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

The Warrington Safeguarding Children Board (WSCB) is a statutory Board and a strategic partnership. The Board does not commission or deliver direct front line services, (other than multi-agency safeguarding children training), but scrutinises, challenges and evaluates all local services, making clear where improvements are needed to keep children and young people in Warrington safe. The Board provides strong, forward thinking, outcome focused, visible leadership promoting delivery of continuous improvements in the care and protection of our children and young people that will reduce risk of potential, actual or future harm.

The Board assesses of the quality of work undertaken by partners using a number of methodologies identifying actions to deliver improvements. The Board monitors the implementation and delivery of its recommendations to be assured they are implemented by partners, resulting in sustained changes to partners' practice that impacts on outcomes evidencing children are safer.

To support this process we are pleased to present the **Warrington Safeguarding Children Board (WSCB) Learning and Improvement Framework**, which, in compliance with Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children 2015 details how the Board will do this.

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

The Warrington Safeguarding Children Board (WSCB) Annual Report provides a rigorous and transparent assessment of the performance and effectiveness of local services, including identifying areas of weakness, the causes of those weaknesses and the action being taken to address them as well as other proposals for further action. This analysis identifies, in addition to core safeguarding activity, a discreet number of defined areas which we have concluded are the most important to deliver real improvements over the next year. These are detailed in the WSCB Business Plan as priorities.

The WSCB Learning and Improvement Framework explains how the Board evaluates the quality of services by providing an underpinning framework of activity to support the rigorous and transparent assessment of safeguarding activity.

We recognise that our workforce is our most important asset and want to ensure we support a highly skilled and competent workforce. One key to partnership success has to do with the capacity of practitioners and their managers to learn; learn from mistakes as well as learn from successes. The WSCB Learning and Improvement Framework supports the Board in understanding what has worked well and where improvements can be made enabling the workforce to apply this learning to continually develop and improve.

3. The methodology

The challenge is to improve the quality of practice and safeguarding outcomes, not just provide an analysis of the effectiveness of safeguarding activity.

3.1. Using the appropriate balance of performance information

The WSCB will use the following sources to obtaining performance information:

- 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 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. Schools undertake audits of the effectiveness of their arrangements by undertaking S175 audits,
- Peer and independent reviews and challenge activity, including Ofsted Review of LSCBs
- Learning reviews including serious case reviews
- Planned programme of multi-agency audits, both thematic and at key transition points, including repeat audits to test out developments after 6 or 12 months
- Listening to the voice of children and parents of cases audited
- Specific activity to learn the views of children on a particular matter
- Experience of front line workers and managers
- Single agency information about the quality of their safeguarding activity including compliments and complaints
- Organisational issues such as workforce, learning capacity, safeguarding wisdom supervision and support, organisational culture, use of resources and evidence based practice.

The Board uses this intelligence to inform assessment of safeguarding activity using a thematic approach that considers

- Early Help services.
- Services for vulnerable groups including
    1. Children at risk of sexual exploitation or missing
    2. Children at risk of radicalisation
    3. Children at risk of female genital mutilation
    4. Children in care and those returning home form care and care leavers
    5. Children subject to child protection plans
    6. Young victims of crime
    7. Children using Accident and Emergency services
- Local priority areas identified in the Business Plan or from inspections

In addition the Board has agreed an Accountability Responsibility Framework. All partners have agreed to keep the Board informed of any issues that might impact on their safeguarding services for children (for example staffing ort budget pressures).

3.2. Assessing the quality of safeguarding activity and improving the quality of that activity

The intelligence from all these sources is analysed to identify trends, anomalies and risk. This enables the identification of a discrete number of defined areas or priorities and these become the focus of the next phase of the performance work which ensures improvements in practice to address the areas of concern.

3.3. Dissemination learning

We use a number of methods to ensure learning is disseminated across the partnership. These are:

- Events for front line staff. These included information sharing and application
- Learning Logs
- Learning Posters
- Each Board member given specific responsibility to take back areas of learning to their agency to ensure change and to feedback outcomes.
- An annual quality assurance event where the main messages from quality assurance work by the Board are shared and considered. This allows partners to reflect on the information, determine the story and agree what immediate action is required to improve practice or safeguarding arrangements. This also provides an opportunity to review the quality assurance programme for the following year.

3.4. Improving safeguarding activity

Activity to address the areas for improvement includes activity that changes professional behaviour and also crucially professional or team culture by ensuring learning is looped back into the start of the system, using a double loop learning process to deliver *sustained* change.

The Board has clear action logs and records of recommendations to enable tracking of actions. We will deliver specific action plans relating to a case or audit. We will also develop a strategic action plan that will address how key learning is to be applied to changes in practice by all partners.

4. Performance data

Professor Eileen Munro is clear that improving outcomes for children and young people should be central to all service provision and that organisations and partnerships should collect data intelligently to evidence the effectiveness of work undertaken to help and protect children and young people. To support the framework the Board has developed a Performance Dashboard as well as aligning the priorities in the Business Plan to performance information to regularly measure our progress to allow us to recognise and respond to significant shifts in local methods of intervention.

This framework builds upon the Board's previous published frameworks and takes account of good practice from the work produced by the London Safeguarding Children Board '*Improving local safeguarding outcomes – developing a strategic quality assurance framework to safeguard children*', Rochdale Borough

Safeguarding Children Board '*Strategic Performance Management and Quality Assurance Framework'* and work undertaken across Greater Manchester and the Midlands in developing a more strategic approach to performance data.
The Board has access to large amounts of performance information from across numerous agencies. The Board therefore needs to analyse performance information effectively to know if we are making a difference to the lives of children and young people locally, keeping them safe and promoting their welfare.

Every quarter the WSCB receives a report from the local authority for scrutiny which sets out data on

- Child Protection Conferences Quarterly Activity
- Professional Participation in Child Protection Conferences
- Children in Care Case Review Activity
- Activity in Relation to Foster Carer Reviews
- Activity in Relation to Children in Care from Other Local Authorities
- Missing Child Sexual Exploitation Trafficking Operational (MCSETO) Group Activity
- Activity in Relation to Children Reported Missing to Police
- Activity in Relation to Local Authority Designated Officer (LADO)

Our performance dashboard contains key indicators from different agencies showing performance across a number of areas so that the Board can see information to demonstrate that:

- We know about all children and young people in the local area, what their needs are and how are they doing.
- We know about groups of children with particular needs.
- We are safeguarding and supporting children in specific circumstances
- Children, young people and families are able to access early help when they require it, and it is effective
- Thresholds are clear and appropriate, planning and decision making is effective
- We are safeguarding and supporting children who are in need of protection
- The LA fulfils its corporate parenting role and looked after children and care leavers have good outcomes
- There is effective use of resources and workforce
- Agencies in the local area and the LSCB provide leadership and governance, and agencies work together effectively
- Services are judged as effective at safeguarding children and providing early help (Inspection outcomes).

5. Learning from Section 11 audits and Education Act Section 175 or 157 audits

A template and format has been agreed for a Pan Cheshire S11 audit process, including a common self-assessment tool for all partner agencies including schools. Eight key standards have been established, along with an agreed timetable.

Agencies identify improvement actions at a single agency level, which is then shared and multi-agency improvement priorities and actions are identified, in addition to sharing good practice examples.

The quality and effectiveness of S11 audits are scrutinised by the Pan Cheshire S11 panel which agrees actions for improvement. The Warrington Borough Council Education Safeguarding Team scrutinises the S175 audits submitted by schools and provides reports on their effectiveness to the Board.

The Board may test out that agencies have implemented learning from the framework by adding additional questions to S11 or S175 audits.

6. Learning from peer and independent reviews and challenge activity, including Ofsted Review of LSCB's

The Board will commission Independent Peer Reviews from time to time to ensure scrutiny of its work. In addition the Board is subject to statutory Reviews and Inspections by Ofsted.

The Board will ensure Improvement plans address all actions from independent scrutiny reports and will monitor activity to ensure improvement impacts on the Boards understanding of the quality of practice and safety of children.

6. Learning reviews and serious case reviews

The WSCB will commission Reviews with respect to cases in Warrington to ensure learning is applied locally to improve practice. We will also ensure that the Board is informed and applies the learning from reviews commissioned by other LSCBs in which Board member agencies are involved.

6.1. Type of 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 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.

Threshold criteria

Cases in Warrington that meet one of the above criteria will always trigger a Serious Case Review. In addition we will also commission a 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 1983
- a child aged 16 or 17 was the subject of a Deprivation of Liberty Safeguard order under the Mental Capacity Act 2005
- where a child or young person died by suspected suicide.

We will also commission a serious case review or a WSCB Case Review for cases that do not meet the threshold criteria but there are lessons to be learnt and applied by the partnership.

6.2. 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
- ensure 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

6.3. 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

6.4. Notifiable incidents

A notifiable incident is an incident 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).

The local authority will report any incident that meets the above criteria to Ofsted and the WSCB within five working days of becoming aware that the incident has occurred.

"Seriously harmed" 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.

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

6.5. Activity

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 Criteria Panel.

- The WSCB Criteria Panel will consider if the incident meets the threshold criteria for a Serious Case Review or there are lessons to be learnt even though the threshold criteria have not been met. 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 Criteria Panel will ensure notification of any incident that meets the threshold criteria is sent to Ofsted, Department of Education (DfE) and the National Panel of Independent Experts on Serious Case Reviews within 5 working days of the Chair's decision
- The 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, DfE and the National Panel of Independent Experts on Serious Case Reviews know their decision.
- A record will be kept of all decisions
- If the Board decides not to initiate an SCR, we understand the decision may be subject to scrutiny by the National Panel of Independent Experts on Serious Case Reviews. The Board will provide information to the National Panel of Independent Experts on Serious Case Reviews on request to inform its deliberations and the Board Chair will be prepared to attend in person to give evidence to the panel.
- In cases where the WSCB is challenged by the national panel to change its original decision, we will inform Ofsted, DfE and the National Panel of Independent Experts on Serious Case Reviews of the final outcome.
- If the Board decides to initiate an SCR or Case Review, the Criteria Panel will consider the draft terms of reference for the Serious Case Review or Case Review and consider proposals for an independent chair to chair the review
- 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 on Serious Case Reviews with the name(s) of the individual(s) they appoint to conduct the SCR. The Board will consider carefully any advice from the National Panel of Independent Experts on Serious Case Reviews 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 or 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 an SCR or 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 SCR is in progress to:
  (i) capture points from the case about improvements needed; and
  (ii) take corrective action to implement improvements and disseminate learning.

6.6. Agreeing improvement action

The WSCB will oversee the process of agreeing with partners what action they need to take in light of the SCR or Case Review findings, establish timescales for action to be taken, agree success criteria and assess the impact of the actions.

6.7. Publication of reports:

- All reviews of cases 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. If the child could be identified in a Case Review the learning and not the full report will be published.
- From the very start of the SCR and Case Review, the fact that the report will be published will be taken into consideration and discussed with the family and inform the process. 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.
- When compiling, and preparing to publish, reports we will consider carefully how best to manage the impact of publication on children, family members and others affected by the case.
- We will comply with the Data Protection Act 1998 in relation to SCRs, including when compiling or publishing the report, and with any other restrictions on publication of information, such as court orders.
- The timing of publication will have due regard to the impact on any ongoing legal proceedings, including any inquest.
- We will send copies of all SCR reports, including any action taken as a result of the findings of the SCR, to Ofsted, DfE and the National Panel of Independent Experts on Serious Case Reviews at least seven working days before publication.
- If we consider that an SCR report should not be published, we will inform DfE and the National Panel of Independent Experts on Serious Case Reviews. The National Panel of Independent Experts on Serious Case Reviews may provide advice to the WSCB. The WSCB should provide will relevant information to the panel on request, to inform its deliberations. In cases where we are challenged by the panel to change our original decision about publication, we will inform Ofsted, DfE and the National Panel of Independent Experts on Serious Case Reviews of our final decision.

6.8. Final 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:
    1. actions which have already been taken in response to the review findings
    2. the impact these actions have had on improving services and
    3. what more will be done.

6.9. 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 Review
- Action Learning Sets led by the Chair or Author of the 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.
- Leaning will be disseminated by publication of learning posters
- Learning will be disseminated through learning logs for staff
- Learning will be incorporated into existing WSCB multi-agency training where appropriate.
- Referencing learning from Reviews in the Annual Report including the differences made to practice and impact on outcomes for children and young people.

7. Planned programme of multi-agency audits, both thematic and at key transition points, including repeat audits to test out developments after 6 or 12 months

Case audits:

- Provide a consistent approach to assessing work on a multi-agency or single agency basis with a child or 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.

7.1. Multi-agency case 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.

7.2. WSCB Audit Days

The Board will undertake three audit days per year with 12 cases being audited on each of the days.

The methodology used to deliver the audit days is effective and enables identification of areas of practice that are working well and those that need improvement across the partnership. Audits also promote service improvement through the identification of key practice issues which are addressed in action plans that are implemented and monitored by the WSCB via its core team. Practitioners from all partners involved in the case being audited are invited to the Audit Day to a forum facilitated by Audit Focus Group leads who are senior representatives of the organisations on the Board and their managers complete audit tools in preparation for the day. Children and their families are also interviewed if appropriate to ascertain their views of the quality of help offered them.

Learning from the audit days is added to the learning logs for practitioners and key messages recorded on posters.

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.

7.3. 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

8. Listening to the voice of children and parents of cases audited and specific activity to learn the views of children on a particular matter

The WSCB Audit Day methodology includes has a process for listening to the voice of children and parents of cases audited. The Board analyses views for themes. In addition the Board will undertake specific activity to learn the views of children about the safeguarding risks in relation to particular themes.

9. Experience of front line workers and managers

The WSCB Safeguarding Children Operational Group (SCOG) and the WSCB Practitioner (Reference) Group provide strong forums for the Board to listen to the experience of front line workers and managers.

The Board will also use focus groups, Board members visits to meet with practitioners, practitioner events and surveys to ensure views are listened to and test out the strength and impact of constant feedback loops from the front line to senior managers within partner agencies.

Single agency information about the quality of their safeguarding activity including compliments and complaints

The Board will receive reports from partner agencies including compliments and complaints evidencing the impact of their safeguarding activity on practice and outcomes for children.

The accountability and responsibility framework agreed at the Board in July ensures that partners notify the Board of internal organisational or casework risks as appropriate. The intelligence from this process must be included in the triangulation of intelligence from all the methodologies.

10. Organisational issues such as workforce, learning capacity, safeguarding wisdom supervision and support, organisational culture, use of resources and evidence based practice.

A programme of scrutiny of organisational issues that follows up and is in line with the discrete number of priority issues identified for the year by the Board will consider intelligence about organisational issues such as workforce, learning capacity, safeguarding wisdom, supervision and support, organisational culture, use of resources and evidence based practice.

11. Regular assessments of partner responses to Child Sexual Exploitation (CSE) and children missing from home (MFH)

Working Together 2015 requires that the WSCB undertake regular assessments on the effectiveness of Board partners' responses to Child Sexual Exploitation (CSE). The Board has agreed the methodology for undertaking these assessments and we will include information on the outcomes from the assessments including actions required in the WSCB Annual Report. The assessments will include the analysis of how partners have used data to promote service improvement vulnerable children including those who are missing from home, returning home from care, in care, care leavers or subject to a child protection plan.

12. Pan Cheshire Child Death Overview Panel (CDOP)

In compliance with legislation the WSCB ensures that a review of each death of a child normally resident in Warrington is undertaken by the 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) in partnership with the other three LSCB's in Cheshire and this has provided greater clarity of understanding about local child deaths.