Sunderland Safeguarding Children Board

LEARNING & IMPROVEMENT FRAMEWORK

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Welcome and Foreword by Sunderland Safeguarding Children Board Independent Chair

Welcome to the SSCB Learning and Improvement Framework. This Framework will enable the SSCB to use different methods of learning from practice to enable it to improve how we work together to safeguard and protect the children of Sunderland.

The Framework identifies a number of learning and improvement activities which will be embedded across the activity of the Board and ensure that it operates in a culture of learning and improvement. A Learning and Improvement Toolkit will underpin the Framework which will provide a variety of robust ways of learning and improving. This Toolkit will continually develop through learning activity and best practice examples. Importantly we must also improve our ability to learn from good practice where staff have worked together effectively to achieve good outcomes for children.

The Toolkit will be used by multi agency manager and practitioners across Sunderland from frontline staff to Senior Managers to ensure expertise, skill, knowledge and experience from all those who have a responsibility to safeguard children and young people in Sunderland.

I would like to thank the Learning and Improvement in Practice sub-committee for producing this Framework.

With best wishes

Colin Morris
SSCB Independent Chair
May 2015

SSCB LEARNING & IMPROVEMENT FRAMEWORK

Introduction

Sunderland Safeguarding Children Board (SSCB) is the key statutory mechanism for agreeing how relevant organisations will co-operate to safeguard and promote the welfare of children in Sunderland.

The SSCB has nine sub-committees, six of which are SSCB and three of which are combined SSCB and Sunderland Safeguarding Adults Board (SSAB) sub-committees which ensure its functions are carried out. These are:

- Executive Group
- Learning and Improvement in Practice sub-committee
- Missing Sexually Exploited and Trafficked (MSET) sub-committee
- Local Child Death Review Panel
- Quality Assurance sub-committee
- Multi-Agency Looked After Partnership (MALAP)

The joint sub-committees listed below are chaired by a Senior Manager who sits on both safeguarding boards:

- Communication and Engagement sub-committee
- Legal, Policy and Procedures sub-committee
- Training and Workforce Development sub-committee

For further information on the function, structure and responsibilities of the Board please go the SSCB website at www.sunderlandscb.com

SSCB Learning and Improvement Framework

Working Together to Safeguard Children and Young People 2015 requires Local Safeguarding Children Boards (LSCBs) to have a local Learning and Improvement Framework embedded across local organisations who work with children and their families. This Framework should enable organisations to be clear about their responsibilities, to learn from experience and improve services for children, young people, and their families as a result.

Professionals and organisations protecting children need to reflect on the quality of their services and learn from their own practice and that of others. Good practice should be shared so that there is a growing understanding of what works well. Conversely, when things go wrong there needs to be a rigorous, objective analysis of what happened and why, so that important lessons can be learnt and services improved to reduce the risk of future harm to children. Appendix A outlines the SSCB Learning and Improvement Cycle.

Learning & Improvement Exercise

A Learning and Improvement exercise is any activity that is outlined in the SSCB Learning & Improvement Framework with the aim of learning about safeguarding children practice and improving outcomes for children and young people in Sunderland.

Learning and Improvement Exercises can be mandated by the Board, Executive Group or any of the sub committees. In addition the Board may be advised by an external agency such as the National Probation Service or a multi-agency partnership such as the Sunderland Domestic Violence Partnership about a learning and improvement exercise that is required and where the Board may be the most appropriate partnership to take this forward.

Cases that need to be considered for a leaning review including a serious case review must be referred to the SSCB Business Manager by any professional or volunteer who believes that the criteria for a serious case review is met. The referral form to inform the SSCB that a review is required is available at www.sunderlandscb.com

Once a Learning and Improvement exercise is undertaken the findings will be analysed. This analysis will lead to identifying the key learning and improvement issues for the SSCB to consider. A report will be produced detailing the findings and issues for the SSCB and where appropriate it will be presented to the SSCB or the relevant sub-committee. This work may identify learning and improvement actions for single agencies or partnerships and they will be passed to the relevant party as appropriate. It may also be appropriate for the SSCB to monitor the implementation of the actions for improvement and to audit the impact of this activity.

The SSCB as a Learning Partnership

The SSCB Constitution outlines the function of each sub committee, Task and Finish and Working Group of the Board, with the Board itself having overall responsibility for all aspects of learning and improvement within that structure. Reporting arrangements between the Board, sub committees, and working groups are set out in the SSCB constitution. All groups of the Board and the Board itself are responsible for implementation of the SSCB Learning and Improvement Framework.

Principles for Learning and Improvement

Reviews are not ends in themselves. The purpose of these reviews is to identify improvements which are needed and to consolidate good practice. LSCBs and their partner organisations should translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children. The SSCB framework covers the full range of reviews and audits which are aimed at driving improvements to safeguard and promote the welfare of children across Sunderland. Some of these reviews (i.e. SCRs and child death reviews) are required under legislation.

Governance arrangements

The SSCB is one of a number of partnerships with responsibility to ensure improved outcomes for children. This includes the Health and Wellbeing Board, the Children's Trust,

the Risk and Resilience Board etc. Further information on the governance arrangements is available in the SSCB Constitution at www.sunderlandscb.com

Scrutiny and Challenge
The SSCB is subject to external scrutiny through challenge from other partnerships such as the Health and Wellbeing Board and through the LSCB Inspection by Ofsted. The framework for LSCB inspection is available at www.ofsted.gov.uk

The SSCB Framework supports the work of the SSCB and their partners so that:

- Reviews are 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;
- Reviews look at what happened in a case, and why, and what action will be taken to learn from the review findings;
- Action results in lasting improvements to services which safeguard and promote the welfare of children and help protect them from harm; and
- There is transparency about the issues arising from individual cases and the actions which organisations are taking in response to them, including sharing the final reports of Serious Case Reviews (SCRs) with the public.

SSCB also conduct reviews of cases which do not meet the criteria for an SCR, but which can provide valuable lessons about how organisations are working together to safeguard and promote the welfare of children in Sunderland. Although not required by statute these reviews are important for highlighting good practice as well as identifying improvements which need to be made to local services. Such reviews may be conducted either by a single organisation or by a number of organisations working together.

The SSCB will apply the following principles when conducting reviews:

- There should be a culture of continuous **learning and improvement** including identifying opportunities to draw on what works and with a particular focus on promoting good practice;
- Case reviews should be **proportionate** according to the scale and level of complexity of the issues being examined;
- Serious case reviews should be led by individuals who are independent of the case organisations whose actions are being reviewed;
- Professionals must be involved fully in reviews
- 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 (British Association for the Study and Prevention of Child Abuse and Neglect in Family involvement in case reviews, BASPCAN, see further information on involving families in reviews);
- The process should be transparent including publishing final SCR reports and the SSCB's response. 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 LSCB annual reports and will inform inspections; and

- Improvement must be sustained through regular monitoring and review so findings from reviews make a real impact on improving outcomes for children in Sunderland.

SSCB Methodology (further information regarding the following methods is available in the SSCB Learning and Improvement Toolkit at www.sunderlandscb.com)

The different types of review include:

Serious Case Reviews

Serious Case Reviews (SCRs) are multi-agency reviews of how professionals and organisations have worked together with a child and their family when a serious incident has occurred. This serious incident can be the death of or serious harm to a child.

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the functions of LSCBs which includes the requirement for LSCBs to undertake reviews of serious cases in specified circumstances. Regulation 5(1) (e) and (2) set out an LSCB's function in relation to serious case reviews, namely:

5(1) (e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

(2) For the purposes of paragraph (1) (e) 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.

Cases which meet one of these criteria (i.e. regulation 5(2) (a) and (b) (i) or 5 (2) (a) and (b) (ii) above) **must always** trigger an SCR. In addition, 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 a secure children's home, or where the child was detained under the Mental Health Act 2005. Regulation 5(2) (b) (i) includes cases where a child died by suspected suicide.

"Seriously harmed" in the context of paragraph 18 below and regulation 5(2)(b)(ii) above 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. LSCBs should ensure that their considerations on whether serious harm has occurred are informed by available research evidence.

Where a case is being considered under regulation 5(2) (b) (ii), unless it is clear that there are no concerns about inter-agency working, the LSCB **must** commission an SCR. The final decision on whether to conduct the SCR rests with the LSCB Chair. If an SCR is not required because the criteria in regulation 5(2) are not met, the LSCB may still decide to commission an SCR or they may choose to commission an alternative form of case review.

The SSCB procedures for undertaking serious case reviews can be found at www.sunderlandscb.com.

SSCB Learning Lessons Review (LLR)

A Learning Lessons Review (LLR) is a multi-agency discussion of events or a time period within a case that enables the individuals to reflect on their involvement in the case and identify good practice and areas for development.

The main purpose of the LLR and the role of the facilitator is to support reflection in a case which would include considering why work was undertaken, the reasons for the decisions that were made, the nature of the professional relationships, and the impact for staff so that lessons can be learned without apportioning blame. A case can be considered for LLR if there has been issues regarding the practice in the case and any case referred to be considered for LLR must be agreed by the SSCB Learning and Improvement subcommittee and the Independent Chair of SSCB

The process can only be undertaken when there is more than one agency involved in the work with the family.

After Action Review

An After Action Review (AAR) is a multi-agency discussion of an event/situation that enables the individuals to reflect on their involvement in the case and consider the following issues:

- What happened?
- Why did it happen?
- What went well?
- What needs improvement?
- What lessons can be learned from the experience?

The main purpose of the AAR and the role of the facilitator is to support reflection in a case which would include considering why work was undertaken, the reasons for the decisions that were made, the nature of the professional relationships, the impact for staff so that lessons can be learned without apportioning blame.

A case can be considered for AAR if there has been issues regarding the practice in the case and any case referred to be considered for AAR must be agreed by the SSCB Case Review subcommittee and the Independent Chair of SSCB

The process can only be undertaken when there is more than one agency involved in the work with the family.

Live Observation Audits of multi-agency practice
Live Observation Audits of multi agency practice are exercises when Board members and senior managers from partner agencies attend meetings such as Initial Child Protection Conferences and Child Protection Review Conferences and analyse the quality of the practice including preparation and engagement of the family, application of thresholds and the work of the core group etc. A report with identified areas for learning is produced and embedded as appropriate,

Multi-agency case file audits
Multi-agency audits will review the systems in place and the standard of co-operation and collaboration between the key agencies charged with responsibilities to safeguard children. The overall aim is to secure positive outcomes for children by highlighting good practice and identifying shortfalls in order that we are able to learn fully from past successes and mistakes. In assessing the current systems the quality of joint working and past practice and the SSCB Safeguarding Children Procedures will be used as a benchmark. Further information on the multi-agency audits is at Appendix B.

Case File Audits
Case file audits can be undertaken by one or more professionals and look at specific themes or issues such as if the threshold for referral to Children's Safeguarding Services was met or how appropriately was neglect was being used as the category for a child who has a child protection plan due to domestic violence. A sample of cases is audited and the audit tool is developed depending on the nature of the audit.

Section 11 Audits
Local Safeguarding Children Boards "should have a particular focus on ensuring that those key people and organisations that have a duty under section 11 of the Children Act 2004 or section 175 or 157 of the Education Act 2002 are fulfilling their statutory obligations about safeguarding and promoting the welfare of children". (Working Together 2015)

Section 11 of the Children Act 2004 places a statutory duty on key organisations to make arrangements to ensure that in discharging their functions they have the regard to the need to safeguard and promote the welfare of children. Section 11 does not give agencies any additional functions, but requires that they carry out their existing functions in a way that takes into account the need to safeguard children. This audit tool is designed to monitor and evaluate compliance of the Local Authority and partner agencies with their specific and general duties in respect of safeguarding as defined in Section 11 of the Children Act 2004. There are similar duties on schools and Colleges under Section 175 of the Education Act 2002 (see next page). Schools and the college are asked to use this tool along with other agencies. Limited modifications will be appropriate to suit the particular circumstances of individual organisations.

Audits of single agency practice
These audits can be undertaken on behalf of the SSCB or by an individual agency in respect of one agency's practice in a given area or theme. A sample of the practice will be audited and the audit tool is developed depending on the nature of the audit.

SSCB Quality Assurance and Performance Framework
The SSCB Quality Assurance and Performance Framework is used to give Board members an understanding of the multi agency performance in Sunderland around areas such as numbers of children subject of a child protection plan and the reason for the plan, the numbers of missing children, and the number of allegations against staff working with children and young people. By studying the performance information areas for improvement are identified and have led to activity such as the Deep Dive into Domestic Violence etc.

Quality Assurance of Single agency and SSCB Training
All organisations have a legal duty under Section 11 of the Children Act 2004 to ensure that their staff, and staff employed by services they commission, participate regularly in relevant training tailored towards their individual roles and that they are trained to be alert to the potential indicators of abuse and neglect of children and to be able to respond appropriately to their role in addressing concerns for the care and safety of children.

Participation & Engagement with Children & Young People, Parents/Carers
The views of children, young people, and parent/carers will shape the work of the SSCB. Their views will be sought through consultation work and community events. These consultations may be about specific subjects or more generic issues. Work undertaken to date includes consultation with the Children's Trust Advisory Network to identify who children and young people would go to if they were concerned about a friend and improving the SSCB website page for children and young people. Future work includes the development of literature for children and young people.

Front line staff meetings
Frontline staff meeetings are held on a quarterly basis and are the opportunity for staff and volunteers from all agenceis to meet board members, find out more about the SSCB and its work but most importantly to discuss key issues around working with children and families in Sunderland. The sessions are themed around key issues such as domestic violence and sexual exploitation and staff are asked to share what works well and what needs to be improved around these areas of work.

Index of Excellence
The Index of Excellence is a quality assurance framework that aims to continuously improve child safeguarding and welfare arrangements across the City of Sunderland. The Index of Excellence works as an assessment tool which will provide a judgement of the key strengths and areas for improvement in relation to safeguarding and promoting the welfare of children across Sunderland.

To ensure that the Index of Excellence provides a reliable judgement, the assessment framework has been categorised into key sections. Each section acts as a key individual component that makes up the overall framework. Each component has been placed within the Index of Excellence because it is considered as being a vital ingredient to operating successful services that achieve better outcomes. Categorising the framework into relevant components will help the SSCB and each agency to pin point strengths and areas for improvement more specifically. This should help pin point and prioritise actions more effectively, as well as ensuring that priorities are focussed on areas where the strongest impact can be made.

There are 6 categories in the framework:

- Leadership
- People Management and Development
- Strategic Direction
- Managing Partnerships
- Service Delivery and Processes
- Performance

Each category is then broken down into sub categories. This helps to further pin points where strengths and areas for improvement are.

Deep Dive reviews

This process is used to undertake a detailed analysis of the data available to the SSCB around a specific issue impacting on the safety and welfare of children in Sunderland. The SSCB undertook a deep dive review into domestic violence in 2012 with the aim of highlighting what services were being offered to protect children and families from the impact of domestic violence, the prevalence of both domestic violence and service use in Sunderland, and highlight issues that the Board should discuss around the way in which domestic violence services are utilised. The report explored the data that is available for this analysis, and made recommendations for the advancement in data services across agencies in order to improve the analysis available to the Board. The data from several agencies used in this report was supplemented by a case study exercise. This identified a sample of families, chosen at random, who met the criteria for analysis. The criteria were designed to allow for the analysis of the families "story" through the Child Protection process, and identify several themes. A follow up piece of work into the longer term outcomes for these children was undertaken at the end of 2012.

Ofsted inspection of the Effectiveness of the LSCB

Ofsted intends to undertake a review of the effectiveness of the Local Safeguarding Children Board at the same time as the inspection the local authority. This review will be conducted under 15(A) of the Children Act 2004. Inspectors will make their judgements on a four point scale:

- outstanding
- good
- requires improvement

- inadequate

Inspectors will use these criteria to evaluate the effectiveness of the LSCB in meeting its statutory functions. Inspectors will make a judgement of 'good' where the characteristics set out in the description of 'good' are widespread and common practice. In addition, inspectors will consider how effectively the LSCB evaluates and monitors the quality and effectiveness of the local authority and statutory partners in protecting and caring for children, including the provision of improvement advice. Inspectors will deploy professional judgement to determine the weight and significance of their findings. When considering the effectiveness of the Local Safeguarding Children LSCB, inspectors will use the descriptors of 'good' as the benchmark from which to grade performance. A judgement of 'good' will be made where the inspection team concludes that the evidence overall sits most appropriately with a finding of 'good'. This is what Ofsted describes as 'best fit'.
A report of the review will be published on the Ofsted website. This will also be the case where the review does not take place at the same time as the single inspection of the local authority.

Inspections
Partner agencies of the SSCB such as Children's Safeguarding, Children's Homes, Children's Centres, and the Clinical Commissioning Group etc will be inspected in respect of their safeguarding arrangements. Learning and areas for action will be identified as part of these inspections and the SSCB will monitor implementation of the action plans and seek assurances that partners have robustly embedded the improvements within their multi agency practice.

Thematic inspection
Themed inspections of particular areas of practice are undertaken both with local and national agencies. These inspections include the recent themed inspection of the Local Authority's response to child sexual exploitation. Any findings and actions for improvement for Sunderland agencies and the SSCB will be implemented and monitored to ensure they are robustly embedded to improve outcomes for children in Sunderland.

Child Death Review Process
Regulation 6 of the Local Safeguarding Children Board Regulations 2006 places a statutory duty on LSCBs in relation to the deaths of any children normally resident in their area and guidance is provided in Chapter 5 of Working Together to Safeguard Children 2015. This function became a statutory requirement from 1st April 2008. This process relates to the deaths of all children and young people from birth (excluding those babies who are stillborn or planned terminations that are within the law but including children with life-long or life limiting conditions*)* up to the age of 18 years.

"Regulation 6 requires the collection and analysis of information about each child death in their area with a view to identifying:

i. Any case giving rise for the need for a Serious Case Review;
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."

SSCB shares a Child Death Overview Panel with Gateshead and South Tyneside LSCB's covering a population greater than 500,000. The Panel reviews the appropriateness of the professionals responses to each unexpected death of a child, their involvement before the death and relevant environmental, social, health and cultural aspects of each death, to ensure a thorough consideration of how such deaths might be prevented in the future; and identifies any patterns or trends in the local data and reports these to the individual relevant LSCB. For further information relating to the Child Death Review Process go to www.sunderlandscb.com

Sharing and Embedding Learning in Sunderland

This guidance outlines the process the SSCB will follow to ensure lessons that have been learnt from the work undertaken through the Sunderland Learning and Improvement Framework. Learning and improvements must be robustly shared and embedded as widely as possible across the multi agency workforce and within communities as appropriate. The full SSCB Learning & Improvement Framework and Toolkit can be found at www.sunderlandscb.com

Role of SSCB Independent Chair

On receipt of the learning and the action required for improvement the SSCB Chair will:

- Ensure that the learning is disseminated fully across partner agencies
- Ensure robust arrangements are in place to implement the actions for improvement and audit the implementation
- Make an SSCB Challenge if improvements are not made as a result of the learning

Role of SSCB members

On receipt of the learning and the action required for improvement board members will:

- Share the learning and the actions for improvement with all levels of staff throughout their organisation
- Ensure the learning is embedded within their agency and take steps to assure themselves that this is improving outcomes for children
- Provide regular updates on progress of how the learning is embedded to their own staff and to the SSCB
- Provide assurance to the SSCB that the learning and actions for improvement has been embedded
- Identify any continuing concerns to the SSCB
- Support staff to attend Learning and Improvement Workshops and relevant SSCB training and workforce development activities

Role of Frontline Managers

On receipt of the findings frontline managers will:

- Read SCR Overview reports and attend Learning and Improvement workshops as appropriate

- Read SSCB Briefing papers and apply the learning in practice
- Attend single agency and multi agency training
- Support staff to attend Learning and Improvement workshops
- Discuss the learning and actions for improvement with teams
- Ensure learning is incorporated into frontline work as a means of evidence based practice

Role of individual practitioners

On receipt of the findings practitioners will:

- Read SCR Overview reports and attend Learning and Improvement workshops as appropriate
- Read SSCB Briefing papers and apply the learning in practice
- Attend single agency and multi agency training
- Contribute to agency improvement through team meeting and supervision discussions
- Incorporate into assessments as means of evidence based practice

Role of SSCB Business Unit

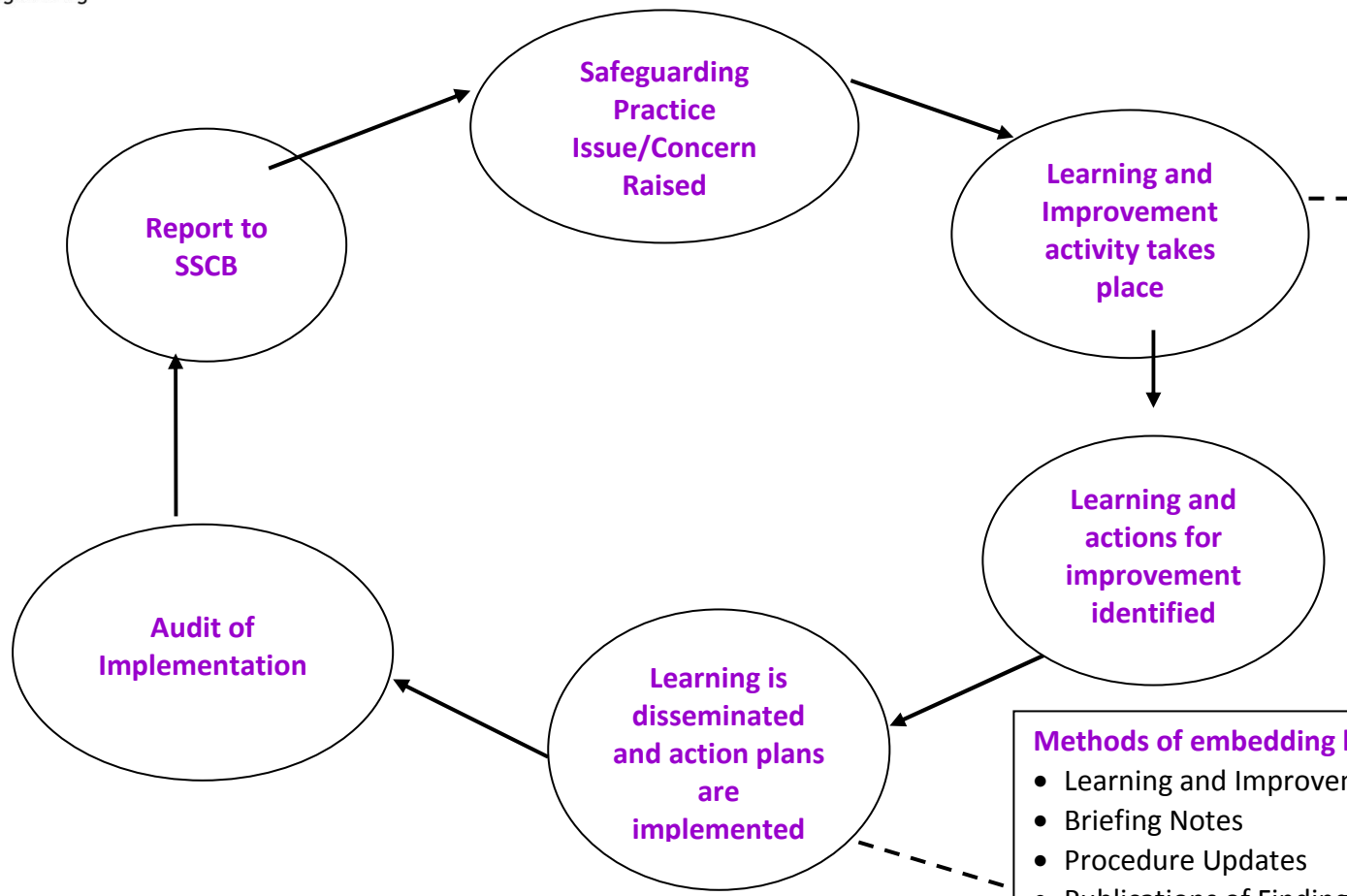
On receipt of the learning and the action required for improvement board members will:

- Support the delivery of Learning and Improvement Workshops and disseminate the learning as widely as possible
- Review and update SSCB training as appropriate
- Support the audit process used to evaluate the implementation of the actions for improvement
- Provide advise and guidance on the implementation of the actions for improvement as appropriate
- Coordinate the collation of the single and multi agency action plans from the learning activity

Appendix A

Sunderland Safeguarding Children Board

SSCB Learning and Improvement Cycle



Learning and Improvement exercise:

- Data Set Review
- Deep Dive
- Serious Case Review
- Multi-Agency Audit
- Single Agency Audit
- Impact of QA of training
- Root Cause Analysis
- Learning Lessons Review
- After Action Review
- Consultation
- S11 Audit
- Index of Excellence

Methods of embedding learning:

- Learning and Improvement Workshops
- Briefing Notes
- Procedure Updates
- Publications of Findings and Overview Report
- SSCB Challenge
- SSCB Annual Report
- Team Meetings
- SSCB Training