BSCB Bristol Safeguarding Children Board

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# Learning and Improvement Framework

2014

This Framework covers the requirements within chapter 4 of Working Together to Safeguard Children 2013. Chapter 4 describes the way that professionals and organisations safeguarding children need to reflect on the quality of their services and learn from their own practice and that of others.

## Scope

This Framework covers the requirements within chapter 4 of Working Together to Safeguard Children 2013. Chapter 4 describes 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 outlines the requirements for an integrated local learning and improvement framework and the principles to be used when undertaking Serious Case Reviews, as well as other types of review and audit.

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## 1. Principles

### 1.1 Learning and Improvement Framework

Working Together 2013 requires that the Local Safeguarding Children Board maintain a shared local learning and improvement framework across those local organisations working with children and families.

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. The different types of review include:

- Serious Case Review (see Section 2, Serious Case Review Process);
- Child death review (see chapter 5 Child death reviews of Working Together 2013: a review of all child deaths under the age of 18);
- Review of a child protection incident which falls below the threshold for a Serious Case Review;
- Review or audit of practice in one or more agencies.

### 1.2 Purpose of a Local Framework

The aim of this framework is to enable local organisations to improve services by being clear about their responsibilities to learn from experience. Particularly through the provision of insights into the way organisations work together to safeguard and promote the welfare of children.

This should be achieved through:

- Regular single and multi-agency reviews of practice;
- Reviews to encompass both those circumstances which meet statutory criteria (i.e. Serious Case Reviews and child death reviews) and situations which may provide useful insights into the way organisations are working together to safeguard and protect the welfare of children;
- Reviews examining what happened with respect to a particular child and their family , why what happened occurred and what **action** will be taken to learn from the findings;
- Learning from both effective and more problematic practice about the organisational strengths and weaknesses within local services for safeguarding children;
- Actions that have been taken resulting in lasting improvements to services;
- Transparency about the issues arising and the resulting actions organisations take in response to the findings from individual reviews; this will include sharing the final reports of Serious Case Reviews with the public (unless there are clear reasons this is not possible);
- Any review should ensure that the views and experiences of children and their families are clearly incorporated into the review.

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

### 1.3 Principles for a Culture of Continuous Improvement

There should be a culture of continuous learning and improvement within and between every organisation that works to safeguard and promote the welfare of children in Bristol. The guiding principle is to identify what works and what can be done to promote good practice.

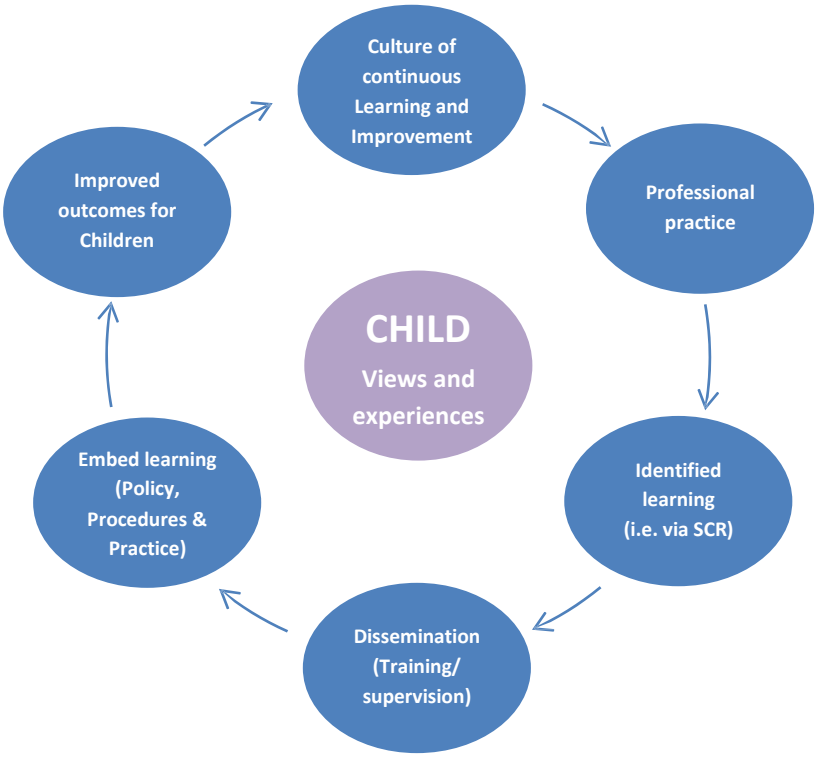
Within this culture the principles include:

- **The child**: will always be at the centre of the process their views and experience must always be apparent within the work of agencies involved in any review;

- **A proportionate response**: according to the scale and level of complexity of the issues being examined, i.e. the scale of the review is not determined by whether or not the circumstances meet statutory criteria;
- **Independence**: Reviews of serious cases to be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- **Involvement of practitioners and clinicians**: Professionals should be fully involved in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- **Offer of family involvement**: Families, including surviving children, should be invited to contribute to reviews and be provided with an understanding of how this will occur;
- **Transparency**: will be achieved by the publication of the final reports of Serious Case Reviews and the BSCB's response to the findings. BSCB annual reports will explain the impact of Serious Case Reviews and other reviews on improving services to children and families and on reducing the incidence of deaths or serious harm to children. This will also inform inspections;
- **Sustainability**: 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.

In order to be fully effective each organisation that is a member of the BSCB along with its managers and practitioners should develop a reflective, non-blaming, systemic and analytical approach to their own practice that enables them individually and as an organisation to achieve meaningful improvements and the best possible outcomes for children and young people in Bristol. This should clearly enable each organisation to demonstrate how it captures and incorporates the views and experiences of children and families into practice and service development.

Key aspects of this approach reflect the a cycle of learning:



## 2. Serious Case Review Process

### 2.1 Criteria

BSCB must undertake reviews of serious cases in specified circumstances. Regulation 5(1) (e) and (2) of the Local Safeguarding Children Boards Regulations 2006 set out the LSCB's function in undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

A Serious Case Review must **always** be initiated when:

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.

Situations meeting either of these criteria must always initiate a Serious Case Review:

1. Abuse or Neglect of a child is known or suspected AND the child has died (including by suicide); OR
2. Abuse or Neglect of a child is known or suspected AND 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. In this situation, unless it is clear that there are no concerns about inter-agency working, a Serious Case Review must be commissioned.

Additionally, even if these criteria are not met a Serious Case Review 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 a secure children's home or where the child was detained under the Mental Health Act 2005.

### 2.2 Decisions Whether to Initiate a Serious Case Review

BSCB must decide whether an incident notified to them meets the criteria for a Serious Case Review where the child concerned would normally be resident in Bristol (see Section 2.1, Criteria). Notification should be made in writing to the independent chair of Bristol Safeguarding Children Board. The decision should normally be made within one month of notification of the incident and will be referred to the Serious Case Review Sub-Group for advice and guidance. This may require an extraordinary meeting of the SCR Sub-Group. The final decision rests with the Chair of the BSCB. The Chair may seek peer challenge from another LSCB Chair when considering this decision (and also at other stages in the Serious Case Review process).

BSCB will notify Ofsted and the National Panel of Independent Experts of the decision. A decision not to initiate a Serious Case Review may be subject to scrutiny by the national panel and require the provision of further information on request and the BSCB chair may be asked to give evidence in person to the panel.

If the Serious Case Review criteria are not met, BSCB may still decide to commission a Serious Case Review or an alternative form of case review in order to ensure that the learning from the case is available to all agencies in order to ensure on-going improvement.

### 2.3 National Panel of Independent Experts on Serious Case Reviews

Working Together to Safeguard Children 2013 announced a plan for a National Panel of Independent Experts to advise and support LSCBs about the initiation and publication of Serious Case Reviews to be implemented during

2013/14. The panel will report to the relevant Government departments their views of how the system is working. LSCBs should have regard to the panel's advice on:

- Application of the Serious Case Review criteria: whether or not to initiate a Serious Case Review;
- Appointment of reviewers;
- Publication of Serious Case Review reports.

LSCB Chairs and LSCB members should comply with requests from the panel as far as possible, including requests for information such as copies of reports and invitations to attend meetings. The BSCB Chair will follow the guidance of the National Panel as required and in accordance with Working Together 2013.

### 2.4 Methodology for Learning and Improvement: Serious Case Reviews

Working Together 2013 does not prescribe any particular methodology to use in such continuous learning, except that whatever model is used it must be consistent with the following 5 principles:

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

Whilst Working Together 2013 stops short of advocating any specific method the systems methodology as recommended by Professor Munro (The Munro Review of Child Protection: Final Report: A Child Centred System) is cited as an example of a model that is consistent with these principles.

BSCB has experience of the SCIE Learning Together model, as a member of the SCIE south west pilot and also in a Serious Case Review. This is the preferred model for Serious Case Reviews in Bristol. However, to ensure that a review using this model can be referred to as such it is required to be quality assured by SCIE.

**SCIE Learning Together**[1] (LT) has been piloted and evaluated during the Working Together consultation period[2] and is recognised as one which values practitioner contributions, is sympathetic to the context of the case and is experienced as a more transparent process by those involved.

Examples of other learning models which may be considered are:

- **Root Cause Analysis** (RCA) has been used within health agencies as the method to learn from significant incidents. RCA sets out to find the systemic causes of operational problems. It provides a systematic investigation technique that looks beyond the individuals concerned and seeks to understand the underlying causes and environmental context in which the incident happened[3].
- **Child Practice Reviews**[4] replaced the Serious Case Review system as the statutory guidance in Wales on 01.01.13, this process consists of several inter-related parts: Multi-Agency professional Forums to examine

[1] Fish, S., E. Munro, and S. Bairstow, Learning together to safeguard children: developing a multi-agency systems approach for case reviews. 2008, Social Care Institute for Excellence: London)
[2] Undertaking Serious Case Reviews using the Social Care Institute for Excellence (SCIE) Learning Together systems model: lessons from the pilots. March 2013
[3] Root Cause Analysis (RCA) Investigation website (Need link)
[4] Protecting Children in Wales. Guidance for Arrangements for Multi-Agency Child Practice Reviews. 2013

case practice, Concise Reviews in order to identify learning for future practice, and an Extended review which involves an additional level of scrutiny of the work of the statutory agencies.

- **Significant Incident Learning Process** (SILP) was developed as a way of providing a process to review cases just below the mandatory threshold for serious case reviews. It has subsequently been used in formal serious case reviews. This approach explores a broad base of involvement including families, frontline practitioners and first line managers view of the case, accessing agency reports and participating in the analysis of the material via a 'Learning Event' and 'Recall Session'.
- **Appreciative Inquiry (AI),** rooted in action research and organisational development, is a strengths-based, collaborative approach for creating learning change. SCR's conducted as an appreciative inquiry seek to create a safe, respectful and comfortable environment in which people look together at the interventions that have successfully safeguarded a child; and share honestly about the things they got wrong. They get to look at where, how and why events took place and use their collective Serious Case Reviews hindsight wisdom to design practice improvements.

Serious case Reviews are not limited to systems methodology; there may be cases which require the inclusion of issues from outside a strictly defined systems model, though any approach must ensure that the 5 principles outlined above are adhered to.

### 2.5 Appointing Reviewers

BSCB will appoint one or more suitable individuals to lead the Serious Case Review. Such individuals should have demonstrated that they are qualified to conduct reviews using the '5 principles' and incorporate the SCIE Learning Together systems methodology.

The lead reviewer(s) should be independent of the BSCB and the organisations involved in the case.

BSCB will provide the National Panel of Independent Experts (see Section 2.3, National Panel of Independent Experts on Serious Case Reviews) with the name(s) of the individual(s) appointed to conduct the Serious Case Review and consider carefully any advice which the panel provides about the appointment(s).

Working Together 2013 does not specify the need for an independent chair or for a chair for the process: the need or not for this will depend on the nature or complexity of the review and the individual choice of the BSCB and the review model selected.

### 2.6 Timescale for Serious Case Review Completion

BSCB will aim for completion of the Serious Case Review within six months of initiating it. If this is not possible (e.g. because of potential prejudice to related court proceedings, or significant complexity), every effort should be made while the Serious Case Review is in progress to:

- Capture points from the case about improvements needed; and
- Take any corrective action identified as required.

### 2.7 Engagement of Organisations

BSCB will ensure appropriate representation in the review process of professionals and organisations involved with the child and family. Agencies that are members of the BSCB are expected to fully co-operate with the BSCB with regards to any review that is initiated whether it is a serious case review or a Child Protection Incident Review.

BSCB may decide as part of the Serious 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 form in which such written material is provided will depend on the methodology chosen for the review.

BSCB will notify each organisation that is a partner of the BSCB of the decision to initiate a Serious Case Review and what is expected of each organisation as part of the review. This notification will be sent to the chief executive of the relevant organisation and the board representative of the organisation.

### 2.8 Agreeing Improvement Action

BSCB will oversee the process of agreeing with partners what action they need to take in light of the Serious Case Review findings. On receipt of the final report the BSCB will:

- Formulate a response to the findings and issues raised into improvement action this will be done by the Executive in collaboration with the SCR Sub-group.
- When appropriate to do so and following the conclusion of any concurrent processes (criminal, family Law etc.). publish the report in full on the BSCB website and notify partner agencies, the chair of the Health and Wellbeing board and the Mayor of Bristol.
- All relevant findings and agreed BSCB Actions will be shared with the Training & Development Sub-group.
- The Training and Development Sub-group will ensure that these are part of the agenda of the next meeting in order to consider how they will be implemented and any specific activity planned. As a minimum this should include:
    - Review of inter-agency training provided by BSCB and where necessary integrate into course content;
    - Produce a briefing note to provide to single agency training providers to ensure that the content is included within single agency safeguarding training. This will also be able to be used as a Practice briefing note for all agencies to highlight key messages for use within individual supervision and team/staff meetings;
    - Where necessary a minimum of 3 multi-agency area practice briefings to ensure that messages are clearly communicated within Area Networks.

### Individual agency responsibilities

Where an agency has been directly involved in a SCR they may have developed specific actions which will have been incorporated within the SCR report. All partners within the BSCB should, as a minimum respond to a BSCB Serious Case Review as follows:

- On receipt of notification of the publication ensure that measures are taken to disseminate the report within the organisation.
- Agency managers should reflect on the content of the report and extract learning that is specific to their organisation or that has implications for their service(s). Actions or changes required to service provision should be identified and a clear action plan for these to take effect developed and report to the BSCB.
- Team/staff meetings and individual supervision should include as an agenda item earning from the SCR based upon the individual agency needs and the briefing provide by the BSCB.

### Practitioners responsibilities

Anyone who works with children in Bristol should actively engage with the learning opportunities provided by Serious Case Reviews. Practitioners are responsible for ensuring that they are equipped with the necessary skills and training to perform their role by:

- Reading SCR publications
- Reading SCR briefing notes
- Attending appropriate single and inter-agency training

- Contribute to staff and team meetings and supervision
- Support colleagues and staff in other agencies in implementing the learning from Serious Case reviews.

### Serious Case Reviews from other LSCBs

Other LSCBs also regularly publish Serious Case reviews which may contain valuable learning for Bristol. The NSPCC maintains a National repository of published case reviews[5] with summaries of each Serious Case Review. The BSCB Serious Case Review Sub-group will review select SCR's for consideration by the Serious case review group. This will be a standing agenda item at each regular SCR Sub-group Meeting. The findings from each will be discussed and where it is considered the findings merit further consideration this will be identified and referred to the Executive Board for Action.

### 2.9 Publication of Reports

In order to provide transparency and to support national sharing of lessons learnt and good practice in writing and publishing such reports, all reviews of cases meeting the Serious Case Review criteria will result in a readily accessible published report on the LSCB's website. It will remain on the BSCB web-site for a minimum of 12 months and thereafter be available on request.

The fact that the report will be published must be taken into consideration throughout the process, with reports 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'* and consideration given on how best to manage the impact of publication on those affected by the case. The BSCB will comply with the Data Protection Act 1998 and any other restrictions on publication of information, such as court orders.

The final Serious Case Review report should:

- 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.

BSCB will publish in a separate document, information about:

- Actions already taken in response to the review findings;
- The impact these actions have had on improving services; and
- What more will be done.

BSCB will send copies of all Serious Case Review reports to the National Panel of Independent Experts at least one week before publication. If the BSCB considers that a report should not be published, it should inform the national panel which will provide advice. The BSCB will provide all relevant information to the panel on request, to inform its deliberations.

### 2.10 Considerations for Local Processes

BSCB will decide in each case how they will decide to progress with the following matters:

- Engagement of families, children and service users;
- Coordination with parallel review processes (that still require formal IMR's such as Domestic Homicide Reviews).

[5] http://www.nspcc.org.uk/Inform/resourcesforprofessionals/scrs/case-reviews-repository_wda99541.html

### 3. Review of Child Protection Incidents

Where a request for a serious case review has been raised (i.e. the BSCB Chair has been notified of a serious incident) and it is not considered necessary that a serious case review be initiated a Child Protection Incident Review will be undertaken by the BSCB. A CPIR is a local review of the circumstances of a child's death or serious injury that has not met the criteria for a serious case Review but it is considered by the BSCB chair on advice from the SCR sub-group that there is merit in undertaking a review.

There are also situations that have not resulted in a notification for a Serious Case Review but the circumstances would demand a level of scrutiny and analysis of the issues raised. In this situations a Child Protection Incident Review will be considered. The decision for such a review will be for the Serious Case Review Sub-group, the review process will be led by the Quality Sub-Group.

CPIR reports will not be published however the learning from these Reviews will be incorporated into the BSCB Annual report and the Learning and Improvement Framework and incorporated into BSCB training and policy development.

CPIR's should generally follow the 5 principles that are applicable to serious case reviews. The degree at which an external reviewer is required will be decided on the merits of each review. It is not necessary to inform the National Panel of the CPIR, unless there was originally a consideration to undertake a Serious Case Review. Equally the National Panel will not need to be informed of who is to undertake the role of lead reviewer. Agencies that are members of BSCB should seek to engage with a CPIR with the same level of engagement with which they would a Serious Case Review.

### 4. Child Death Reviews

Child Death Reviews are also required in statute and a crucial source of understanding working practices. Regulation 6 of the Local Safeguarding Children Boards Regulations 2006 outlines LSCB responsibilities in relation to a child death. LSCBs are therefore accountable for:

a) collecting and analysing information about each death with a view to identifying
    i. any case giving rise to the need for a review mentioned in regulation 5(1)(e);
    ii. any matters of concern affecting the safety and welfare of children in the area of the authority;
    iii. any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area; and
b) putting in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

Bristol, North Somerset, South Gloucestershire and Bath & North East Somerset Safeguarding Children Boards have taken a collective approach and commissioned a West of England: Child Death Overview Panel (CDOP). The CDOP conducts a comprehensive review of the circumstances surrounding a child's death. Qualitative and quantitative data is collected including all single agency reporting, critical incident reports, serious incident reports and the Coroner's Inquisition.

The CDOP meets quarterly to report on learning from CDOP which is then disseminated to the four Boards. The CDOP also produces an annual report identifying themes, trends and learning for the four LSCBs.

## 5. Audits

Alongside Serious Case Reviews, CPIR/MAR's and Child Death Reviews BSCB and individual agencies undertake a wide range of audit activity. The results of these audits are reported to the board via the performance sub-group. Any audit undertaken by a single agency should indicate how the views and experiences of children and families have been considered within the audit. Agencies should undertake regular audits focusing on children's experiences and views regarding the organisations services, especially those that are intended to safeguard and promote the welfare of children.

The Quality Sub-group undertake regular Multi-agency themed file audits. The themes are agreed by the BSCB Executive Board and form part of the annual business plan. Each audit will

### Multi-Agency Practice Audits - Proposal

Quality sub-group will adopt a process of Multi-Agency Practice Audits. A current or recently closed period of involvement will be chosen as the subject of the audit. Practitioners who are or were involved with the child will be brought together in order to discuss the child's experience within the safeguarding system in Bristol. Lessons learnt and examples of good practice and good partnership working will be highlighted and a report identifying themes will be presented to the BSCB Executive Board. The views of the Child and their family will be a key element of each Multi agency Audit Learning from these audits will also be incorporated into Multi-agency training as case examples.

The Quality sub-group will also monitor the Multi-agency themed file audits which will in future be undertaken by Multi-Agency area networks. Collating the themes and presenting these to the Executive Board and Training and Development Sub-groups.

### Section 11 Audit.

Section 11 of the children Act 2004 requires a range of organisations to undertake a self-evaluation of Practice and compliance with safeguarding procedures. Bristol have not undertaken a S.11 Audit since the implementation of s.11 of the Children Act 2004. It is planned to undertake the first S.11 audit in Bristol in March 2014 this will be in conjunction with Bath & North East Somerset, Somerset and North Somerset LSCB's. Using a template developed by Bath & North East Somerset LSCB. This means agencies which provide services over more than one of the 4 LSCBS will only have to return one submission.

Future audits will be undertaken following a 3 year cycle, the next Audit will be in 2016, in the interim smaller audits focussed on areas of weakness identified within the main audit will be undertaken. Any organisations that have identified improvements to be made during this period will be expected to provide evidence that these improvements have been undertaken.

### Section 175/157 Audit – Annual Schools Safeguarding Audit.

Section 175 of the Education Act 2002 came into effect on the 1 June 2004. Section 175 requires school governing bodies, local education authorities and further education institutions to make arrangements to safeguard and promote the welfare of children. Such arrangements will have to have regard to any guidance issued by the Secretary of State. Similar requirements are in place for proprietors of Independent Schools under Section 157 of the Education Act 2002.

The Bristol Safeguarding Children Board (BSCB) is required to monitor the effectiveness of safeguarding arrangements in schools and has developed an online self-assessment Section 175/157 Safeguarding Audit. This audit includes Early Years, Primary, Secondary, Special School, Post 16 provision and the Independent sector.

The Section 175/157 Audit of Schools will be undertaken on an annual basis. The findings of the audit are analysed by the local authority with suggested improvements made to assist schools who have not yet reached the required standard.

### 4. Review or audit of safeguarding practice in an agency

This process will be overseen by the Quality Sub-group and a minimum of one audit per annum will be completed. Specific details as to the audit process will be developed during 2015 – 2016 as part of the business plan for 2015 – 2016.

### 5. Dissemination and embedding learning in practice

A significant amount of time and effort is expended in undertaking case reviews and auditing. This is only effective when the findings and learning are effectively disseminated and shared across all organisations that are part of the BSCB. Sharing what works and well and learning from when things have gone wrong is an essential element of any learning organisation. To ensure that learning leads to positive outcomes for children and young people it must be embedded within day to day practice.

Routes for Dissemination of learning include:

- single agency training
- BSCB inter-agency training
- BSCB Annual Safeguarding Conference
- Multi-Agency Area Networks
- BSCB Newsletter
- BSCB Briefing notes

Activity for embedding learning into practice

- Policy, procedure and practice guidance development
- Effective use of reflective practice and reflective supervision
- Team/staff meetings
- Multi-Agency Area Networks

### Single Agency Training

All agencies mentioned in Working Together 2013 on P47 onwards have a clear responsibility to ensure that their staff 'are competent to carry out their responsibilities for safeguarding and promoting the welfare of children…'. The provision of appropriate training is the responsibility of the individual agency and each agency should ensure that the content of training is regularly reviewed in order to ensure it reflects and shares the learning from both local and other area Serious Case Reviews.

### BSCB Inter-Agency Training

Each LSCB has a clear function under regulation 5 of the LSCB regulations 2006 to provide for 'the training of persons who work with children or in services affecting the safety and welfare of children'.

The BSCB provides a large part of its own training programme and commissions some courses as required. The Inter-agency Training Programme is revised each year and published every January. It is designed to ensure that it meets the needs of a range of professions and organisations to ensure that they are equipped to work effectively together in practice.

The BSCB will continue to use the framework provided by the previous (2010) iteration of Working Together which outlines the target groups and levels or stages of training. This is cross referenced with the Intercollegiate Document Safeguarding Children and Young people roles and competences for Health Care Staff (2010)[6]. The relevant target groups are detailed in  South West Inter-Agency Training .

### BSCB Training Monitoring and Evaluation

BSCB has a statutory obligation to monitor and evaluate the effectiveness of training both within agencies and Inter-agency provision. The effectiveness of interagency training provided by BSCB is continually monitored by the use of evaluation forms an follow up surveys.

BSCB is required to quality assure single agency training to ensure its effectiveness in safeguarding and promoting the welfare of children. A quality assurance process is in development by the BSCB.

### Effective training and positive outcomes for children and young people

BSCB will ensure that the training that it provides and quality assures is effective in the stated aim of keeping children and young people safe. BSCB will seek feedback from anyone who has attended its training provision to ascertain whether or not the training has assisted the practitioner to be more effective in practice. It is essential that the BSCB continually reflects on the training that it provides in order to ensure that training is improving outcomes for children and young people.

| Version | Date | Amendments | Date Agreed by Board |
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6 http://www.rcpch.ac.uk/system/files/protected/page/Safeguarding%20Children%20and%20Young%20people%202010%20final_v2.pdf