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"

Warrington Safeguarding Children Board

Learning Improvement Framework

Introduction

The Warrington Safeguarding Children Board (WSCB) is a strategic partnership which has a statutory obligation 'to ensure the effectiveness of what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area'[1].

The Board also has a number of statutory functions including;

1. monitoring and evaluating the effectiveness of what is done by the local authority and their Board partners individually; and
2. collectively to safeguard and promote the welfare of children and advising them on ways to improve[2]; and
3. undertaking reviews of serious cases and advising the local authority and their Board partners on lessons to be learned[3]

Working Together to Safeguard Children highlights the need for professionals and organisations protecting children to reflect on the quality of their services and learn from their own practice and that of others.[4]

In order to support professionals and organisations reflect and learn the WSCB has developed this learning and improvement framework which sets out the ways in which we will review practice and ensure that we identify positive practice and areas for improvement.

Learning and Improvement Framework

In order to support professionals and organisations reflect and learn the WSCB uses a number of methodologies to gather information and intelligence for analysis in order to identify actions and make recommendations. The WSCB will use the following sources to obtain information and intelligence:

- Performance Dashboard
- Single agency self-assessment audits
- Multi-agency case file audits
- Multi-agency deep dive case file audit
- Notifiable incidents
- Serious case reviews / Case reviews / Other Learning Processes

[1] Section 14 (1) (a) Children Act 2004
[2] Regulation 5 (1) (c) Local Safeguarding Children Boards Regulations 2006
[3] Regulation 5 (1) (e) Local Safeguarding Children Boards Regulations 2006
[4] Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children March 2015 Page 72

- Escalation Process
- Child Death Review
- Peer reviews
- Ofsted Review of Local Safeguarding Children Board's (LSCBs)
- Specific single agency reports
- Board members visit to practitioners

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.

Performance Dashboard

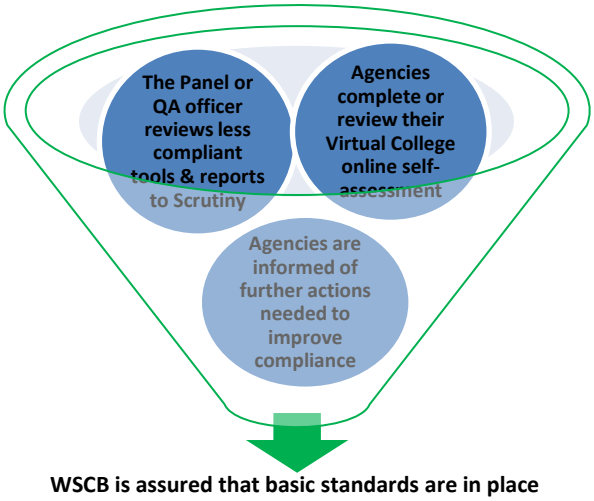
The WSCB gathers key performance data on a quarterly basis which focuses on providing basic information on safeguarding across Warrington and information regarding the Boards priorities contained in the Business Plan in order to measure our progress and to allow us to recognise and respond to significant shifts in local methods of intervention.

Single agency self-assessment audits (known as Sec 11 and Sec 175 audits)

Key agencies and organisations have a statutory duty[5] to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children. Governing bodies of maintained schools and further education institutions have a similar duty[6] and schools within the independent sector (including academy schools, free schools and alternative provision academies) and non-maintained special schools have a duty set out in standards regulations[7,8] in relation to safeguarding and promoting the welfare of pupils.

In order for Board partners to assure the Board that they are fulfilling their obligations regarding safeguarding and promoting the welfare of children, they undertake a self-assessment audit. A Pan Cheshire[9] self-assessment audit template is in place and is completed electronically by each agency via a Virtual College online tool.

The quality of self-assessment audit tools are scrutinised regularly by the Board team and reported to Scrutiny subgroup. Further scrutiny and challenge is also brought via a meeting where a panel of WSCB representatives review



[5] Section 11 of the Children Act 2004
[6] Maintained schools (including maintained nursery schools) Sec 175 Education Act 2002
[7] Education (Independent School Standards) (England) Regulations 2014.
[8] Non-Maintained Special Schools (England) Regulations 2015
[9] Cheshire East, Cheshire West & Chester, Halton and Warrington Local Safeguarding Children Boards

the self-assessment submission of any agency identified as having lower rates of compliance with the tool. For those agencies with a footprint across one or more Cheshire LSCB areas a Pan-Cheshire panel meeting is held with representatives from the various LSCBs. In order to facilitate focus on those education settings requiring more support to achieve good levels of compliance the Board works with Warrington Borough Council's Education Safeguarding Team. They regularly monitor the audits of schools they support and provide updates on compliance to the Board.

Multi-agency case file audits

The WSCB undertakes a program of planned audit days. Each audit day focuses on a particular theme identified by the Board and 12 cases are reviewed on each day. These cases are selected randomly and all those agencies or organisations involved in that case are asked to complete and submit an 'audit tool' and attend the audit day.

On the day of the audit each case is reviewed by two facilitators (Board partner agency managers) who then lead a Focus Group with practitioners involved in the case. The facilitators will report on any learning identified and promote service improvement through the identification of key practice issues which are addressed via single and/or multi agency actions. They may also visit the families of the cases audited where appropriate to provide opportunities for children and young people, their parents and Carers to express views and feelings about local services and how well partners took into account their wishes.

Each audit day identifies overarching tends and themes identified in practice locally and results in a multi-agency report and action plan outlining activity to address areas for development. The Board oversees this improvement activity via their Scrutiny sub group who receives the audit day report and monitor and report on progress against the identified activity.

Multi-agency deep dive case file audit

The WSCB can also undertake a deep dive audit to investigate and scrutinise in greater depth specific areas emerging as a potential concern. This provides the board with strong evidence about the quality of partnership services on the ground to keep children and young people safe in relation to challenging areas.

The process for undertaking a multi-agency deep dive case file audit is similar to multi-agency case file audit. All those agencies involved in the case are asked to review their agencies involvement and provide a report and / or chronology of events. A Multi-agency Deep Dive Case File Audit Review group is created from appropriate Board partner agencies to overview the process through meetings with practitioners and managers. This group can be chaired by either a member of the Board or where necessary an independent chair. The Chair of the Case Review group will report to Board on any learning identified and promote service improvement through the identification of key practice issues which are addressed via single and/or multi agency actions.

Notifiable incidents

Working Together to Safeguard Children (2015) provides a definition[10] of a notifiable incident:

> 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).

Working together also defines the term 'seriously harmed'[11]:

> "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.

Working together requires the local authority to report any incident that meets the above criteria to Ofsted and the Local Safeguarding Children Board within five working days of becoming aware that a notifiable incident has occurred[12]. Warrington Borough Council will inform Warrington Safeguarding Children Board (WSCB) of any such notifiable incident using the WSCB Notification Form attached at **Appendix 1**.

Where the WSCB are informed about a 'notifiable incident' by the local authority, the WSCB Business Manager will inform the WSCB Independent Chair and a decision will be made on what local learning action, if any, needs to be taken in accordance with the processes identified within this framework.

[10] Working Together to Safeguard Children A guide to inter-agency working to safeguard and promote the welfare of children (March 2015) Para 13, page 74.
[11] Working Together to Safeguard Children A guide to inter-agency working to safeguard and promote the welfare of children (March 2015) Para 17, page 76.
[12] Working Together to Safeguard Children A guide to inter-agency working to safeguard and promote the welfare of children (March 2015) Para 14, page 75.

Serious Case Reviews (SCRs)

The WSCB has a statutory responsibility[13] to undertake a Serious Case Review (SCR) in certain specified circumstances. Working Together (2015) outlines the specified circumstances[14]:

> 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.

The Working Together document also specifies the additional circumstances were a Serious Case Review should be undertaken[15]:

> In addition, even if one of the criteria is not met, an SCR should always be carried out when a child dies in custody, in police custody, on remand or following sentencing, in a Young Offender Institution, in a secure training centre or secure children's home. The same applies where a child dies who was detained under the Mental Health Act 1983 or where a child aged 16 or 17 was the subject of a deprivation of liberty order under the Mental Capacity Act 2005.

Any agency or person can make a referral to the Chair of the WSCB for the consideration of undertaking a serious case review using the notification form at Appendix 1. In circumstances where the WSCB are informed by the local authority of a notifiable incident the WSCB Business Manager, in consultation with the Chair of the WSCB, will consider if the information provided necessitates the consideration for a Serious Case Review.

The Chair of the Warrington Safeguarding Children Board will decide within 24 hours if the matter requires referral to a WSCB Criteria Panel. The WSCB Criteria Panel will be drawn from managers from partner agencies. A Chair will be selected from an appropriately independent partner agency or where required an external independent chair will be recruited to run the criteria panel meeting.

WSCB Criteria Panel Process

All organisations involved in the case will be identified and asked to complete and submit an 'agency report' where they review their agencies involvement in the case, the report should be completed by a manager from that agency.

[13] Regulation 5 (1) (e) Local Safeguarding Children Boards Regulations 2006
[14] Working Together to Safeguard Children A guide to inter-agency working to safeguard and promote the welfare of children (March 2015) page 75.
[15] Working Together to Safeguard Children A guide to inter-agency working to safeguard and promote the welfare of children (March 2015) paragraph 19, page 76

The panel meets to review the available information, from written reports and discussion with practitioners and/or managers, against threshold criteria for a Serious Case Review as outlined above. The panel, within 3 weeks of the date of the initial referral to the WSCB Chair, will make a recommendation to the Chair of the WSCB of the necessary learning process. If for any reason the panel cannot meet this timescale this is notified to the chair of the Board.

The Chair of the WSCB, upon receiving the panel's recommendation, will make the final decision with regards to what next steps will be instigated. This decision will be made within one month of the initial notification. If this timescale is not met reasons for delay will be reported to Board. The Chair may also seek peer challenge from another LSCB Chair when considering this decision and at other stages in the SCR process if it is felt peer insight is required.

The Board will inform Ofsted, DfE and the National Panel of Independent Experts on Serious Case Reviews of all SCR decisions. A log is also kept of all notifications received and decisions made alongside the rationale. This is necessary to as the decisions 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 support their deliberations and the Board Chair will be prepared to attend in person to give evidence to the panel if requested.

In cases where the WSCB is challenged by the national panel to change its original decision, the Chair of WSCB will make the final decision we will inform Ofsted, DfE and the National Panel of Independent Experts on Serious Case Reviews of the Chair's decision.

SCR learning process

If the Chair decides that a SCR should take place, a Case Review Group will be set up with appropriate membership from partner agencies. They will meet initially to identify the purpose of the review and outline Terms of Reference. An Independent Author will be commissioned to undertake the review and chair the Case Review Group. The Independent Author will, in consultation with the Chair of the WSCB, set out a program for the review, which will include the methodology for the review, the number of case review meetings to take place and the involvement of practitioners, managers and the family.

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 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 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 to implement improvements and disseminate learning.

The Independent Author will present a final report of the review with, where necessary, appropriate recommendations for further action, to the WSCB main board. Working together (2015) outlines what should be included in a final report[16]:

The final report 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).
- 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.
- be discussed with the family

The WSCB will consider carefully implications of publication and will take into account any relevant legislation, including, the Data Protection Act 1984 and the Human Rights Act 1998, any other restrictions on publication, such as court orders and how best to manage the impact of publication on children, family members and others affected by the case. 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. The Board will inform Ofsted, DfE and the National Panel of Independent Experts on Serious Case Reviews of their decision on publication at least seven working days before publication. 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.

Where publication is agreed as appropriate the final report 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. The timing of publication will have due regard to the impact on any ongoing legal proceedings, including any inquest. The report will also be shared with the NSPCC national repository so that learning is shared nationally through the agreed mechanism.

A multi-agency action plan based on any recommendations contained within the final report will be developed. The WSCB will oversee the process of agreeing with partners what action they need to take in light of the SCR findings and recommendations, establish timescales for action to be taken and monitor progress.

[16] Working Together to Safeguard Children A guide to inter-agency working to safeguard and promote the welfare of children (March 2015) page 79

The WSCB will ensure that practitioners and managers involved in the case are made aware of the report's findings and learning. Any learning pertinent to a single agency will be disseminated via the agency's own training, development and awareness raising pathways. Multi-agency learning will be incorporated into existing WSCB multi-agency training where appropriate and referenced in the WSCB Annual Report including the differences made to practice and impact on outcomes for children and young people.

Case Review Process

Where a case does not meet the criteria for a Serious Case Review then the Criteria Panel may identify to the Chair of the WSCB that there are concerns regarding how agencies worked together and recommend that a 'case review' be undertaken.

If the Chair decides that a 'case review' should take place, then the process will follow the same format outlined above with the exception that the process and final report do not require external vetting or approval. It will be for the WSCB to identify how best to disseminate the learning from the review, such as a formal report or lessons learnt overview or learning workshops.

Other Learning Processes

In certain circumstances, were it has been decided that an SCR or case review isn't required but it is considered that there may be some valuable lessons to be learned the Chair may decide to undertake another learning process, for example, a 'table top de-brief, informal practitioner de-brief'.

Escalation Process

The four Pan Cheshire LSCBs (Cheshire East, Cheshire West, Halton and Warrington have devised a Pan Cheshire Escalation policy which standardises the multi-agency escalation / dispute resolution process across the Pan Cheshire area.

The policy can be accessed via the Pan Cheshire Procedures website:

http://www.proceduresonline.com/LimitedCMS_centrally_managed_content/pancheshire/shared_files/escalation_policy.pdf

The WSCB monitors trends and themes from this process by requesting that partners report Level 3 cases to the Board and recording all Level 4 (board level) cases. These are monitored when appropriate via the Scrutiny sub group.

Child Death Review Process

In compliance with legislation[17] 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). In accordance with guidance[18] WSCB have joined with the other Pan Cheshire

[17] Regulation 6 of the Local Safeguarding Children Boards Regulations 2006, made under section 14(2) of the Children Act 2004

[18] Section 5. Working Together to Safeguard Children: A guide to inter-agency working to safeguard and

LSCBs to develop a Pan Cheshire CDOP as this provides for better opportunities to identify significant recurrent contributory factors from a much larger population and makes it easier to aggregate findings and maximise learning opportunities.

The WSCB will ensure that all notifications of a child death in Warrington will be forwarded to Pan Cheshire CDOP for review. Pan Cheshire CDOP will then be responsible on behalf of WSCB for reviewing the death and informing the Board of the outcome of all reviews. This will normally be done via the provision of a quarterly and annual report by the Chair of Pan Cheshire CDOP.

Where trends and themes are identified CDOP will ensure this information is made available to WSCB to cascade to professionals via newsletters or 7 minute briefings. The WSCB will also incorporate these messages into training or lunchtime workshops as relevant.

Peer reviews

The WSCB may commission a 'Peer Review' whereby another LSCB (or other body) will be invited to review the Board or a particular function or process. For example, a Peer review may be conducted on Child Sexual Exploitation so the area can identify strengths and areas for development in their adopted approach. Peer Reviews will only be used in circumstances where it is felt an external perspective outside of local partners is necessary to identify areas for development or receive assurances about the local approach.

Ofsted review of LSCB's

The Office for Standards in Education (Ofsted) carries out targeted inspections of local authorities and Local Safeguarding Children Boards (LSCBs).

Ofsted produce a report with recommendations and where necessary improvement plans with specific actions to aid LSCBs to improve their approach. The WSCB will ensure that any recommendations / actions are appropriately addressed and will monitor activity to ensure improvement impacts on the Boards understanding of the quality of practice and safety of children.

Specific single agency reports

The WSCB receives themed reports from the local authority and Board partners for scrutiny which sets out data on specific activity, for example;

- Child Protection Conferences
- 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)
- Individual agency workforce capacity and development issues

The intelligence from all these sources is analysed to identify trends, anomalies and any potential risks. 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.

Board Member Visits

WSCB members will undertake visits to agencies and organisations front line staff. The purpose of these visits is to allow Board members to find out what it is like for frontline services working with children, young people, their families and carers and to listen to any concerns or issues regarding safeguarding and multi-agency working together they may have.

If you would like to be involved in these please let us know; we genuinely want to hear and understand your views.

Dissemination and transfer of learning

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

- Each Board member given specific responsibility to take back areas of learning to their agency to ensure change and to feedback outcomes
- Publication on WSCB and Partner Websites
- Promotion of key learning messages and products via WSCB and Partner Social Media Accounts e.g. 7 minute briefings
- Delivery of events for front line staff, including training sessions & lunchtime workshops
- Incorporation of messages within existing multi agency training courses
- Development of new multi-agency training courses

Warrington Safeguarding Children Board recognises the importance of ensuring that learning has been translated into improvements in practice and outcomes. The board will look to triangulate information regarding improvements via monitoring performance data in key areas, commissioning specific and themed reports and undertaking follow up audits and reviews.

Work in this area will be monitored by the Boards Scrutiny sub-group which receives updates and oversees the progress of all audits and reviews. It monitors the action plans arising from the audits and reviews and ensures that they are completed in a timely fashion. The group also scrutinises performance information and will track key areas of practice to monitor progression against action plans arising from the audits and reviews in order to evidence impact on practice.

Appendix 1: Warrington Safeguarding Children Board Notification Form

1. CASE OUTLINE: Include any critical incident, status of child i.e. Subject of a Child Protection Plan, Looked After Child, disability, etc				
2. CHILD's DETAILS				
Child's Last Name/s:		**Child's Date of Birth:**		
Child's Forename/s:		**Age:** [If DOB not known]		
Also known as:		**Gender:**	Male	Female
Ethnicity: Please specify		**Disability**		
Child's Home Address:				
Mother's Name				
Mother's DOB				
Mother's Address				
Father's Name				
Father's DOB				
Father's Address				
Sibling's Name(s)				
Sibling's DOB(s)				

3. REASONS FOR REQUESTING A REVIEW/REFERRAL: Tick all appropriate options:

- ☐ Notifiable Incident:
  [Please specify appropriate criteria from Working Together to Safeguard Children, Chapter 4]
- ☐ Serious Case Review:
  [Please specify appropriate criteria from Working Together to Safeguard Children, Chapter 4]
- ☐ Serious Case Review:
  [Please specify]

4. PARTICULAR CONSIDERATIONS: Please specify any considerations for this case, for example; Is there media interest? Are there criminal proceedings? Is the case linked to a complex abuse case?

5. DECISIONS OF THE SUB GROUP / ACTIONS NEEDED:
☐ **Serious Case Review to be undertaken** ☐ Multi-Agency Review ☐ Single Agency Review ☐ Referral to other LSCB ☐ Other [Please specify] Any formal processes required

Serious Case Review Process