Suffolk Safeguarding Children Board

Learning and Improvement Framework

2018/19

Policy Version History

Version	Date	Detail	Author/Reviewer
4.0	October 2014	Updated to reflect new case review process	Paul Nicholls LSCB Professional Advisor
5.0	April 2015	Changes from Working Together 2015	Paul Nicholls LSCB Board Manager
6.0	October 2015	Reflect Priorities from 2015-16 Annual Report	Paul Nicholls LSCB Board Manager
7.0	August 2017	Reflect 2017 Priorities	Tracy Murphy LSCB Professional Advisor
8.0	February 2019	Reflect Changes in Working Together 2018 and 2018/19 Priorities.	Tracy Murphy LSCB Professional Advisor

Contents

1. Background and Legislation

Following the publication of Working Together to Safeguard Children 2018 there is a statutory requirement to set up new multi-agency safeguarding arrangements for children in Suffolk. These will replace the current requirements to have an LSCB.

The arrangements need to be published by June 2019 with implementation by no later than September 2019.

The Children Act 2004, as amended by the Children and Social Work Act 2017, places new duties on key agencies in a local area. Specifically, the police, clinical commissioning groups and the local authority are under a duty to make arrangements to work together, and with other partners locally, to safeguard and promote the welfare of all children in their area.

Working Together 2018

"There is a shared responsibility between organisations and agencies to safeguard and promote the welfare of all children in a local area. The responsibility for this join-up locally rests with the three safeguarding partners who have a shared and equal duty to make arrangements to work together to safeguard and promote the welfare of all children in a local area."

Everyone who comes into contact with children and families has a role to play

The Suffolk LSCB Annual Report - September 2018 lists its specific priorities as:

- Develop the multi-agency safeguarding arrangements in line with Working Together 2018 to be in place by July 2019.
- Lead the delivery of the Child Exploitation action plan across Suffolk. This will recognise the impact of the multi-agency response to the County Lines and gangs and groups in Suffolk.
- Monitor the effectiveness of the Violence Against Women and Girls (VAWG) Strategy and its impact on domestic violence in Suffolk.
- Monitor the safeguarding risks of children not in appropriate full-time education.
- Monitor the impact of the delivery of the Emotional Health and Wellbeing Strategy.
- Develop a robust Neglect Strategy and monitor its implementation and impact.

Learning and Improvements Under the New Arrangements from June 2019

The local arrangements will support and enable local organisations and agencies to work together in a system where:

"learning is promoted and embedded in a way that local services for children and families can become more reflective and implement changes to practice".

2. Suffolk LSCB's Commitment to Continuous Improvement

Suffolk LSCB is committed to a culture of continuous learning and through this framework will:

- Ensure there are a full range of reviews and audits monitored and reported though their Learning and Improvement sub group **(See Appendix A).**

The group's main responsibilities are:

- To develop challenging and rigorous approaches to monitoring and evaluating the impact of services on safeguarding primarily through S11, multi-agency, thematic audits and learning reviews.
- To collect and analyse performance information in relation to all aspects of safeguarding, identifying areas requiring action and report these to the LSCB in July and December each year.

The range of reviews and audits conducted through learning and Improvement include:

- Annual Section 11 reviews and action plans.
- Partnership learning reviews.
- Thematic Audits.
- Multi Agency Case Audits.
- Single Agency reviews.
- Annual risks register review.
- Review of regular practitioner network meeting issues.

2.1 Dissemination of Learning from the LSCB

The LSCB are committed to learning from cases, performance information, audits and practice issues.

The dissemination of learning is undertaken in a variety of ways:

- Via the LSCB regular newsletter and website.
- Through the Training Support Forum and Policy and Training Sufficiency Group.
- Via the LSCB quarterly update given to the three Area Network Meetings.
- Through the monthly Learning and Improvement Group.
- Through attendance at Practitioner Workshops for Early Help and Social Care practitioners.
- Through Early Help and Social Care Service Manager's meetings.
- Through a number of safeguarding forums; in particular the District and Borough safeguarding forum and the forum for Children's Homes.

2.2 Suffolk LSCB and Safeguarding Training

Suffolk LSCB does not deliver safeguarding training. It is currently the responsibility of the Suffolk County Council Workforce Development Team, individual partner agencies and the Schools Choice service for training in schools.

Suffolk LSCB provide a quality assurance framework which includes the following:

- An endorsement and quality assurance process for all single and multi-agency training based on regionally agreed standards.
- Advice and guidance on any training issues across the partnership.
- Access to a free E-Learning Safeguarding training system to level 2 for over 1000 users.
- Learning to inform training from Partnership reviews through the Learning and Improvement Group.
- Input into the Workforce Development Trainers forum half yearly.
- Six monthly performance figures reported to the LSCB Board to demonstrate that staff are trained at the appropriate level.

3. Measuring Impacts and Outcomes

It is Suffolk LSCB's responsibility to ensure that processes are in place to measure the impact or outcome for any safeguarding intervention or training. This is done primarily through the range of reviews and audits outlined in **Appendix B.**

These measures are both quantitative and qualitative which should ultimately lead to improved outcomes.

The Suffolk outcome framework model (on page 8) gives examples of how the LSCBs audit work has led to improved outcomes.

Measure	Evidence	Targets or Indicators
Quantitative Data (Impacts) e.g. • How much? • How many?	➢ No. of contacts received by the MASH. ➢ No. of CAFs completed. ➢ No. of looked after children. ➢ No. of serious case reviews. ➢ Attendees at training courses.	➢ Targets set in service plans.
Qualitative Information (Interim outcomes*) e.g. • How well did we do?	➢ % of attendees has increased. ➢ % of complaints. ➢ No. of referrals to Specialist teams decreases. ➢ % of LACs who say they feel safe in their placement. ➢ Audits by the CYP QA team.	➢ Local measures and performance data. ➢ Evaluations.
Outcomes e.g. • How are children/families better off? • How have outcomes improved?	➢ % of families reporting improved wellbeing increases. ➢ Trainees report improved self-esteem and confidence. ➢ % of parents interviewed who say their skills have improved. ➢ % of cases where the investigation did not identify a risk to children. ➢ Feedback from families captured as part of the CYP Audit process.	➢ Customer Surveys. ➢ Face to face feedback. ➢ Audits.

4. The Suffolk LCSB Quality Assurance Framework

This process is designed to provide a systemic approach to quality assurance. It outlines the role of the LSCB at each stage.

Systemic Approach	LSCB Roles and responsibilities
Step One – Identify content areas and agree priorities • Identify partner and LSCB areas for measurement? ○ Are the partner priorities linked to the LSCBs latest performance indicators?	• Challenge and agree priorities. • Agree measures. • These are based on sound local needs analysis?

Step Two – What does 'good' look like
• What does 'good 'look like for the LSCB priority area and each content area?
  ○ Work with each agency and partners to identify what 'good' looks like for their service.
  ○ What service standards are currently in place that define these?
	• Provide support for definitions of 'good' in each content area.
	• Capture case study data and share where appropriate.

Step three – Identify source of current performance information
• What information does the LSCB or partner currently collect?
  ○ Is it qualitative, quantitative?
  ○ What targets are these linked to?
  ○ What are the timelines?
	• Ensure that data is up to date and accurate.
	• Is the data relevant to LSCB Performance Indicators?

Step Four – Identify sources of any additional information • What additional information/data do you need to collect to contribute to the 'good' indicators in step two? ○ How do you capture this information?	• Assist partners with information gathering. • Do any other partners collect similar data?

Step Five – Agree a quality assurance timetable
• What is the LSCB or partner 'quality assurance' timetable to ensure this information continues to be captured?
  ○ How can LSCB support
  ○ Will it be captured as part of Section 11 review?
	• Agree QA timetable with partners and peer review support where appropriate.
	• Identify any risks which need to be captured at partners or LSCB strategic level.

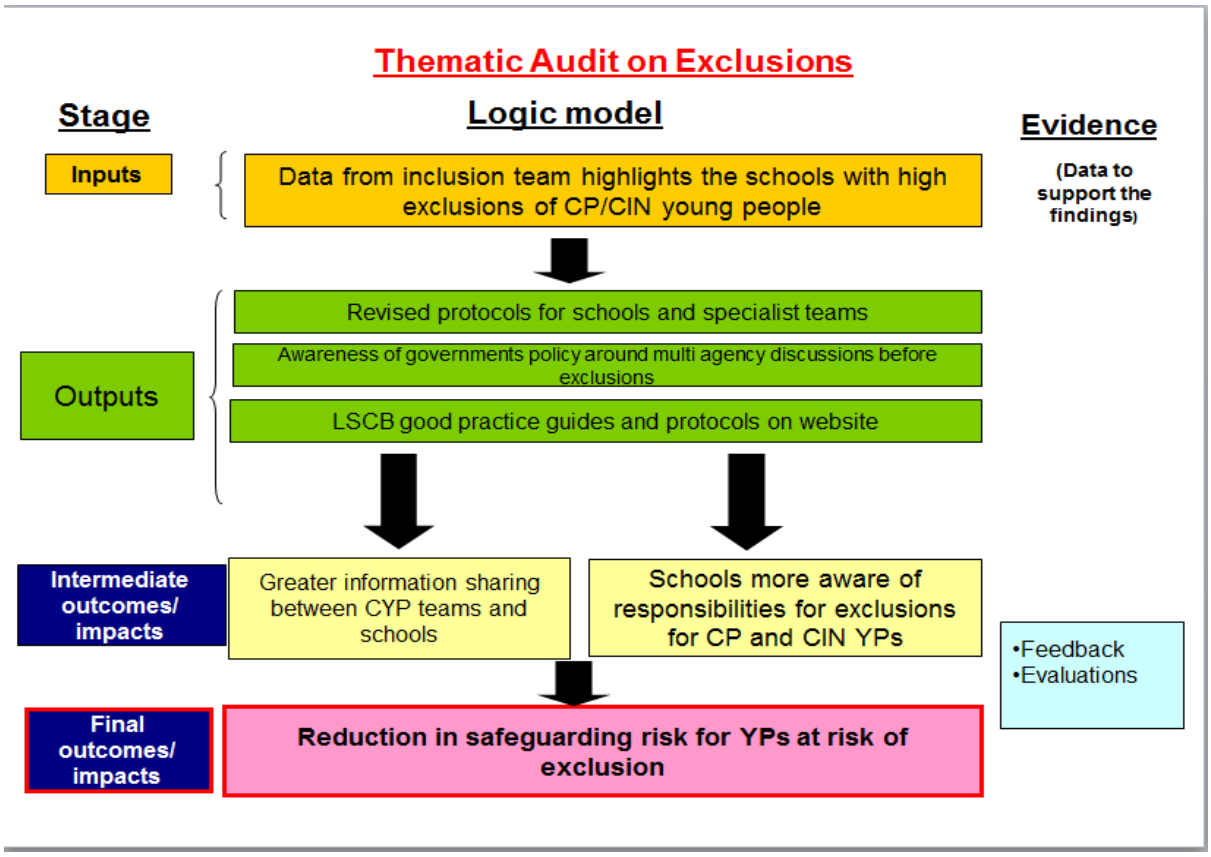
4.1 Success Criteria - What does 'Good' look like across the LSCB Partnership?

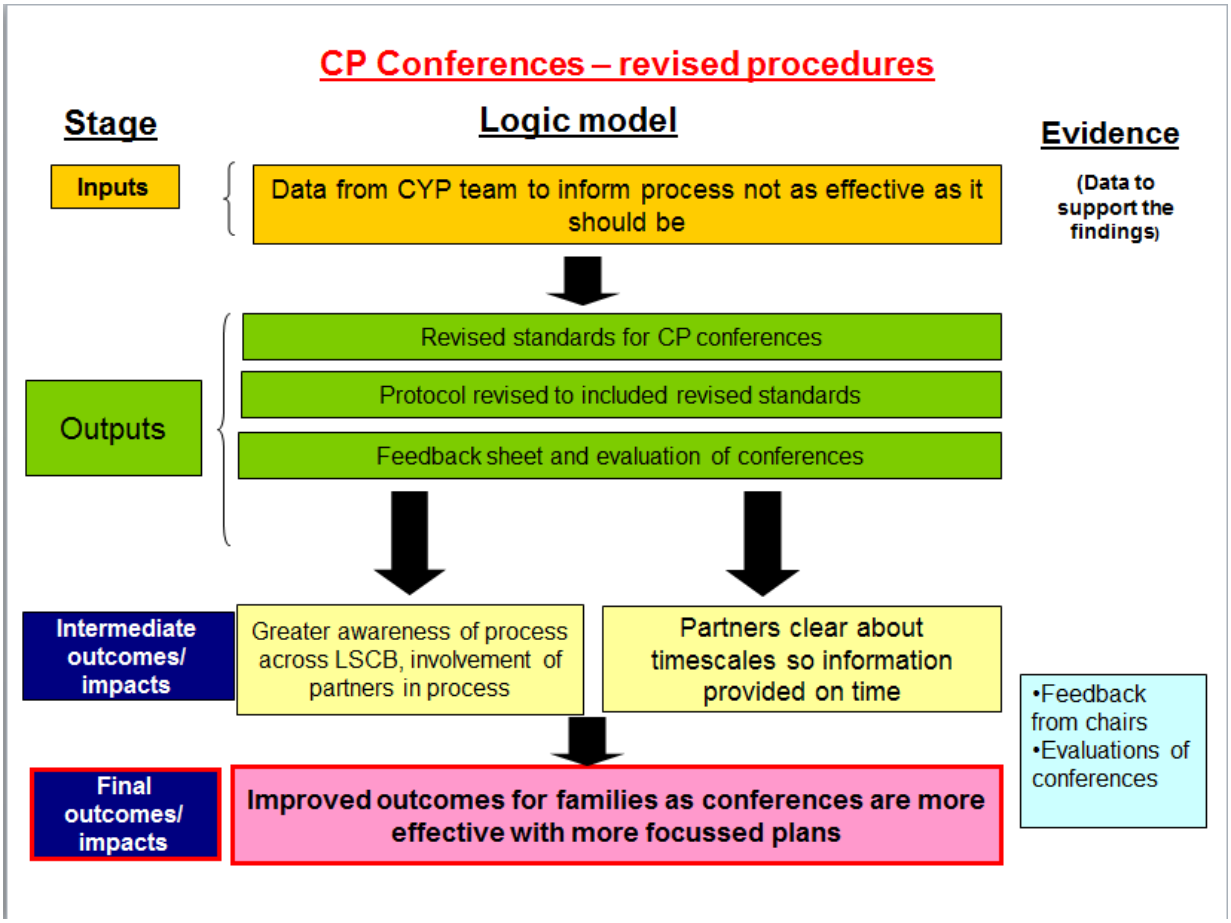
Quality can only be measured if there is a 'desired picture' for each service/content area which can be compared against performance data. Measures of quality should result in **sustained improvement**.

Some examples below of what 'good' may look like in terms of outcomes/Impact across LSCB partners:

Examples of outcome statements	Examples of Impact measures
Children's Services • Child protection plans result in objective, tangible improvements in the wellbeing and safety of children and their families. • Parents feel empowered and more confident as a result of the involvement of the service. • Young people are reporting that they feel safe to walk the streets at night. • Young people who are not attending school have a route to improve their educational outcomes which in turn is improving their confidence and self-esteem. • Young people are reporting that a result of the intervention their mental health has improved and consequently their risk-taking behaviors have decreased.	• YOS are reporting that crime levels in a particular location are decreasing and targeted individuals are receiving increased levels of 1-1 support. • Mental Health referrals from Schools are decreasing. • Incidents of assault on the location have decreased. • The number of children reported as 'missing' has decreased over the past 6 months.
Police • Families are reporting that Police attending domestic violence incidents treat them with respect, involve the children and provide clear information. • Staff feel more confident in dealing with domestic incidents.	• The number of DV/DA incidents reported to the police has decreased. • Referrals to Social Care arising from DV incidents have decreased.
Health • Antenatal midwifery services are effective in identifying potentially vulnerable mothers thereby reducing their concerns. • Parents report that they are treated empathetically by staff in A+E.	• The number of safeguarding cases at Ipswich A+E has decreased. • The number of complaints from Parents have decreased in the past 3 months.
Safeguarding Training (All agencies) • Staff who have received level 3 safeguarding training report that they feel more confident in dealing with particular family interventions. • Professionals in the service are operating at a required level of safeguarding children practice competence.	• Training evaluations show that and increased no of delegates marked 'excellent'. • The numbers of people attending courses has increased.

4.2 Examples of Suffolk Outcomes Framework





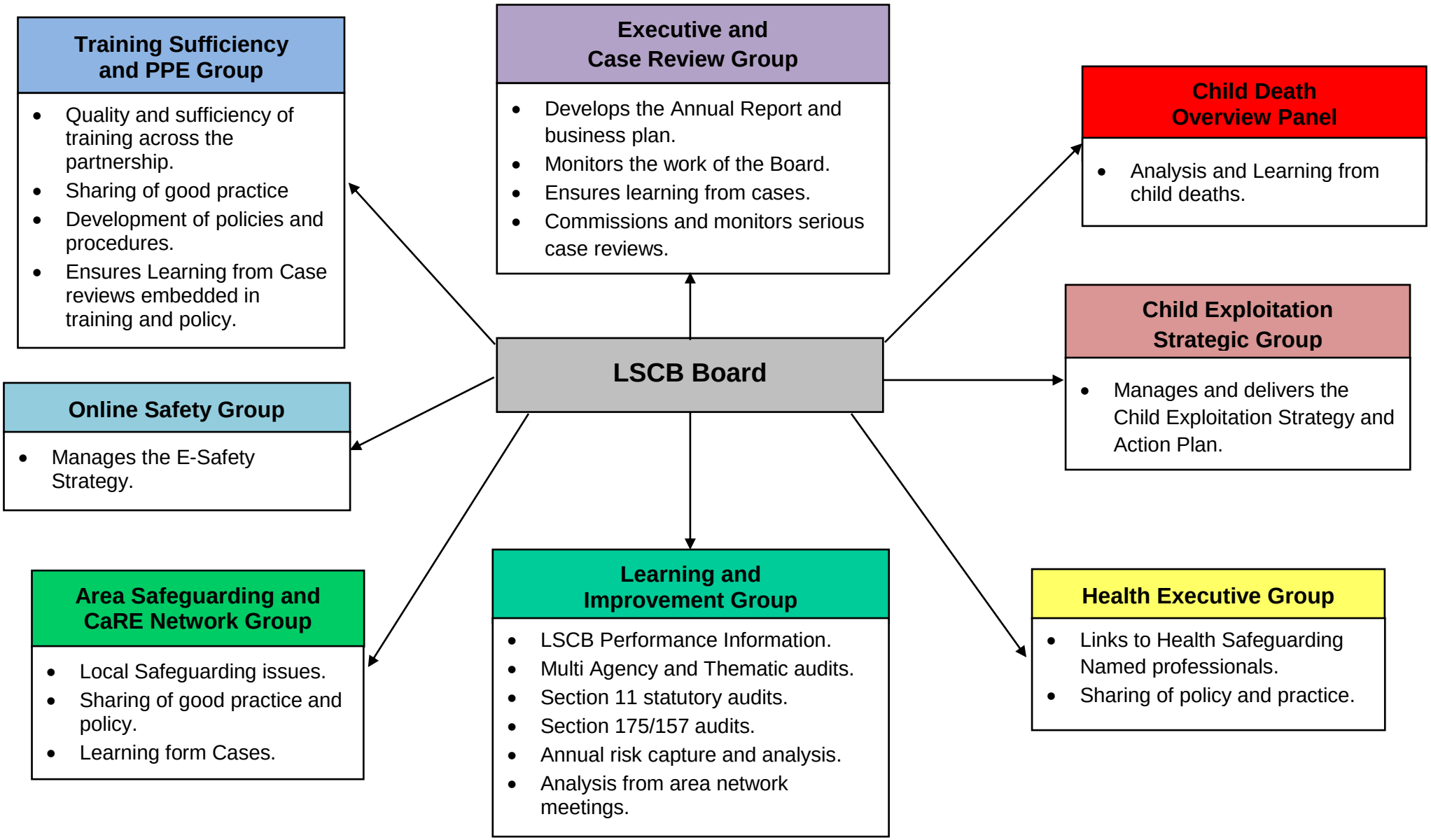
Appendix A: List of Potential Audits 2018-19

Audits for consideration in 2018 - 19

LSCB Themed Audits Schedule 2018/19 - Audits and reviews undertaken and agreed by LSCB Learning and Improvement Group

Themed Audits	Details	Proposed Date of Audit	Lead for Audit
Domestic Abuse	A multi-agency audit of contacts received into the MASH for DA to ascertain what services and support both parents and children; but particularly children, received from agencies and workers at the time of receipt of the contact and subsequently after assessment and outcome decision.	November 2018	LSCB Professional Advisor
Neglect and Graded Care Profile Audit	A follow-up audit to the first audit which was undertaken to ascertain how the Graded Care Profile tool is being used with families in children's services and more specifically, to explore its impact on practice and its impact on worker's confidence in working with neglect.	TBC – Possibly March 2019 (dependent on LL database)	
Performance Report Audits 1. Re-referral Audit Undertaken to Support QA Thematic Re-Referral Audit in September 2018.	QA team to identify key thematic audits from the CYP data and analysis in the LSCB Performance Report LSCB to support QA on audits for CYP.	Ongoing	QA and Professional Development Team.
Emotional Wellbeing Hub	An SOS audit of approx. six randomly selected referrals to the hub in the MASH in order to gather feedback on the service from the service users. An SOS review of the service with staff will be undertaken at the same time via a team meeting.	February/March 2019	LSCB Professional Advisor

Appendix B: Learning and Improvement Partnerships in the LSCB

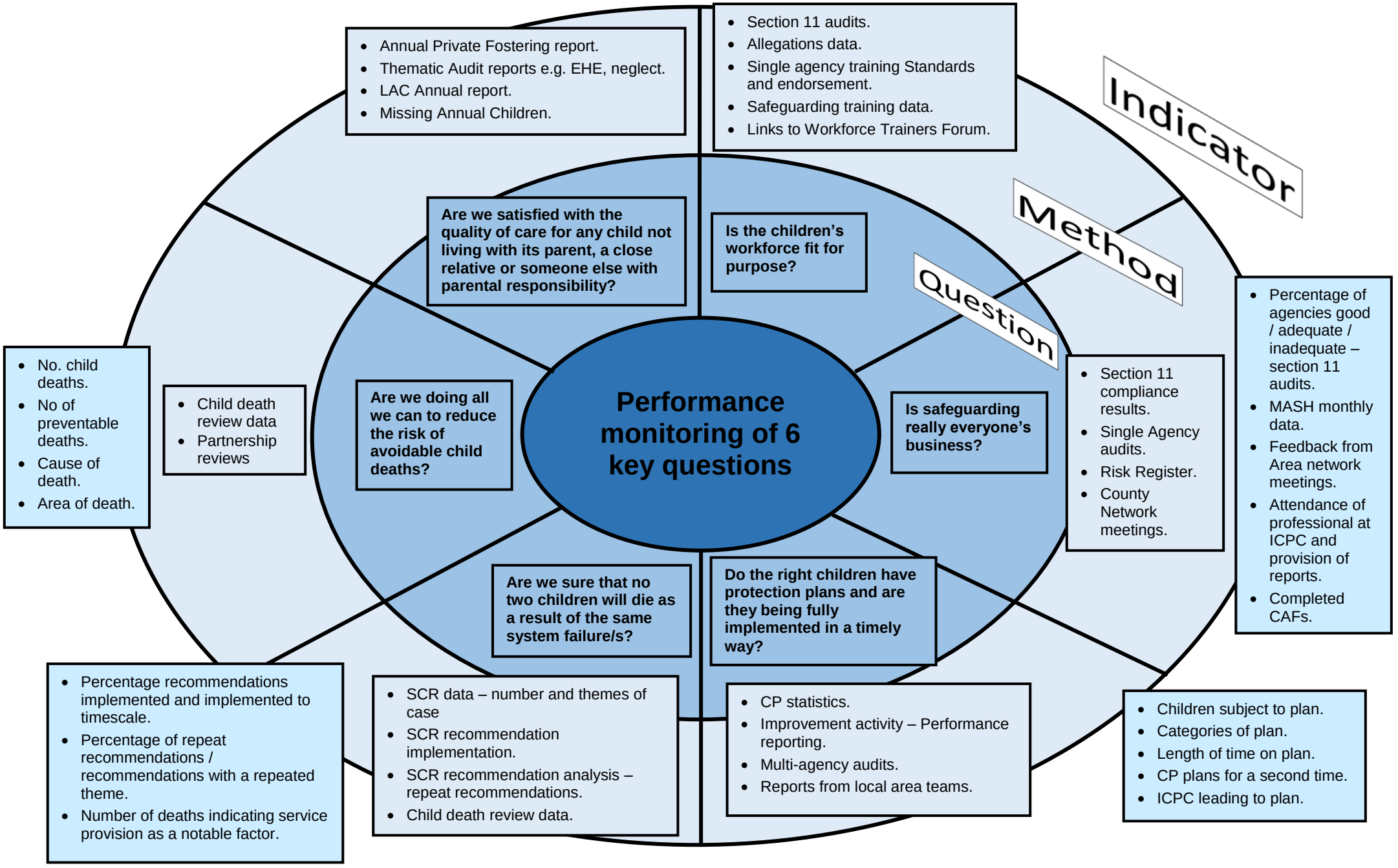


Appendix C: Suffolk LSCB – Detailed Learning and Improvement Schedule

	Description and purpose of Review or Audit	Reporting and Timescale
Serious Case Reviews	To assure the Board that recommendations arising from the lessons learned from Serious Case Reviews are implemented and positively impact on the improvement of safeguarding and promoting the welfare of children.	Update to Case Review Panel as SCRs arise. To LSCB as part of half yearly Performance report.
Child Death Review Data	To regularly update the Board on performance in numbers of preventable deaths of children and identify recommendations for action to reduce the number of preventable deaths.	Annual full report to LSCB. Quarterly updates via CDOP subgroup report to LSCB.
Partnership reviews	Criteria for SCR considered but deemed not to reach the threshold. Where referral gives rise to a concern around multi agency working and lessons need to be learned. Timeframe of 8-12 weeks.	Update to L&I Subgroup as cases arise. Recommendations to LSCB.
S.11 Audits and annual reviews	Self-assessment tool designed in partnership with Norfolk LSCB. Designed to assist LSCB partners to self-evaluate their own policies, procedures and activities in relation to safeguarding as defined in Section 11 of the Children Act 2004. Helps agencies to reflect upon their practice, identify strengths and weaknesses and to develop an action plan to further enhance effectiveness.	Rolling annual programme of reports on Action Plans to LSCB by partner agencies over 3 year cycle.
Section 175/157 Audits	Section 175 of the Education Act 2002 places a statutory duty on the LEA, Governing Bodies of schools, and FE institutions to safeguard and promote the welfare of children. Section 157 of the same act places the same duty on Independent schools. Audit conducted by Safeguarding Learning and Quality Assurance (SLQA) Team and reported annually to Board via L&I Subgroup.	Annual programme of audits. Report to LSCB via L&I Subgroup.

	Description and purpose of Review or Audit	Reporting and Timescale
Single Agency audits and data	To assure the Board that members are monitoring their own Safeguarding practice effectively, this function provides independent scrutiny of targets and performance. Reports to the L&I Subgroup will identify any performance area which might be of concern to the Board, together with action being taken by the Agency e.g. Hospital A+E admissions	Reports to L&I Subgroup and LSCB by single agency when requested.
Performance Information Framework	To regularly update the board on areas of performance which the Board has identified as priorities for the year. Performance Information Framework regularly updated to give a more outcome focused view across the partnership.	6 monthly progress and annual report to LSCB.
Thematic Audits	To assure the Board on areas of particular concern identified by the Board from performance information. Different mechanisms in Suffolk which allow themes or current issues to emerge, which may lead to the need for a thematic audit.	Progress reported monthly to L&I Subgroup. Findings reported to LSCB if appropriate.
Annual Risk Register	As part of the process of recording and monitoring risk, the L&I Subgroup recorded and reported LSCB Partners' risks.	Annually to L&I Subgroup and part of performance reporting where appropriate.

Appendix D: The Performance Monitoring Wheel



Appendix E: Process for Rapid Reviews and Learning from Rapid Reviews in Suffolk

---

Process for 'Rapid Review' of cases (as per Working Together 2018 and National panel guidance)

This process allows the LSCB to meet its obligations under the WT2018 guidance regarding serious incidents for review **within 15 days.**

LSCBs have a duty to notify the National Panel of their decision to complete a local review (or not) within this timescale.

Day	LSCB Action	Lead
1-2	The Local Authority must notify the LSCB at the same time as they make a notification of a serious incident to the National Panel and Ofsted – **See Appendix 1.** On receipt the LSCB Business Manager should send the notification to the Chair of the Case review group and review group members for initial views on whether case should proceed to a local review.	LSCB Central Team
3	Send referral to all members of the Case Review Group (including leads for key agencies - L.A, CCG & Police) advising of referral and request a brief summary of involvement with the family (information required within 3 days) - see the form in **Appendix 3**.	LSCB Central Team
6-7	Collate initial information regarding agency involvement in the case and send composite to Case Review Group requesting views on whether the case meets the criteria for a local review based on the information known at that point (information required within 3 days).	LSCB Central Team
10 -13	Discussion and decision by Chair of Case Review group, local authority Head of Safeguarding, LSCB Business Manager including identification of any immediate or urgent actions for agencies.	LSCB Independent Chair
14-15	Notification of rapid review decision to National Panel by LSCB together with justification of decision (copied to nominated leads and Chair).	LSCB Business Manager
Next Steps	At the next scheduled panel: • Identify reviewer if appropriate. • Convene review panel. • Await National Panel decision.	

Points to Note:

- In absence of a nominated lead from a partner agency – then a nominated deputy will carry out the role.
- In absence of the LSCB Chair, the Vice Chair will oversee the process.
- Potential decisions for the Rapid Review are:
    - Local Child Safeguarding Practice Review – however recommending that the national panel take over the case as being of national importance.
    - Local Child Safeguarding Practice Review – no apparent national importance issues to recommend to the Panel.
    - Alternative local process e.g. Partnership Review.
    - No further action.

This updated process is in line with the new statutory requirements effective immediately for LSCBs to carry out a rapid review process of any new cases and inform the panel of an initial decision of whether or not to carry out a review within 15 days.

It is thus **essential** that all partners adhere to these timelines for the initial investigation.

Appendix 1

Reporting Safeguarding Incidents

From 29 June 2018 local authorities in England must notify the national Child Safeguarding Practice Review Panel within 5 working days of becoming aware of a serious incident.

You should report incidents where the local authority knows or suspects that a child has been abused or neglected and:

- The child dies (including suspected suicide) or is seriously harmed in the local authority's area.
- While normally resident in the local authority's area, the child dies or is seriously harmed outside England.

You should also report the incident to the relevant Local Safeguarding Children Board (LSCB) at the same time as notifying the panel.

Appendix 2

Extract from Working Together 2018 re Rapid Review of Cases

‘’The safeguarding partners should promptly undertake **a rapid review of the case**, in line with any guidance published by the Panel. The aim of this rapid review is to enable safeguarding partners to:

- Gather the facts about the case, as far as they can be readily established at the time.
- Discuss whether there is any immediate action needed to ensure children’s safety and share any learning appropriately.
- Consider the potential for identifying improvements to safeguard and promote the welfare of children.
- Decide what steps they should take next, including whether or not to undertake a child safeguarding practice review.

As soon as the rapid review is complete, the safeguarding partners should **send a copy to the Panel.** They should also share with the Panel their decision about whether a local child safeguarding practice review is appropriate, or whether they think the case may **raise issues which are complex or of national importance** such that a national review may be appropriate.

They may also do this if, during the course of a local child safeguarding practice review, new information comes to light which suggests that a national review may be appropriate. As soon as they have determined that a local review will be carried out, they should inform the Panel, Ofsted and DfE, including the name of any reviewer they have commissioned.”

On receipt of the information from the rapid review, **the Panel must decide whether it is appropriate to commission a national review of a case or cases.** They must consider the criteria and guidance below.

The criteria which the Panel must take into account include whether the case.

- Highlights or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified.
- Raises or may raise issues requiring legislative change or changes to guidance issued under or further to any enactment.
- Highlights or may highlight recurrent themes in the safeguarding and promotion of the welfare of children.

Learning from the Rapid Review

Learning from all Rapid Reviews is captured in the report and disseminated through the Learning and Improvement Group for agreement on wider dissemination and learning for partners. The Rapid Review action plan is monitored at the LIG meeting.