



**Southampton  
Local  
Safeguarding  
Children Board**

## **LEARNING AND IMPROVEMENT FRAMEWORK**

Version 1	Ratified:	September 2017
	Review Date:	September 2018

## **1. Introduction**

The Southampton Local Safeguarding Children Board is a learning partnership and through its statutory functions reviews, scrutinises and challenges local safeguarding arrangements and practice in order to improve services to safeguard and promote the welfare of children in Southampton. To support this work, Southampton LSCB has adopted a quality assurance framework, developed regionally for South East LSCB's, see [www.southamptonlscb.co.uk](http://www.southamptonlscb.co.uk), and has developed this Learning and Improvement framework which is aligned with our other local 4LSCB's of Hampshire, Portsmouth and Isle of Wight.

Statutory safeguarding guidance, Working Together to Safeguard Children (DfE, 2015) states that professionals and organisations protecting children need to reflect on the quality of their services and that they learn from their practice where this is good and where it needs work, and that of others in order to improve local safeguarding practice. In order to support this there is a requirement placed on LSCBs to develop and maintain a local learning and improvement framework:

“Local Safeguarding Children Boards (LSCBs) should maintain a local learning and improvement framework which is shared across local organisations who work with children and families. This framework should enable organisations to be clear about their responsibilities, to learn from experience and improve services as a result”<sup>1</sup>

## **2. Roles and responsibilities**

This framework is for the Southampton LSCB, partner agencies and all local organisations that work with children and families.

The LSCB will maintain and develop this framework responding to local and national policies and agendas.

Partner agencies and all local organisations who work with children and families are expected to endorse this framework and embed this into their organisational and workforce learning and development policies. In addition partner agencies and local organisations are responsible for:

- Providing staff and other resources to deliver the framework.
- Contributing to reviews of practice undertaken by Southampton LSCB.
- Ensuring lessons learnt from these reviews of practice are disseminated widely within their organisation (e.g. internal training, policies/procedures, implementing actions plans).
- Ensuring that lessons learnt from these reviews of practice are embedded into practice (e.g. evaluation via auditing, staff surveys).

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<sup>1</sup> DfE (2015) *Working Together to Safeguard Children*, page 72.

### 3. Overview

This framework seeks to promote continuous improvement via a feedback loop as described in Appendix 1.

The building blocks to this framework are:

Learning from experience:

- a) Reviews of safeguarding practice
- b) Identification of learning

Improving services

- c) Embedding learning in practice
- d) Evaluation of learning

#### **Learning from experience**

- a) Reviews of practice.

“The local framework should cover the full range of reviews and audits which are aimed at driving improvements to safeguard and promote the welfare of children.”<sup>2</sup>

Learning opportunities, and opportunities to build on examples of good practice from safeguarding practice arise from a variety of sources. This framework sets out the key practice reviews that the Southampton LSCB, partner agencies and other local organisation undertake. Within all reviews the voice of children and young people will be threaded, ensuring this is heard and acted upon.

Type of review	Description	Who	Reporting
Serious case review	Where abuse or neglect is known or suspected and either: 1) a child dies; or 2) a child is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child. <sup>3</sup>	Partner agencies Relevant organisations. Independent Reviewer. LSCB Business Unit.	LSCB via the Serious Case Review Sub Group and/or a serious case review panel.
Multi-agency partnership reviews	Review of a safeguarding incident which falls below the threshold for an SCR.	Partner agencies Relevant organisations.	LSCB via Serious Case Review Sub Group

<sup>2</sup> DfE (2015) *Working Together to Safeguard Children*, page 72.

<sup>3</sup> Criteria for an SCR are set out in Regulation 5 of the Local Safeguarding Children Boards Regulations 2006.

Type of review	Description	Who	Reporting
		Possible Independent Reviewer or author. LSCB Business Unit.	
Multi-Agency Thematic Review	Review of a specific safeguarding theme, prompted by one or a number of cases that do not meet threshold for an SCR.	Partner agencies Relevant organisations. Possible Independent Reviewer or author. LSCB Business Unit.	LSCB via Serious Case Review Sub Group
Individual Management Review (IMR)	Review of a safeguarding incident which falls below the threshold for an SCR and where there are limited concerns about how organisations or professionals worked together to safeguard the child	Partner Agency	LSCB via Serious Case Review Sub Group
Child Death Review	A review of all child deaths up the age of 18. <sup>4</sup>	Child Death Overview Panel (CDOP)	LSCB
Multi-agency thematic case audits (also known as 'deep dive' audits)	Audit of practice relating to a specific safeguarding issue (case sample) as highlighted in multi or single agency.	Partner agencies Relevant organisations. LSCB Business Unit.	LSCB via Monitoring and Evaluation Sub Group
Multi-agency case audits	Audit of practice relating to a child's journey though the system (case sample). Highlighting where things go well as well as opportunities to improve.	Partner agencies Relevant organisations. LSCB Business Unit.	LSCB via Monitoring and Evaluation Sub Group
Single agency audits and	Audit of practice (case samples etc) as reported regularly to Monitoring and Evaluation Group. Highlighting	Partner agencies as detailed in the	LSCB via Monitoring and Evaluation Sub

<sup>4</sup> The LSCB's function in relation to child deaths is set out in Regulation 6 of the Local Safeguarding Children Boards Regulations 2006.

Type of review	Description	Who	Reporting
reports	where things go well as well as opportunities to improve.	schedule or reports	Group
Section 11 reviews	Self-assessment of an organisation's safeguarding arrangements and practice against Section 11 of the Children Act 2004. Highlighting where things go well as well as opportunities to improve.	Partner agencies	LSCB and Monitoring and Evaluation Sub Group
Section 175/157 audits	Self assessment of a schools safeguarding arrangements and practice (s.175/157 of the Education Act 2002)	Schools	LSCB via Monitoring and Evaluation Sub Group
National research, SCRs, etc.	Key messages from research, other LSCB's SCRs, Children's Commissioner, government reviews, etc	LSCB Business Unit and Sub Groups	LSCB and Sub Groups

#### Principles for conducting reviews;

The following principles, outlined in *Working Together to Safeguard Children 2015*, will be applied by the Southampton LSCB and their partner organisations to all reviews:

- 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 serious cases should be led by individuals who are **independent** of the case under review and of the organisations whose actions are being reviewed;
- Professionals should 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 children**, should be invited to contribute to reviews where this is appropriate. 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 SCRs **must be published**, including the LSCB's response to the review findings, in order to achieve **transparency**. The impact of SCRs 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 the LSCB annual report 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.

#### Protocols for conducting reviews:

*Working Together to Safeguard Children 2015* outlines the requirements for conducting case reviews, specifically serious case reviews and child death reviews. Appendix 4 of this document gives the current process for delivering reviews within Southampton.

b) Identification of Learning

Identification of key learning is achieved through the function of the Serious Case Review Sub Group of the LSCB. Appendix 2 gives the current terms of reference for this group.

Reviews of practice are commissioned by two of the LSCB subgroups: the Serious Case Review Sub Group and the Monitoring and Evaluation Sub Group.

The Serious Case Review Sub Group may commission a Serious Case Review (SCR) multi-agency partnership review of a case or request a single agency review in order to provide an analysis, lessons from the case and recommendations for any changes in policy or practice.

The Monitoring and Evaluation Sub Group has a responsibility for scrutiny and quality assurance of safeguarding arrangements and practice across Southampton. It exercises this responsibility by taking an overview of performance, conducting case audits, overseeing the Section 11 self-assessment process and receiving regular agency/organisation/service and specialist reports.

### **Improving services**

c) Embedding learning

In order to improve safeguarding practice learning identified from reviews of practice must be embedded into current practice. This is achieved by:

<b>How</b>	<b>What</b>	<b>Who</b>	<b>Reporting</b>
<b>Dissemination of learning</b>	Multi-agency training programme.	Partner agencies Inspire and SCC Workforce Development LSCB business unit.	LSCB via Learning and Development Sub Group
	LSCB Learning from case reviews workshops	Partner agencies Relevant organisations. LSCB business unit.	LSCB Serious Case Review Sub Group
	Publication of serious case review final reports	LSCB Business Unit Media and comms leads.	LSCB
	Single agency training	Partner Agencies	LSCB via Learning and Development Sub Group
	Newsletter Briefings	LSCB business unit	LSCB
<b>Actions to improve practice</b>	Single and Multi-agency action plans from case reviews.	Partner agencies Relevant organisations. LSCB business unit.	LSCB via Serious Case Review Sub Group And Serious Case Review Panels
	Single and Multi-	Partner agencies	LSCB via Monitoring

	agency action plans from case audits.	Relevant organisations. LSCB Business Unit.	and Evaluation Sub Group
	Single and Multi-agency action plans from Section 11 and Section 175 audits.	Partner agencies Relevant organisations. LSCB Business Unit.	LSCB and Monitoring and Evaluation Sub Group
	Actions arising from reporting to LSCB/Monitoring and Evaluation Sub Group.	Partner agencies Relevant organisations. LSCB Business Unit.	LSCB Monitoring and Evaluation Sub-Group

d) Evaluation of learning.

The evaluation processes detailed below are part of Southampton LSCB's quality assurance framework (A regional quality assurance framework has been adopted) - through scheduled reporting and reviews as well as one off or regular audits of practice and work. The aim of the activity outlined in this framework is to highlight good practice, make a positive impact on frontline practice, improve the child's journey through services and outcomes for children and young people in Southampton.

The quality assurance framework adopted by LSCB allows the board to evaluate the impact of lessons learnt from reviews of practice. Evaluation includes:

How	Who	Reporting
Single and Multi-agency case audits.	Partner agencies Relevant organisations. LSCB Business Unit.	LSCB via Monitoring and Evaluation Sub Group
Case reviews	Partner agencies Relevant organisations. LSCB Business Unit.	LSCB via Serious Case Review Sub Group
Reporting on case review action plans.	Partner agencies Relevant organisations. LSCB Business Unit.	LSCB via Serious Case Review Sub Group and Serious Case Review Panel/s
Evaluation of training.	Partner agencies Relevant organisations. LSCB Business Unit.	LSCB via Learning and Development Group

This evaluation process identifies whether or not lessons have been learnt and can identify new issues. This process completes the learning lesson feedback loop outlined in Appendix 1.

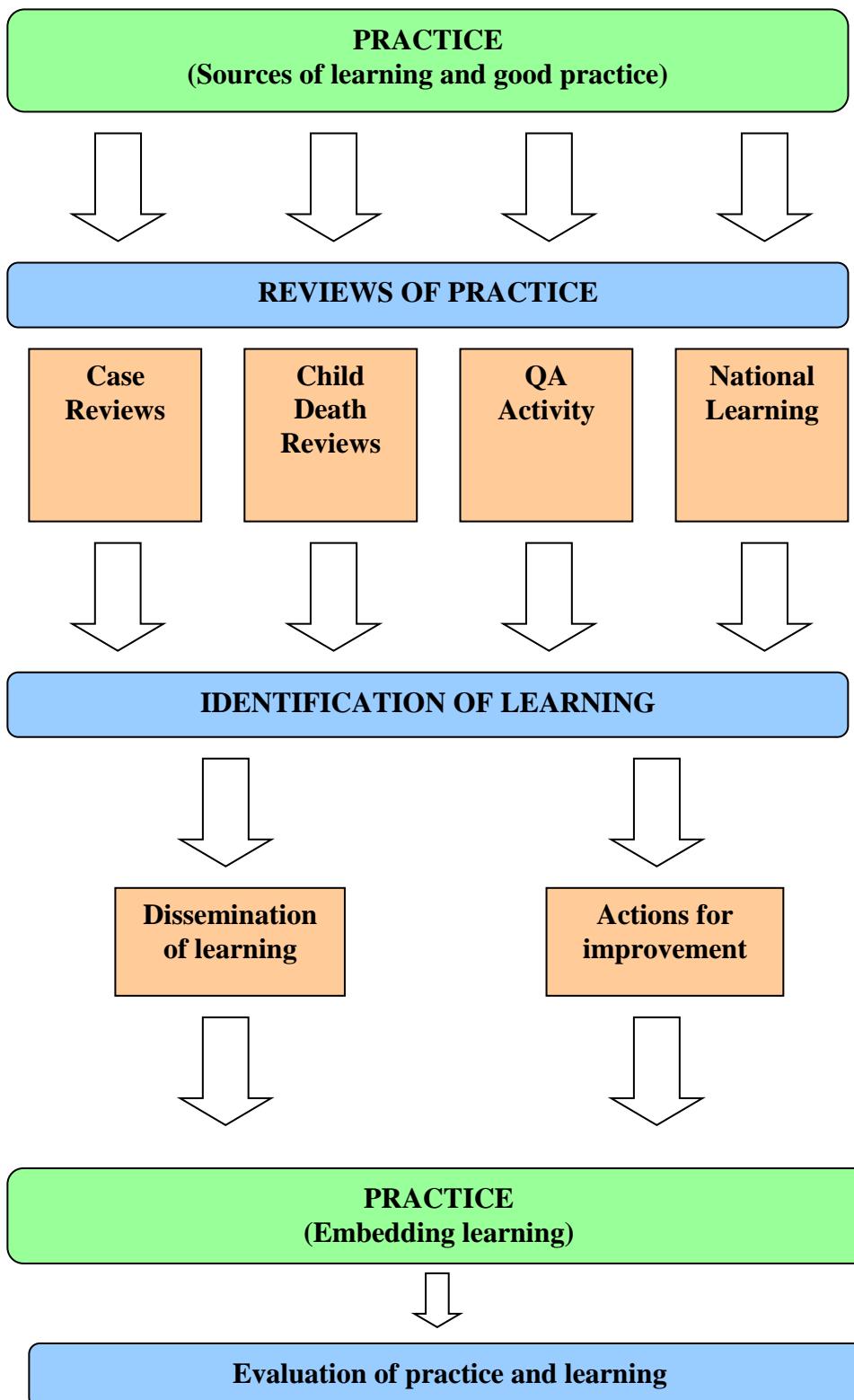
#### **4. Monitoring and review of this framework**

This framework will be monitored via the Serious Case Review Sub Group and reviewed on an annual basis (or sooner in response to delivery of this framework, government guidance, national agendas, etc).

Contributions to review will also come from the Monitoring and Evaluation and Learning and Development Sub Groups, as well as the LSCB Business Unit and Main Board.

SCRs and other case reviews and audits will test this framework and contribute to its annual review.

## Appendix 1: Southampton LSCB Learning Lessons Feedback Loop



## **Appendix 2: Southampton Serious Case Review Group Terms of Reference**

### **Serious Case Review Group**

### **Terms of Reference June 2017**



#### **Aims**

- To enable the LSCB to undertake reviews of cases that require lessons to be learned, including Serious Case Reviews (SCR's) as detailed in Working Together 2015 and to provide a mechanism for the LSCB to deliver reviews of cases that do not meet the threshold for a SCR.
- To ensure that lessons learned from SCRs and other reviews are shared and acted upon as follow up to the work of SCR panels.

#### **Functions of the Group**

The SCR group will deliver the functions below to meet these aims:

- Receive referrals of cases to be considered as SCR's
- Link with the Southampton LSCB Child Death Overview Panel in addition to the CDOPs from other areas as necessary
- Consider these cases against the statutory definition of a 'serious case' as detailed in Regulation 5 of the LSCB Regulations and in Working Together 2015
- Refer cases that are deemed by the group to meet the definition of an SCR to the Independent Chair of the LSCB for decision
- Monitor and evaluate progress of actions to ensure lessons learned from SCRs once the panel has completed its role and the number of actions is manageable by this means
- Identify the scope of agencies involved in cases subject to review to be involved
- Lead the initiation and delivery of reviews of cases that do not meet the criteria for a SCR
- Ensure proportionality of these reviews in the methodology that is adopted
- Oversee and monitor actions coming from these (non SCR) reviews
- Once actions are completed to pass information to the Monitoring & Evaluation group to monitor delivery and impact.

In addition the Committee will:

- Contribute to the development and maintenance of an effective Learning & Improvement Framework for Southampton as detailed in Working Together 2015.
- To work with other Southampton LSCB committees & groups to ensure multiagency activity is co-ordinated and business plan activities are delivered. In particular this group will work closely with Learning & Development, Practice & Policy, and Monitoring and Evaluation groups.

## **Membership**

- Children's Social Care
- Education & Early Years
- Health:
  - Southampton City CCG
  - Solent NHS
  - Southern Health
  - UHS
- Police
- Housing
- Youth Offending Service
- National Probation Service/CRC
- LSCB manager / business coordinator

Other LSCB members may be invited to attend as necessary.

## **Chair**

The group will be chaired by Katherine Elsmore, Southampton City CCG

Vice Chair will be Ruth Attfield, Hampshire Constabulary

## **Reporting and Accountability**

The group will report to the Executive Group on progress against delivery of business plan priorities. The group will raise issues that need resolution beyond the remit of its members to the executive who will forward to the Board if these cannot be resolved.

## **Frequency of Meetings**

The group will meet every 6 weeks for 2 hours.

## **Roles and Responsibilities of Members**

- To actively participate and take a lead role for their own agency in terms of serious case reviews
- To support the group to achieve its aims and functions
- To promote a culture of learning and improvement in terms of safeguarding children and young people.
- To be a point of contact for information about SCRs
- To share and cascade relevant guidance, tools and other resources in relation the work of the committee
- To monitor and evaluate actions coming from reviews
- To highlight areas of good practice and areas for development.
- To ensure issues relevant to their agency are reported to the responsible senior manager / Board lead / decision makers for safeguarding within their agency

- To positively contribute to meetings and to the work of the group.

**To be reviewed June 2018**



### **Appendix 3: Referral Form**

#### **REQUEST FOR CONSIDERATION OF A CASE (serious case review or otherwise)**

<b>1. Child's Details</b>			
Child's First Name		Surname	
Other Names Known			
Date of birth		Date of death (as appropriate)	
Ethnicity		Religion	
Address			
Previous address (if known)			
Parent/Carer			
Name of sibling/s and their date of birth/s			

<b>2. Referral Details</b>	
Date of referral to LSCB	
Your name	
Your role	
Organisation	
Address	
Tel. No.	
Email	
Date of notification	
Any linked cases:	

<b>3. Agencies known to be involved with the case (please tick)</b>			
Childrens Services			
Police			
School / Nursery			
Health Services			
Education			
GP Surgery			
Others (please specify)			

**6. Case Outline**

Please give a summary of the circumstances of this case

*(Please continue on a separate sheet if necessary)*

**7. Serious Case Review Criteria**

Please explain why you feel this case should be considered for a Serious Case Review. The headings below reflect the criteria for a SCR as set out in Working Together (2015):

**A child has died or has been seriously harmed**

**Abuse or neglect of a child is known or suspected**

**There is a cause for concern as to the way the authority, Board partners or other persons have worked together to safeguard the child**

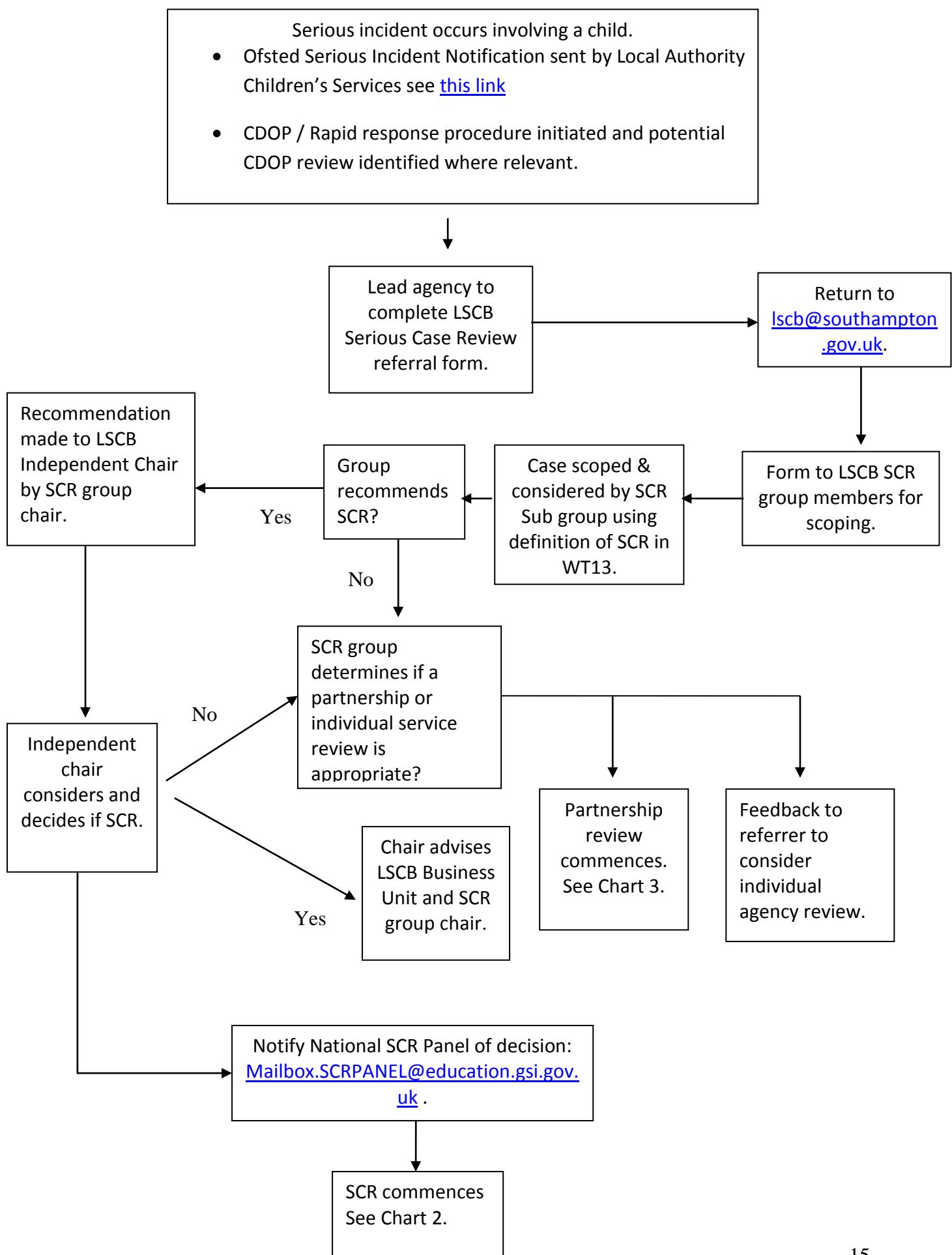
(Please continue on a separate sheet if necessary)

**PLEASE RETURN THIS COMPLETED FORM TO:**

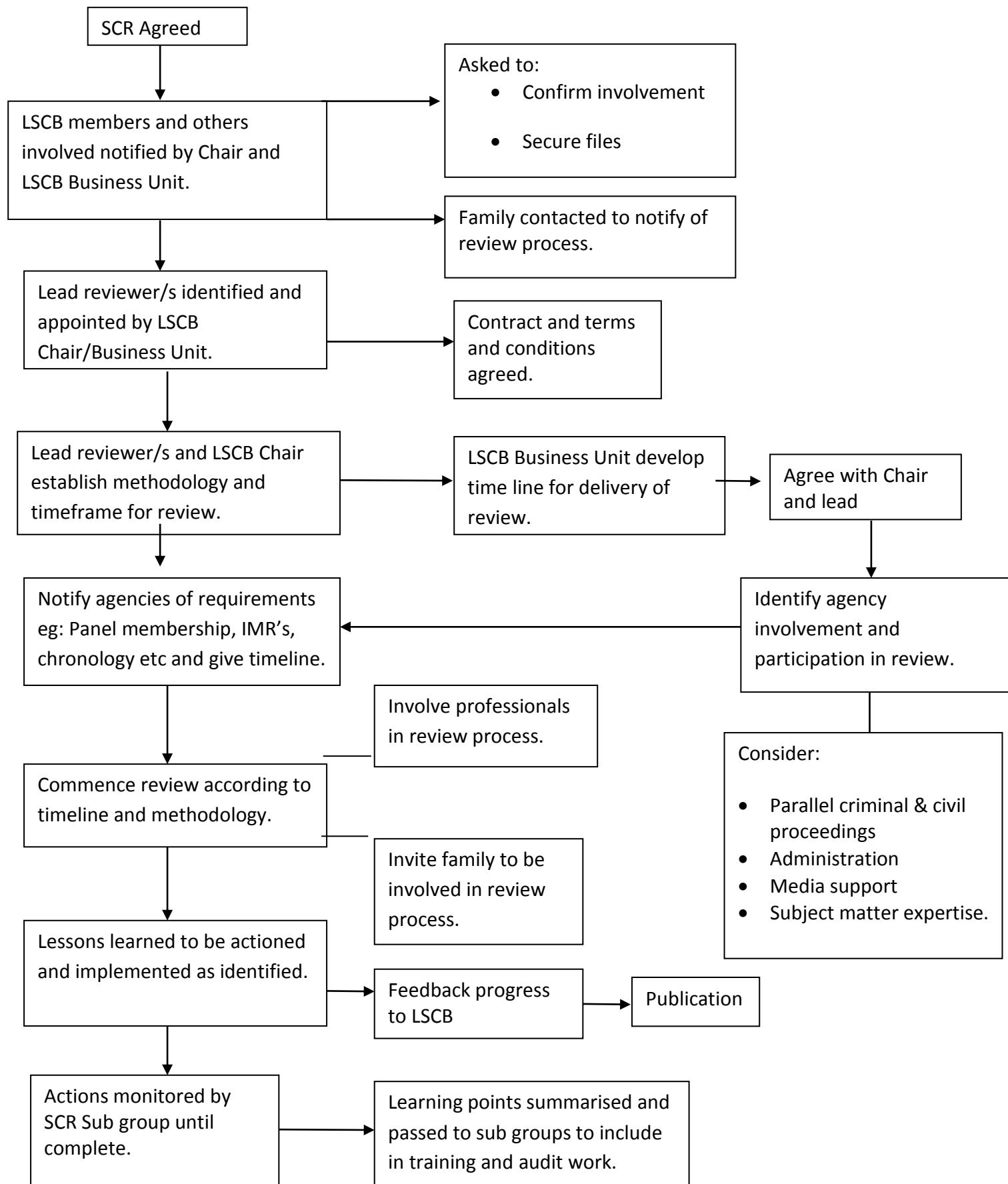
Southampton LSCB: [lscb@southampton.gov.uk](mailto:lscb@southampton.gov.uk) Please password protect this document or send securely to [emma.gilhespy@southampton.gcsx.gov.uk](mailto:emma.gilhespy@southampton.gcsx.gov.uk) and title your email "Confidential SCR referral".

<b>For Office Use:</b>	
Date case discussed by LSCB SCR Committee	
<b>Recommendation to be made by Serious Case Working Group to Chair of LSCB</b>	
This case fits the criteria within Working Together 2015 and should be considered for a Serious Case Review	
This case does not meet the criteria within Working Together and should not be considered for a Serious Case Review	
This case does not fit the criteria within Working Together for a full Serious Case Review, however we recommend a review, detail below:	
Chair of Serious Case Review Committee: Signed.....	Date.....

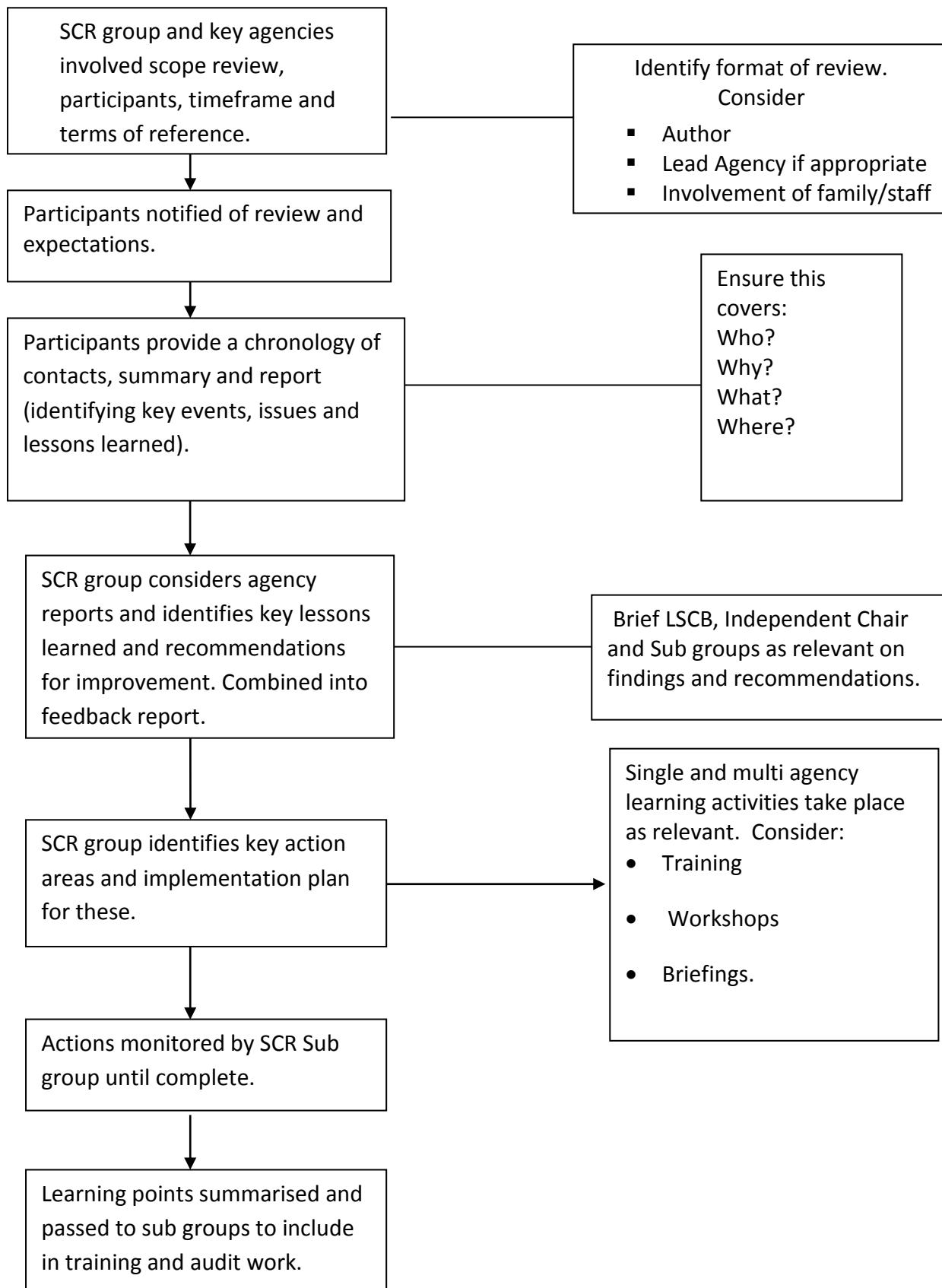
## Appendix 4: Chart 1: Serious Case Review Consideration and Decision



## Chart 2: Serious Case Reviews



### **Chart 3: Partnership / Multi Agency Review**



## **Appendix 5: Monitoring and Evaluation Group Terms of Reference**



### **Monitoring & Evaluation Group** **Terms of Reference**

#### **Aim**

The group delivers monitoring and evaluation activity to ensure that the Southampton Local Safeguarding Children Board (LSCB) fulfils its statutory function to ensure the effectiveness of Board members and local service providers to safeguard and promote the welfare of children and young people.

#### **Functions of the Group**

The group will work to the South East LSCB Quality Assurance (QA) Framework adopted by Southampton LSCB. The group will deliver the functions below to meet its aims and deliver the QA framework:

1. To receive presentations of Section 11 (Children Act 2004) reviews from those agencies prescribed within Working Together 2015, to scrutinise findings from reviews and action plans for improvement.
  - a. For Services that operate in multiple areas across Hampshire and the IOW, this activity will take place jointly with the LSCBs for Hampshire, Portsmouth and the Isle of Wight.
2. To monitor and evaluate the delivery of actions for improvement as identified in single agency reports and Section 11 reviews, ensuring a focus on outcomes for children and young people and to gain assurance that improvement actions are embedded in routine practice.
  - a. For Services that operate in multiple areas across Hampshire and the IOW, this activity will take place jointly with the LSCBs for Hampshire, Portsmouth and the Isle of Wight.
3. To link information identified in Section 11 reviews and data to form a comprehensive multi-agency picture and to feed this back to the LSCB and other QA work.

4. To highlight good practice, and any areas of concern arising from audits and data to the Board
5. To have oversight of multi-agency data, identify trends and escalate any concerns to the board as necessary.
6. To deliver multi-agency, thematic audits of agreed activities and where necessary commission deep-dive audits.
7. To ensure through further monitoring activities that implementation of actions to address lessons learned from audits and reviews are undertaken.
8. To scrutinise information presented and request further audit or analysis where areas of concern are highlighted.
9. To agree the format of multi-agency data to be monitored regularly by the LSCB main board.
10. To provide templates to aid in provision of data and Section 11 reviews.

## **Membership**

The group will include;

- Southampton City Council Housing Services Representative
- Southampton City Council Children and Families Service Quality Assurance Service manager
- Public Protection DI Hampshire Constabulary
- Southampton City Clinical Commissioning Group for the Health economy
- Integrated Commissioning Unit
- National Probation Service
- Hampshire and Isle of Wight Community Rehabilitation Company
- LSCB Business Unit
- LSCB Lay Member
- Other members will be invited to attend as necessary.

## **Chair**

The group will be chaired by the Service Lead for Quality Assurance, Southampton City Council Children and Families Service.

Vice Chair is TBC

## **Reporting and Accountability**

The group will report to the Local Safeguarding Boards Executive on progress of its aims and functions and against delivery of business plan priorities. The group will raise issues that need resolution beyond the remit of its members to the Executive who will forward to the Board if these cannot be resolved.

## **Frequency of Meetings and Attendance**

The group will meet 6 times per annum for three hours. A minimum of 4 agencies should be represented for a meeting to take place.

## **Roles and Responsibilities of Members**

- To ensure that the relevant single agency report, performance information and Section 11 review is presented to the group according to the schedule of reports.
- To contribute resources to ensure the delivery of one multi agency thematic audit or other multi agency quality assurance activity.
- To support the group achieve its objectives and to promote a culture of learning and improvement in terms of safeguarding children and young people.
- To be a point of contact for information about monitoring and evaluation and quality assurance issues for workers in their organisation/service.
- To share and cascade relevant guidance, tools and other resources in relation the work of the group.
- To highlight areas of good practice in their agency and areas for development.
- To carry out work that supports the aim and functions of the group
- To ensure issues relevant to their organisation are fed up to the responsible senior manager / Board lead / decision makers for safeguarding within their organisation.
- To positively contribute to meetings and to the work of the group.

**To be reviewed June 2018.**