "the overall effectiveness of the multi-agency arrangements for the protection of children and young people in Warrington" to be **"good."** We recognise that our highly skilled and competent workforce was a key factor in achieving this judgement. Our workforce is our most important asset. The Warrington Safeguarding Children Board (WSCB) Learning and Improvement Framework builds on this solid base, enabling organistions to be clear about their responsibilities to learn from experience and improve services as a result.

But we also want to be clear that if things go wrong locally in the future, we will ensure that there is a rigorous objective analysis of what has happened and why, so that we can learn lessons and improve our services to reduce the risk of harm to our children and young people.

This document focuses on the ways we want to quality assure practice, including through joint audits of case files involving practitioners and identifying lessons to be learned,

holding reviews of cases that meet certain threshold criteria to learn lessons that will improve services and commissioning independent reviews as required by statute.

This document should be read in conjunction with the Warrington Safeguarding Children Board Performance Framework which details how we will scrutinise relevant performance data, service evaluations and evaluate the effectiveness of training, including multi-agency training.

2. How this framework will support the work of the WSCB and partners.

The framework ensures that:

- reviews are conducted appropriately, (on statutory and other cases) to ensure that we are able to scrutinise and challenge the way we work together as a partnership to protect our children and young people
- we understand criteria required under legislation for determining if a statutory review is required and that we conduct those reviews when necessary
- we understands the principles detailed in Working Together 2013 when conducting a review of a case that does not meet the criteria for an SCR, but which will provide valuable lessons about how we as a partnership of organisations are working together to keep children and young people safe
- we understand what has happened in all cases we review and that we are clear about what action we will take from the review findings which will result in lasting improvements and
- we deliver transparency about any actions including sharing final reports of Serious Case Reviews (SCRs), including the Board's response to the review findings, with the public.

The framework provides the partnership with guidance on:

- the principles to be applied in any methodology used to identify learning and improvement,
- the principle outcomes any learning and improvement process should achieve,
- the different types of case reviews,
- the thresholds for conducting the different types of reviews and
- information on how we will share and collate learning to ensure practice locally is fully informed by experiences locally, regionally and nationally.

3. Learning from Reviews:

3.1. Purpose

The purpose of all types of reviews is to:

- consolidate good practice and
- to identify improvements which are needed

3.2. The child at the centre

As a partnership when undertaking all reviews, we will ensure that the child or young person is always at the centre of the process. To deliver this we will:

- ensure that our approach to reviews is proportionate according to the scale and complexity of the issues being examined
- ensue that reviews of serious cases and case reviews are led by individuals who are independent of the case under review and of organisations whose actions are being reviewed
- ensure that professionals are fully involved in reviews being able to contribute their views without fear of being blamed for actions they took in accordance with procedures
- ensure families and surviving children and young people are always invited to contribute their views about the effectiveness and impact of the help given, with clear and sensitive management of their understanding and expectation of the review. Families, including children (where possible) are a fundamental partner in visioning, design and delivery of services and in evaluating all service and partnership activity

3.3. Publication: a set of principles

- We will be transparent and clear about disseminating the learning from all reviews including the publication on the website.
- We will ensure that the guiding principle on the publication of all Case Review and Serious Case Review Reports, including any redactions, will be that the welfare of any child involved is paramount
- All reviews of cases meeting the SCR criteria will result in a report which is published and readily accessible on the Board's website for a minimum of 12 months. Thereafter the report will be made available on request. From the very start of the SCR the fact that the report will be published will be taken into consideration and discussed with the family and inform the process. SCR reports will be written in such a way that publication will not be likely to harm the welfare of any children or vulnerable adults involved in the case.
- As a minimum we will publish the learning from all Case Reviews on the WSCB website. We will publish the full report unless there are clear documented reasons for not doing so, including for example, that the publication of the report would be detrimental to the welfare of any child involved.
- All Case Reviews will result in a report. The welfare of any child involved will determine if the report is published. If for example the details of the case mean the child could be identified we will not publish the whole report but we will publish the learning. We will publish the full report if the welfare of any child involved is not impacted. The Board will keep details of all decisions made with respect to publication and the reasons for all decisions.
- The full report or the report detailing the learning from any Case Review will be published and readily accessible on the Board's

website for a minimum of 12 months. Thereafter the report will be made available on request. From the very start of the Case Review the fact that the report will be published will be taken into consideration and discussed with the family and inform the process. Case Review reports will be written in such a way that publication will not be likely to harm the welfare of any children or vulnerable adults involved in the case

4. The different types of reviews

4.1. Serious Case Review

Regulation 5 (2) of the Local Safeguarding Children Boards Regulations 2006 sets out the requirement of the Board to undertake reviews of serious cases (Serious Case Review (SCR)) and to advise Warrington Borough Council and the Board on lessons to be learnt.

A Serious Case Review (SCR) 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.

In addition we will also consider undertaking an SCR when a child or young person dies

- in custody
- in police custody
- on remand
- following sentencing
- in a Young Offenders Institute
- in a Secure training centre
- in a Secure children's home or
- where a child or young person was detained under the mental Health Act 2005

We will also consider undertaking an SCR where a child or young person dies by suspected suicide.

The Board will ensure that in all the above circumstances the following process will be undertaken:

- Details of the notification of the death or serious harm for any child or young person who normally resides in Warrington will be reported to the Chair of the Board who will refer to the WSCB Case Review Criteria Panel. (The Case Review Subgroup will convene a Case Review Criteria Panel).
- The Case Review Criteria Panel will consider if the incident meets the criteria for a Serious Case Review. The Panel will make this decision

within 3 weeks of notification. If the panel does not meet this timescale the reasons will be referred to the chair of the Board.

- The Case Review Criteria Panel will ensure notification of the incident is sent to Ofsted and the National Panel of Independent Experts on Serious Case Reviews
- If the criteria for a Serious Case Review have been met the Case Review Criteria Panel will consider the draft terms of reference for the Serious Case Review and consider proposals for an independent chair to chair the review
- The Serious Case Review Criteria Panel will make recommendations to the Chair of the Board.
- The Chair of the Board will make the final decision. This decision will be made within one month of the notification. If this timescale is not met reasons for delay will be detailed.
- The Chair may seek peer challenge from another LSCB Chair when considering this decision and also at other stages in the SCR process.
- The Board will let Ofsted and the national panel of independent experts know their decision.
- A record will be kept of all decisions (see appendix)
- If the Board decides not to initiate an SCR, we understand the decision may be subject to scrutiny by the national panel. The Board will provide information to the panel on request to inform its deliberations and the Board Chair will be prepared to attend in person to give evidence to the panel.
- If the Board decides to initiate an SCR, the Board will appoint one or more suitable individuals to lead the SCR who have demonstrated that they are qualified to conduct reviews using the approach set out in this framework. The lead reviewer will be independent of the Board and the organisations involved in the case.
- The Board will provide the national panel of independent experts with the name(s) of the individual(s) they appoint to conduct the SCR. The Board will consider carefully any advice from the independent expert panel about appointment of reviewers.
- The Board will ensure that there is appropriate representation in the review process of professionals and organisations who were involved with the child and family. The priority will be to engage organisations in a way which will ensure that important factors in the case can be identified and appropriate action taken to make improvements. The Board may decide as part of the SCR to ask each relevant organisation to provide information in writing about its involvement with the child who is the subject of the review.
- The Board will aim for completion of an SCR within six months of initiating it. If this is not possible (for example, because of potential prejudice to related court proceedings), every effort will be made while the SCR is in progress to: (i) capture points from the case about improvements needed; and (ii) take corrective action.

Agreeing improvement action:

- The Board will oversee the process of agreeing with partners what action they need to take in light of the SCR findings.

Publication of reports:

- All reviews of cases meeting the SCR criteria will result in a report which is published and readily accessible on the Board's website for a minimum of 12 months. Thereafter the report will be made available on request. From the very start of the SCR the fact that the report will be published will be taken into consideration and discussed with the family and inform the process. SCR reports will be written in such a way that publication will not be likely to harm the welfare of any children or vulnerable adults involved in the case.

Final SCR reports will:

- provide a sound analysis of what happened in the case, and why, and what needs to happen in order to reduce the risk of recurrence;
- be written in plain English and in a way that can be easily understood by professionals and the public alike; and
- be suitable for publication without needing to be amended or redacted (unless there are legal reasons for redactions).
- The Board will 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.
- The Board will send copies of all SCR reports to the national panel of independent experts at least one week before publication. If the Board considers that an SCR report should not be published, we will inform the panel and understand that the panel may provide the Board with advice. The Board will provide all relevant information to the panel on request, to inform its deliberations

Disseminating Learning:

The Board will give consideration to using the following as appropriate:

- Learning will be disseminated to practitioners and managers involved in the case in meetings with the Chair of the Serious Case Review
- Action Learning Sets led by the Chair of the Serious Case Review will be set up with practitioners and managers across the partnership
- Learning pertinent to a single agency will be disseminated via the agency's own training, development and awareness raising pathways.
- Learning will be incorporated into existing WSCB multi-agency training where appropriate.

- Referencing learning from Serious Case Reviews in the Annual Report including the differences made to practice and impact on outcomes for children and young people.

4.2. WSCB Case Reviews

A WSCB Case Review can be held when the case does not reach the threshold for an SCR but the Board considers there are significant opportunities for leaning.

The Board will follow process below to commission a Case Review:

- Details of the notification of the incident will be reported to the Chair of the Board who will refer to the WSCB Case Subgroup
- The Case Review Subgroup will consider if a WSCB Case Review should be commissioned.
- The Case Review Subgroup will consider whether to send notification of the incident to Ofsted. Records of decisions will be kept, including reasons if Ofsted are not notified.
- The Case Review Subgroup will consider the draft terms of reference for the Case Review
- The Case Review Subgroup will consider proposals for a chair to undertake the review. This could be either (1) an independent chair or(2) a member of an organisation on the Board whose agency is not involved in the case
- All Case Reviews will result in a report. The Case Review Subgroup will make a recommendation whether to publish the whole report, an Executive Summary or learning points form the Case Review
- The Case Review Subgroup will make recommendations to the Chair of the Board.
- The Chair of the Board will make the final decision. This decision will be made within one month of the notification. If this timescale is not met reasons for delay will be detailed.
- The Chair may seek peer challenge from another LSCB Chair when considering this decision and also at other stages in the Case Review process.
- The Board will let Ofsted know their decision.
- A record will be kept of all decisions (see appendix)
- If the Board decides to initiate a Case Review, the Board will appoint one or more suitable individuals to lead the Review who have demonstrated that they are qualified to conduct reviews using the approach set out in this framework. The lead reviewer will be independent of the Board and the organisations involved in the case or a member of an organisation on the Board whose organisation is not involved in the case.
- The Board will ensure that there is appropriate representation in the review process of professionals and organisations who were involved with the child and family. The priority will be to engage organisations in a way which will ensure that important factors in the case can be identified and appropriate action taken to make improvements. The

Board may decide as part of the Case Review to ask each relevant organisation to provide information in writing about its involvement with the child who is the subject of the review.

- The Board will aim for completion of a Case Review within six months of initiating it. If this is not possible (for example, because of potential prejudice to related court proceedings), every effort will be made while the Case Review is in progress to: (i) capture points from the case about improvements needed; and (ii) take corrective action.

Agreeing improvement action:

- The Board will oversee the process of agreeing with partners what action they need to take in light of the Case Review findings.

Final Case Review Reports will:

- provide a sound analysis of what happened in the case, and why, and what needs to happen in order to reduce the risk of recurrence;
- be written in plain English and in a way that can be easily understood by professionals and the public alike

Disseminating Learning:

- Learning will be disseminated to practitioners and managers involved in the case in meetings with the Chair of the Case Review
- Action Learning Sets led by the Chair of the Case Review will be set up with practitioners and managers across the partnership
- Learning pertinent to a single agency will be disseminated via the agency's own training, development and awareness raising pathways.
- Learning will be incorporated into existing WSCB multi-agency training where appropriate.
- Referencing learning from Case Reviews in the Annual Report including the differences made to practice and impact on outcomes for children and young people.

5. Pan Cheshire Child Death Overview Panel (CDOP)

The Local Safeguarding Children Board (LSCB) functions in relation to child deaths are set out in Regulation 6 of the Local Safeguarding Children Boards Regulations 2006, made under section 14(2) of the Children Act 2004. The Board is responsible for:

a) collecting and analysing information about each death with a view to identifying—

(i) any case giving rise to the need for a review mentioned in regulation 5(1)(e);

(ii) any matters of concern affecting the safety and welfare of children in the area of the authority;

(iii) any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area; and
(b) putting in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

The Board is responsible for ensuring that a review of each death of a child normally resident in the Warrington area is undertaken by a Child Death Overview Panel (CDOP). Figures of all child deaths up to the age of 18, excluding babies who are stillborn and planned legal terminations are low in each LSCB area in Cheshire. This makes it more difficult to aggregate findings and maximise learning opportunities. We have therefore set up a Pan-Cheshire Child Death and Overview panel (CDOP) and this has provided greater clarity of understanding about local child deaths.

The Panel will has a fixed core membership drawn from organisations represented on the four Cheshire LSCB with flexibility to co-opt other relevant professionals to discuss certain types of death as and when appropriate. The Panel undertakes a review of each death of a child normally resident in one of the four the LSCB's areas. Reports from Pan Cheshire CDOP are reviewed by the Board Case Review Subgroup and outcomes reported in the WSCB Annual Report.

Disseminating Learning:

- Learning pertinent to a single agency will be disseminated via the agency's own training, development and awareness raising pathways.
- Learning will be incorporated into existing WSCB multi-agency training where appropriate.
- Referencing learning from CDOP in the Annual Report including the differences made to practice and impact on outcomes for children and young people.

6. Case File Audits

6.1. Case file audits:

- Provide a consistent approach to assessing work on a multi-agency or single agency basis with a child/young person and their family.
- Enable identification of learning points from areas which are working well and those that need improvement.
- Enable the Board to carry out its function of monitoring the effectiveness of what is done to protect children and monitor their welfare.
- Promote service improvement through identification of key practice issues so that recommendations can be drawn together and action plans implemented and monitored.
- Feed into policy and practice guidance, training and development activity and strategy and commissioning processes.

Multi-agency case file audits:

The Board will undertake one or two “deep dive” multi-agency case file audits per year to investigate and scrutinise in depth a number of areas including the quality of management oversight and decision making. This will provide the board with strong evidence about the quality of partnership services on the ground to keep children and young people safe.

However, the board has recognised that to have a coherent understanding of the quality of practice, a sufficient volume of cases must be audited on a multi-agency basis to deliver a proportional analysis. Therefore the Board will consider the outcomes three audit days per year with 12 cases being audited on each of the days.

The Board has agreed that these audits will involve front line practitioners in a forum discussion lead by Board Members. Front line managers working with families will be involved in the practice audits through the completion of an audit tool of the case file to identify strengths, areas for improvements and lessons to be learnt.

Board members who facilitate the practitioner forums will also visit the families of the cases audited (unless there are good reasons for not doing so), to provide opportunities for children and young people and their parents and carers to express their views and feelings about the effectiveness of services, including how well partners took into account their wishes. This will enable the Board assess the effectiveness of the help and protection provided and monitor the experiences and progress of children and young people.

Learning form these audits will disseminated through training and by briefing notes on the Professionals section of the website.

Single-agency case file audits:

Each partner organisation undertakes audits of their own work through auditing their own case files. WSCB requires reports from each agency in rotation at reasonable intervals about the work and outcomes for these audits. This enables the WSCB to:

- share learning about what works well
- share learning about what we can do better
- deliver scrutiny and challenge functions appropriately

Disseminating Learning:

- Learning pertinent to a single agency will be disseminated via the agency’s own training, development and awareness raising pathways.
- Learning will be incorporated into existing WSCB multi-agency training where appropriate.

- Referencing learning from audits in the Annual Report including the differences made to practice and impact on outcomes for children and young people.

6.2. Section 11 audits

Section 11 of the Children Act 2004 places a duty on key agencies and bodies to make arrangements to safeguard and promote the welfare of children. The Board will undertakes to assure, through Section 11 Audits, an assessment of the effectiveness of these arrangements in protecting and keeping safe local children and young people.

The Board will work with Pan Cheshire Partners to undertake a Pan Cheshire Section 11 panel to review outcomes from Section 11 audits for partners whose boarders cover more than one Cheshire LSCB.

The Board will receive reports on outcomes from Section 175 audits undertaken by schools of the effectiveness of their safeguarding arrangements.

Disseminating Learning:

- Learning pertinent to a single agency will be disseminated via the agency's own training, development and awareness raising pathways.
- Learning will be incorporated into existing WSCB multi-agency training where appropriate.
- Referencing learning from audits in the Annual Report including the differences made to practice and impact on outcomes for children and young people.

7. Underpinning Principles for Learning and Improvement

As a Board we want to deliver a culture of continuous learning and improvement across organisations that work to keep children and young people safe, identifying opportunities to draw on what works and to promote good and effective single and multi-agency practice. In order to do this we will use the learning from all reviews and audits to inform developments and improve practice continually.

When we conduct a review or audits we want to ensure that we manage and reduce risk by improving services for children and young people that reduce the incidence of harm. We recognise that we may not eliminate it but we ensure the following outcome principles are followed.

7.1. General principles:

When we conduct case reviews, practitioner forums and case file audits, we will use systems methodology to focus as much attention to learn from what works well by identifying good practice as well as practice that requires

improvement. We will ensure that reviews recognise the complex circumstances in which professionals work together to safeguard children and seek to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight. The reviews will clearly detail the way data has been collated and analysed and how research and case evidence has been used to inform findings. Case reviews, practitioner forums and audits will seek to understand precisely who did what and consider the underlying reasons that led individuals, teams and organisations to act as they did. We will ensure that learning is applied across the partnership to deliver continuous improvements to services that support keeping children and young people safe.

7.2. Reducing risk:

- Learning and reviewing opportunities are transparent so that we identify promptly the need for systemic or organisational changes and ensures timely action is taken
- Professionals in all services working with children and families are given the training, management support and organisational frameworks they need so that they can undertake the complex and difficult work of protecting children with confidence and competence
- Our organisational and multi-agency cultures, and the processes that underpin these cultures, are experienced as fair and just by professionals, and promote supportive work and management environments for them.
- The processes used for learning, the findings from reviews and action taken should provide accountability and reassurance to children, families, the public and government inspectorates

Appendix:

Serious Case Review
Recommendations to Chair of LSCB

Name of Child	
DOB	
Address	
Ethnicity, disability, gender	
Date of Case Review Criteria Panel	
Recommendation from Case Review Criteria Panel	
Reasons for recommendation	
Terms of reference attached	
Other recommended actions	

Case Review Criteria Panel Chair
Name:
Signature:
Date:

COMPLETED FORM TO BE FORWARDED BY THE PANEL CHAIR TO THE WSCB BUSINESS AND PARTNERSHIPS MANAGER

Outcome of WSCB Chair's Decision to Undertake a Serious Case Review

Name of Child	
DOB	
Address	
Ethnicity, disability, gender	
Date of Case Review Criteria Panel	
Evidence of Peer Challenge	
Details of WSCB Chair Consulted:	Name: Date Consultation Undertaken:
Summary of Peer Challenge	
Evidence of Consultation with National Panel of Independent Experts	
Evidence of Consultation with National Panel of Independent Experts	Date Consultation Undertaken:
Summary of Consultation with National Panel of Independent Experts	
Decisions	
Decision of WSCB Chair	
Date Ofsted notified of Outcome	
Date National Panel of Independent Experts notified of Outcome	
WSCB Chair	Name: Signature: Date:

COMPLETED FORM TO BE FORWARDED BY THE PANEL CHAIR TO THE WSCB BUSINESS AND PARTNERSHIPS MANAGER

Warrington Safeguarding Children Board (WSCB) Case Review Subgroup
Case Review

Recommendations to Chair of WSCB

Name of Child	
DOB	
Address	
Ethnicity, disability, gender	
Date of Case Review Subgroup Meeting	
Recommendation from Case Review Subgroup to Board Chair	
Reasons for recommendation	
Terms of reference attached	
Other recommended actions	
Subgroup Chair	Name: Signature: Date:

COMPLETED FORM TO BE FORWARDED BY THE PANEL CHAIR TO THE WSCB BUSINESS AND PARTNERSHIPS MANAGER

Outcome of WSCB Chair's Decision to Undertake a Warrington Safeguarding Children Board Case Review

Name of Child	
DOB	
Address	
Ethnicity, disability, gender	
Date of WSCB Case Review Subgroup Criteria Panel	
Evidence of Peer Challenge	Name: Date if consultation undertaken:
Reasons for Case Review	
Draft terms of reference presented to chair	
Decision of WSCB Chair	
WSCB Chair	Name: Signature: Date:

COMPLETED FORM TO BE FORWARDED BY THE PANEL CHAIR TO THE WSCB BUSINESS AND PARTNERSHIPS MANAGER.