

# LEARNING AND IMPROVEMENT FRAMEWORK

## SCOPE OF THE CHAPTER

The purpose of the NEL Safeguarding Children Partnership Learning and Improvement Framework is to make explicit the way that professionals and organisations protecting children need to reflect on the quality of their services and learn from their own practice and that of others. It explains the requirements for an integrated local learning and improvement framework

## CONTENTS

1. Principles – Learning and Improvement Framework
2. Purpose of Local Framework
3. Principles for a Culture of Continuous Improvement
4. Accountability

## 1. PRINCIPLES – LEARNING AND IMPROVEMENT FRAMEWORK

This local framework covers the full range of single and multi-agency reviews and audits which aim to drive improvements to safeguard and promote the welfare of children. See **NEL Learning and Improvement Framework**. The different types of review include:

- Child Safeguarding Practice Review for every case where abuse or neglect is known or suspected and either:
  - Abuse or neglect of a child is known or suspected **and**
  - The child has died or been seriously harmed
- Lessons from Child death review (see chapter 5 Working Together 2018): a review of all child deaths.
- Review of a serious child safeguarding incident which falls below the threshold for an SCR; and Review or audit of practice in one or more agencies.

## 2. PURPOSE OF THE LOCAL FRAMEWORK

The aim of this framework is to enable NELSCP to improve services through being clear about our responsibilities to learn from experience and particularly through the provision of insights into the way our organisations work together to safeguard and protect the welfare of children.

The framework is shared across all agencies that work with families and children and will enable organisations to be clear about their responsibilities, to learn from experience and improve services as a result’.

This should be achieved through:

- Reviews conducted regularly; not only on cases which meet statutory criteria, but also on other cases which can provide useful insights into the way organisations are working together to safeguard and protect the welfare of children and that this learning is actively shared with relevant agencies.
- Such reviews to encompass both those cases which meet statutory criteria (i.e. Child Safeguarding Practice Reviews (CSPR) and child death reviews) and cases which may provide useful insights into the way organisations are working together to safeguard and protect the welfare of children.
- Reviews examining what happened in the case, why it did so and what action will be taken to learn from the findings.

- Learning from both good and more problematic practice about the NEL SCP strengths and areas for development within local services to safeguard children.
- Action results in lasting improvements to services which safeguard and promote the welfare of children and help protect them from harm; and
- Transparency about the issues arising and the resulting actions organisations take in response to the findings from individual cases, including sharing the final reports of Childs Safeguarding Practice Reviews with the public.

Reviews are not an end in themselves, but a method to identify improvements needed and to consolidate good practice. The NEL SCP and partner organisations will translate the findings from reviews into programmes of action which lead to sustainable improvements.

### **3. PRINCIPLES FOR A CULTURE OF CONTINUOUS IMPROVEMENT**

There should be a culture of continuous learning and improvement across the NEL SCP and partners to safeguard and promote the welfare of children, so as to identify what works and what promotes good practice.

Within this culture the principles are:

- A proportionate response: According to the scale and level of complexity of the issues
- There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice.
- The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined.
- Reviews of Child safeguarding Practice Reviews should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed.
- Professionals must be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith.
- Families, including surviving children, should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring that the child is at the centre of the process.
- Final reports of CSPs must be published, including the LSCB's response to the review findings, in order to achieve transparency. The impact of CSPR and other reviews on improving services to children and families and on reducing the incidence of deaths or serious harm to children must also be described in LSCP annual reports and will inform inspections; and
- Improvement must be sustained through regular monitoring and follow up so that the findings from these reviews make a real impact on improving outcomes for children.

CSPR and other case reviews should be conducted in a way which:

- Recognises the complex circumstances in which professionals work together to safeguard children.
- Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did.
- Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight.
- Is transparent about the way data is collected and analysed.
- Makes use of relevant research and case evidence to inform the findings.

Whilst there is an understandable focus on Child safeguarding Practice Reviews given the profile of this type of review, it should be remembered that they are not the only process that should drive learning and improvement. the CSPR should pay equal or greater attention to the dissemination processes for learning giving consideration to:

- The need to reach a multi-agency audience.
- An understanding of adult learning.
- The on-going training and development needs of certain professional groups.

#### **4. ACCOUNTABILITY**

NEL SCP is committed to these principles and this learning will be implemented and monitored through the LSC B Leadership Board and its strategic delivery and work groups.

The SCP Executive Board through the work of the Improving Practice Group and the Children's Safeguarding Assurance Group will challenge services to improve practice and therefore outcomes for children. The SCP will be responsible for overseeing the progress against the Learning and Improvement Framework.

The SCP strategic delivery groups and working groups are responsible for the implementation of elements of the learning and improvement framework in particular:

- To develop horizon scanning practice that will inform the development of learning opportunities and allow managers and professionals to keep informed of changing issues relating to safeguarding children.
- To communicate key safeguarding messages, research, lessons and procedural expectations to agencies, and professionals, to ensure a consistent approach to safeguarding children and continuous learning.
- To develop strength based approach to learning from CSPR which looks to promote the factors that impact on good practice and minimise those that can contribute to problematic practice.
- To disseminate the learning from the local Child Death Overview panel and evidence impact made.
- Ensure safeguarding training is directly informed through learning from interagency safeguarding practice audits and from safeguarding reviews.
- To demonstrate what difference has been made as a result of the voice and influence of children and young people.

The framework will measure the effectiveness of meeting the SCP priorities as in the Arrangement Plan

1. Neglect
2. Sexual Harm
3. Domestic Abuse