LUTON LSCB - Learning and Improvement Framework

Commitment to a culture of learning and improvement

1) In line with the requirements of *Working Together to Safeguard Children 2013*, Luton LSCB will *'maintain a local learning and improvement framework which is shared across local organisations who work with children and families'*. This framework is designed '*to enable organisations to be clear about their responsibilities, to learn from experience and improve services as a result'* (Working Together 2013, Section 4.1).

2) The LSCB Learning and Improvement Framework will seek to improve outcomes for children through the review of:
   - Ordinary day to day practice, in which agencies often provide good outcomes in difficult circumstances
   - Examples of good and exceptional practice
   - Child deaths and other serious incidents with adverse outcomes.

3) Luton's Learning and Improvement Framework recognises the complexity of work to safeguard children, the difficulty of many of the decisions that have to be made and the importance of both personal and organisational accountability. It recognises that in a complex system dealing with risk and behaviour that is sometimes outside of professional control, errors sometimes occur.

4) Decision makers and senior managers in all of the LSCB's member agencies are committed to the development, implementation and review of this framework. They will adhere to and promote its principles in the way in which they lead services.

5) The LSCB and member agencies have adopted a 'systemic' or 'organisational' understanding of why shortcomings and vulnerabilities in safeguarding services occur and the way in which these may be highlighted through child deaths and other serious incidents with adverse outcomes. Investigations into deaths and other serious incidents will review all of the factors that may have contributed to shortcomings in services. They will address the full range of organisational factors implicated in an incident as well as the decisions and actions of front line staff.

6) Investigations will seek to understand 'why' events have happened in the fullest sense. Managers, commissioners of services and other decision makers understand that the investigation of incidents may touch on their work and will not focus exclusively on the involvement of front line staff and managers who were close to the event. This approach will apply to the conduct of all aspects of the Learning and Service Improvement Framework, including Serious Case Reviews.

7) Learning from practice requires openness in reporting and discussion. The LSCB expects all member agencies to maintain and promote (or in some cases to develop) arrangements which actively encourage front line staff to report 'near misses' and other incidents that they believe

highlight weaknesses in safeguarding arrangements to senior staff in the organisation. Organisations must ensure that staff can report concerning incidents without fear of being 'blamed' because of their involvement.

Components of the Learning and Improvement Framework

8) Reviews and audits will be 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, promote and protect the welfare of children. The Luton Learning and Improvement Framework will include the full range of methods of learning set out in Table 1 (below). Brief descriptions of the key elements follow.

Reflection on ordinary practice

9) The most important element of the Learning and Improvement Framework is the activity that front line staff and managers routinely use in order to manage, reflect on and improve their work. Central to this is reflective discussion and supervision. Discussion of good practice, good outcomes and ordinary activity are as important as discussion of cases with poor outcomes. It shows how professionals cope and adapt when services are dealing with change and high levels of pressure.

Learning from supervision

10) Supervision arrangements will vary between agencies but supervision should always be challenging and offer a 'fresh pair of eyes'. When necessary the supervisor must act as the 'devil's advocate'. This is the most effective way of helping professionals to understand the significance of concerning developments and avoid becoming complacent about the way that risk is being assessed or managed.

Single Agency Audit Activity

11) Audit within individual agencies is a key method of quality assurance. Auditing will be planned as a normal part of member agency management activity. Additional audits will be required in response to specific incidents or concerns about service provision.

12) The key function of audit is to measure quality in order to improve services. The LSCB will expect agencies to demonstrate through reports to its Executive how the learning from audits has been used to improve service provision. It may encourage agencies to conduct fewer audit exercises but to discuss the findings in more detail in order to learn more from them.

Multi-Agency Auditing

13) The LSCB has used a range of approaches to learn from practice during 2012-2014, placing the emphasis on the involvement of front line staff and their managers. In 2014 the LSCB will carry out at least three substantial audit exercises through its multi-agency audit group. Through the audit of clusters of cases it will learn about the effectiveness of practice in key areas, identify areas for potential service improvement and inform the LSCB Business Plan.

14) For an initial period of 12 months beginning in April 2014 this group will have an independent chair and will meet at least every three months to review the records of cases from a range of involved agencies. Membership of the group will be drawn from all provider agencies and will including named professionals and managers directly involved in service provision.

Near miss and serious incident reporting

15) The LSCB will expect agencies to demonstrate how the learning from the 'near miss' reporting system has been used to improve service provision. In the first instance it will be for member agencies to determine which incidents should be included in 'near miss' reporting arrangements.

Learning from important national SCRs

16) The LSCB maintains a regular forum in which the findings of important SCRs published by other LSCBs are discussed. The SCR group will determine which of the many SCRs published nationally appear to be of most direct relevance to agencies in Luton. The role of the forum is to enable local service leaders to test Luton's services against the findings of significant SCRs and to decide how to disseminate the most important findings of SCRs. Outcomes of these discussions will be circulated together with other information to disseminate the findings of significant national SCRs.

Table 1 Elements of the Learning and Improvement Framework

Routine and planned exercises	Responsive exercises	Description of the activity	Frequency of use / intensity of involvement
Challenge of local services against the findings of nationally significant SCRs and other major reviews	Serious Case Reviews	Reserved for the most serious incidents which either meet the statutory criteria or a child has been seriously harmed and there is an indication either a need for public accountability or risk of serious reputational harm to safeguarding services (see section 11 for a definition)	Rarely used and resource intensive – commissioned in response to the most serious incidents
	Other independent reviews commissioned as a result of serious incidents or 'near misses' reported to LSCB	Reserved for serious incidents which do not meet the statutory criteria for a SCR when the potential for significant learning is identified	
Reviews and audits commissioned by the LSCB in order to inform its business plan or strategic objectives		Focused on areas which have been identified as strategic priorities or where the LSCB believes there are risks to services or unmet needs	Planned activity of the LSCB and member agencies to support business planning and service development
Section 11 audits and reviews Assurance reports to LSCB		Routine reporting and challenge to the agency as a whole	
	Responsive single or multi-agency audit	Specific audits commissioned by an agency or the LSCB in relation to identified concerns	
Planned single or multi agency audit exercises		Planned single and multi-agency audit activity. This will form an important component of day to day learning. The more reporting of concerning cases there is the less need for audit	Routine day to day activities that provide the majority of learning from practice experience
Reporting and review of incidents causing concern to front line staff through agency reporting systems		Day to day activity that should form a major component of learning and improvement activity. Needs to take account of both good and sub-optimal practice and outcomes	
Reflective single and multi-agency discussion on cases. Intrusive and challenging supervision			

Detailed Protocols and Procedures to implement the framework

Reporting child deaths and other serious incidents to the LSCB in order to enable the LSCB to make decisions about the need for Serious Case Review (SCR) or other forms of review

17) Member agencies are required to report incidents that meet the following criteria to the LSCB:

I. The death of a child where abuse or neglect (currently or in the past) is known or suspected. The abuse suffered does not need to be the cause of the child's death

II. The death of a child in the secure estate (YOI, STC or Secure Children's Home) or police custody - regardless of the circumstances

III. The death of a child who was being treated in Tier 4 or similar psychiatric provision (whether or not the child was detained under the Mental Health Act 2005)

(The death of a child includes death by suspected suicide or the result of self-harm.)

IV. Incidents in which there has been serious harm to a child which include the following:

- Potentially life-threatening injury caused by abuse or neglect
- Serious and potentially permanent impairment of physical and / or mental health and development through abuse or neglect
- Longstanding or grave sexual abuse.

The decision to conduct a Serious Case Review or another form of LSCB review on cases reported

18) The decision to conduct a SCR will be made by the Independent Chair of LSCB taking into account the recommendation of the Independent Chair and members of the SCR subgroup (or any other group or individual delegated to undertake that task) and the views of member agencies. Dissenting views in the SCR group will be reported to the LSCB Chair. The LSCB Independent Chair will record the reasons for decisions in writing and make them available to legitimately concerned parties. The Independent Chair will take into account the following interpretation of the statutory guidance.

19) The LSCB is required to conduct a SCR in the circumstances described in Section 17 subsections I - III above. [1]

20) The LSCB is required to conduct a SCR in the circumstances described in Section 17 subsection IV above when '*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 judging whether this criterion applies the LSCB Independent Chair will take account of the following factors:

- The nature of the harm to the child or children
- The evidence of concern about the provision of services to the child or family
- The need to maintain and promote public confidence in safeguarding services
- The likelihood of important and additional learning and service improvement arising from a SCR
- The likelihood of such learning and service improvement being achieved through other methods of review

21) In keeping with its existing practice the LSCB may conduct or commission a review or learning exercise in appropriate cases that are judged not to meet the SCR threshold. The method of review chosen should

[1] Working Together 2013 requires an SCR in relation to a child who is detained under the Mental Health Act 1983/2007. The LSCB should consider how it can learn from deaths regardless of the legal status of their hospital admission

take into account the need for an appropriate degree of independence and be proportionate to the seriousness of the events under consideration and the likely learning.

Methodology and capacity for conducting SCRs

22) The LSCB will continue to use whatever it judges to be the most suitable method of review to conduct SCRs in order to comply with the principles for the conduct of SCRs set out in *Working Together 2013*.

23) The LSCB will ensure that there is a pool of available reviewers across all agencies who have a sufficiently good knowledge of the 'systemic' or 'organisational' model of 'why things go wrong' (Paragraphs 1 - 7 of this report) and the skill necessary to enable the LSCB to carry out an SCR that complies with the statutory guidance. It will commission training programmes involving named professionals and managers of sufficient experience from member agencies in order to achieve this.

Reviews and learning exercises conducted and commissioned by the LSCB

24) The LSCB may conduct a review or learning exercise (other than a SCR) in the following circumstances:
   I. 'Near misses' or other cases when a child has been seriously harmed which do not meet the criteria for a SCR
   II. Other cases where there is potential for important learning and service improvement
   III. Review and audit of cases that will help the LSCB understand the progress that it is making in the implementation of its strategic objectives and business plan
   IV. Review and audit of cases that may help the LSCB identify or understand better new areas of vulnerability and risk in the service

25) Arrangements for family involvement and information sharing in relation to the review are set out in the following paragraphs.

Family involvement in SCRs and reviews of 'near misses'

26) The LSCB will determine whether to conduct an SCR or what other form of review to undertake according to the criteria set out above and will not seek the agreement of the family to conduct the review ahead of that decision.

27) The SCR will always seek to involve family members in SCRs and reviews of 'near misses' in accordance with the statutory guidance.

28) The LSCB will expect member agencies and contracted professionals to provide personal information in order for SCRs and reviews of near misses to be undertaken. The LSCB views this as a necessary and proportionate use of its power to request information in order to carry out a statutory function (Working Together 2013, Chapter 3, Paragraph 21). It is not expected that member agencies or contracted professionals will seek the consent of service users before providing information for a review in this category.

29) Once an SCR or near miss review has been conducted the information obtained should be shared with all participating agencies and held on the service user's case records so that it can inform future service provision.

Family involvement in other reviews and learning exercises

30) Other reviews (those falling within paragraphs 25.2 – 25.4 above) are conducted in order to inform the wider learning and service improvement functions of the LSCB. Cases will be selected to illustrate particular themes or problems in service delivery. Hence case selection is not determined by the events in a specific family. In this case family members should be notified of the purpose of the exercise, asked for informed consent to share records and asked to provide their perspective on the services received. This will be done by the LSCB on behalf of all participating agencies.

31) If consent cannot be obtained the LSCB will seek an alternative case to review.

32) At the end of the review process all agencies that are actively working with the family should have access to information obtained and shared during the review, subject to the agreement of the service user concerned.

Publication of the findings of reviews, audits and learning exercises

33) The LSCB will be transparent about the findings of all investigations and enquiries into service provision. At the conclusion of a Serious Case Review the LSCB will publish in full the findings and a statement on the actions that member agencies will be taking to improve services, unless there are compelling legal reasons to delay publication or not to publish.

34) Summaries of the learning from other reviews and learning exercise will be published in an accessible form in the LSCB Annual Report and / or on the LSCB website.

Learning in a systemic way

35) The LSCB will continue its practice of i) closely monitoring the implementation of findings and recommendations of reviews and ii) monitoring the impact of changes in practice and services. The value of the learning will be measured by recognisable service improvements for children and their families.

36) The LSCB will be alert to the unintended consequences of changes in services made as a result of the implementation of its recommendations. If necessary the LSCB will revisit the learning from SCRs and other reviews to check that the findings remain relevant.

LSCB structure, resources, arrangements, website and multi-agency procedures

37) Member agencies and the LSCB will commit resources to the implementation of this framework and make use of the LSCB's performance management framework in order to determine which forms of learning prove to be the most effective.

38) The Luton LSCB website will be reviewed and updated regularly so as to ensure that it reflects the wider Learning and Improvement agenda and appropriate material on SCRs and other reviews, including useful national material and links to research.

LUTON LSCB EXECUTIVE

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