Surrey Safeguarding Children Board
Learning and Improvement Framework

Introduction

The Surrey Safeguarding Children Board (SSCB) Learning and Improvement Framework promotes learning from experience and from reviews against standards. It reinforces continuous improvement in partner agencies and all local organisations who work with children and families. The SSCB Learning and Improvement Framework is informed by learning from reviews, audits, practitioners' feedback and the voice of the child and families.

Working Together (2015) requires that "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". Appreciative enquiry, working with stakeholders, helps to identify good practice. This will be shared so that there is a growing understanding of what works well to improve outcomes for children and families. Conversely, when things have gone wrong the learning will be shared to enable service improvement to reduce the risk of future harm to children.

Professionals and organisations protecting children need to reflect upon the quality of their services and ensure that they learn from their practice, and that of others, in order to improve local safeguarding practice.

The framework will apply to all SSCB partner agencies in their delivery and monitoring of workforce development activities. It will inform single agency frameworks to ensure connectivity and compatibility. It is important that organisational learning resulting from this framework is dynamic, cyclical and a multi-layered process that informs the SSCB's wider strategic planning framework and determines current and future priorities.

Principles for learning and improvement

The principles underpinning the learning and improvement framework as outlined in Working Together 2015 are:

- 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 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;
- Final reports of Serious Case Reviews (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 LSCB annual reports 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.

Surrey Safeguarding Children Board (SSCB) Commitment

The SSCB is committed to supporting the development of a culture of continuous learning across member agencies and through the development and maintenance of this framework will respond to local and national policies and agendas.

SSCB will promote learning from a **'**full range of reviews and audits' which are aimed at driving improvements. SSCB will monitor practice improvements and impact via the Strategic Case Review group, Child Death Overview Panel, the Quality Assurance group and the Learning and Development group. This may also include learning and improvements agreed by SSCB sub groups.

Roles and Responsibilities

Partner agencies and all local organisations that work with children and families are expected to endorse this framework and embed it into workforce learning and development policies.

Partner agencies and local organisations are responsible for:

- Providing staff and other resources to deliver the framework.
- Contributing to the reviews of practice undertaken by the SSCB.
- Ensuring that lessons learnt from reviews of practice are widely disseminated within their organisation through changes to policies and procedures; updating of internal training programmes and through the implementation of action plans.
- Embedding learning into practice and using systems of evaluation, audit and survey to quantify the impact of learning on practice.

SSCB Learning & Improvement Model

The following table provides further details to support the model

SSCB Learning & Improvement Model	
Category	**Informed by**
Practice/Improvement of practice	Sources of learning and review recommendations
Review of Practice/Audit	Serious Case Review Recommendations Domestic Homicide Review Recommendations Partnership Reviews Individual Management Reviews Good Practice Reviews Child Death Reviews Quality Assurance Activity including Multi-agency thematic audits; Multi-agency case audits; Single Agency Audits; Section 11 audits; Section 175/157 audits within schools Feedback from practitioners Feedback from children and families National Learning OFSTED /regulator Improvement Actions

Identification of learning	Identification of learning through: The function of the Strategic Case Review Group and Quality Assurance Group Recognition of where practice improvement is required Planning for change to practice; Action plans
Dissemination of learning	Dissemination of learning through: Training for practitioners Organisational change to policy and practice Effective communication of changes
Embedding learning	Practical support to practitioners through guidance, training and implementation
Monitoring and evaluation	Four-stage impact assessment of training Review of the impact of changes to practice Reflective practice informs continuous learning Challenge and Scrutiny Events

Interface with Quality Assurance and Performance Management

One of the objectives of this framework is to help the SSCB understand and assure itself with regard to safeguarding children in Surrey. The framework alone cannot tell the SSCB everything it needs to know but should be understood as part of a broad range of information the SSCB analyses and reviews. The table below seeks to place the learning and improvement framework in the context of the other sources of information the SSCB draws upon.

Quantitative information on performance Numerical performance indicators (data sets, report cards, SSCB annual report)	**Views of children and their families about services** Quality assurance and audit activity, scrutiny and challenge, thematic reviews and surveys
Learning and improvement Qualitative information from SCRs and other case reviews, quality assurance and audit activity; including focus groups, peer reviews and inspections, thematic reviews and deep dives, scrutiny and challenge	**Feedback from front line staff and managers** Quality assurance and audit activity; including focus groups, scrutiny and challenge, thematic reviews and deep dives

Components of the learning and improvement framework

The following is an outline of key learning and improvement process and activity in relation to the SSCB learning and improvement model.

Notifiable Incidents

A notifiable incident is an incident involving the care of a child which meets any of the following criteria:

- A child has died (including cases of suspected suicide), and abuse or neglect is known or suspected;
- A child has been seriously harmed and abuse or neglect is known or suspected;
- A looked after child has died (including cases where abuse or neglect is **not** known or suspected); or
- A child in a regulated setting or service has died (including cases where abuse or neglect is **not** known or suspected).

The local authority should report any incident that meets the above criteria to OFSTED and the relevant LSCB or LSCBs promptly, and within five working days of becoming aware that the incident has occurred.

NB: If an incident meets the criteria for a Serious Case Review then it will also meet the criteria for a notifiable incident. There will, however, be notifiable incidents that do not proceed through to Serious Case Review.

Contact details and notification forms for notifying incidents to OFSTED are available on OFSTED's website.

Initiation of Case Reviews including Serious Case Reviews

All LSCBs must conduct SCRs in line with requirements in paragraphs 16 to 19 and the checklist on pages 78 to 79 of Chapter 4, Working Together to Safeguard Children (2015).

The SSCB Strategic Case Review Group (SCRG) makes recommendations about cases meeting the criteria for a serious case review, or partnership review and identify learning themes. The review will adopt an appropriate learning model consistent with the principles of Working Together (2015).

The final decision about whether or not a case meets the serious case review criteria rests with the SSCB Independent Chair.

See **Appendix A** for details of alternative reviews undertaken following serious incident notifications; child death reviews (CDOP), Partnership Reviews and Single Agency Reviews.

Serious Case Reviews, Partnership Reviews and Child Death Overview Panel processes use systems methodologies which are tailored to fit individual case requirements. Terms of reference documents for reviews identify the approach to be taken, the panel/reviewing group, the independent overview writer, the scope and timescale of the review.

For details of the serious case review process, methodologies and referral form see www.surreyscb.org.uk/case reviews.

Domestic Homicide Reviews

Whilst these are the responsibility of Boroughs and Districts, there are occasions where joint SCRs/DHRs take place and learning from such reviews should be disseminated to practitioners and managers through the usual channels outlined in this framework. (Criteria for DHRs can be found in the following Home Office document: Multi-agency statutory guidance for the conduct of domestic homicide reviews. 2016 Home Office.)

Principles for Conducting Audits

The SSCB has adopted the standards applied by Surrey County Council when conducting multi-agency audits and case file reviews. Please visit www.surreyscb.org.uk/quality assurance & evaluation for guidance and standards applied by the SSCB when conducting audits.

Working Together 2015 Chapter 3 paragraph 2 says that in order to fulfil its statutory function under regulation 5 a Local Safeguarding Children Board (in this case the SSCB) should use data and as, a minimum, should:

- Assess the effectiveness of the help being provided to children and families, including early help.
- Assess whether SSCB partners are fulfilling their statutory obligations set out in chapter 2 of this guidance (section 11 audit).
- Quality assure practice, including through joint audits of case files involving practitioners and identify lessons to be learnt.
- Monitor and evaluate the effectiveness of training, including multi agency training, to safeguard and promote the welfare of children.

Statutory Section 11 audits are conducted by the Board on a biennial basis and action plans are monitored in the interim to ensure that partners are fulfilling statutory obligations.

Measuring the Impact and Outcomes of Learning Improvements

The SSCB through the Quality Assurance Group and the Learning and Development Group will ensure that processes are in place to measure the impact and/or outcome of learning improvements, intervention or training. The measures used will be both quantitative and qualitative.

Multi-agency training will be evaluated using a four-stage evaluation tool, based on the New World Kirkpatrick model, to measure the impact that training has on practice by quantifying participant knowledge and confidence prior to, during and after training.

Learning improvements should be sustainable. Where a case gives rise to concerns that prior learning from case reviews has not been embedded into practice the SSCB will review practice through practitioner forums or case audits to understand why the learning has not been sustained.

Dissemination of Learning

Wide dissemination of learning outcomes will be a key part of embedding learning into practice.

The SSCB will:

- Facilitate multi-agency learning events for professionals involved in specific cases
- Provide targeted workshops to support partners in embedding learning into practice change and development.
- Provide briefings, newsletters and communications to partner agencies and relevant organisations.
- Publish learning leaflets following completion and publication of Serious Case Reviews.
- Publish Serious Case Review Reports in line with the requirements of Working Together (March 2015).
- Deliver a multi-agency training strategy and training programme.
- Map themes from Serious Case Reviews, Partnership Reviews, Domestic Homicide Reviews and audits to inform planning and service development to identify and address regularly occurring themes.

Partner organisations are expected to:

- Cascade learning outcomes throughout their organisations using appropriate communication channels.
- Update single agency training to reflect current practice and reflect learning outcomes from case reviews and audit.

The SSCB Learning & Improvement Framework is reviewed annually by the SSCB Policy & Procedures Group. The next review date is July 2018.

Appendix A: Types of Review

Serious Case Review

Where cases meet criteria for a Serious Case Review as set out in Regulation 5 of the LSCB Regulations 2006, review activity is proportionate to the specific circumstances of the case.

Strategic Case Review Group will recommend the most appropriate methodology for conducting the review, agree the Terms of Reference, Scope of the review and identify the Independent Chair if required and the Independent Overview Writer.

Partnership Reviews

Partnership reviews are reviews of cases which fall below the SCR threshold which could lead to significant and new learning.

Cases can involve incidents where a child has been harmed, or cases where multi-agency practice is considered to be good (after a child has been harmed or where a child has been prevented from being harmed) and agencies seek to identify the elements of that good multi-agency practice

The methodology used to undertake a review and how the lessons will be disseminated will be decided locally by each LSCB.

Single Agency Reviews

Where a case is considered for a serious case review or partnership review but does not meet the criteria, as the practice requiring further analysis and learning is limited to a single agency, the independent chair may recommend a single agency review.

Child Death Reviews

The SSCB is responsible for ensuring that a review of each death of a child (aged under 18 years of age), normally resident in the SSCB's area is undertaken by a **Child Death Overview Panel** (CDOP). This function is set out in Regulation 6 of the Local Safeguarding Children Boards Regulations 2006. The Panel has a fixed core membership drawn from organisations represented on the SSCB with flexibility to co-opt other relevant professionals to discuss certain types of death as and when appropriate.

The Chair of the CDOP is not directly involved in providing services to children and families in the area. There is also a Designated Paediatrician, who provides expert advice on each child death, including advice about whether the death was unexpected. In addition there is a CDOP Nurse who provides support to the family following a child's death and a CDOP Co-ordinator who receives all death notifications as well as other data relating to child death.

The CDOP Co-ordinator establishes which agencies / professionals have been involved with the child and their family prior to, or at the time of the death of the child. The agency report is sent to the lead professional and any other professionals known to have been involved for completion. Family members are consulted about their views on the services provided, and whether they consider that there was anything that could have been done to prevent the death. All this information is collated for entry on to the data base. This information is sent to all CDOP members for discussion at a Panel meeting.

The CDOP meeting reviews each case in order to

- Classify the cause of death.
- Identify any modifiable factors which may have contributed to the death.
- Decide on preventability of the death.
- Consider whether to make recommendations to the SSCB or other relevant bodies promptly so that action can be taken to prevent future such deaths.
- Identify patterns or trends in local data.
- Where a suspicion arises that neglect or abuse may have been a factor in the child's death, referring the case for consideration of whether an SCR is required.
- Consider whether local procedures should be amended for responding to unexpected deaths of children.
- Co-operate on a national basis with data and local findings with the National Clinical Outcome Review Programme to identify lessons for prevention of child deaths. Aggregated findings from CDOP inform local strategic planning, including the local joint strategic needs assessment.

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See Working Together 2015 for information of Child Death Reviews.