Surrey Safeguarding Children Board
Learning and Improvement Framework

Introduction

The Surrey Safeguarding Children Board (SSCB) Learning & 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.

Working Together (2013) 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".

Professional 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 SSCBs wider strategic planning framework and determines current and future priorities and resource allocation

Surrey Safeguarding Children Board (SSCB) Commitment

SSCB are 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, Development & Communication group.

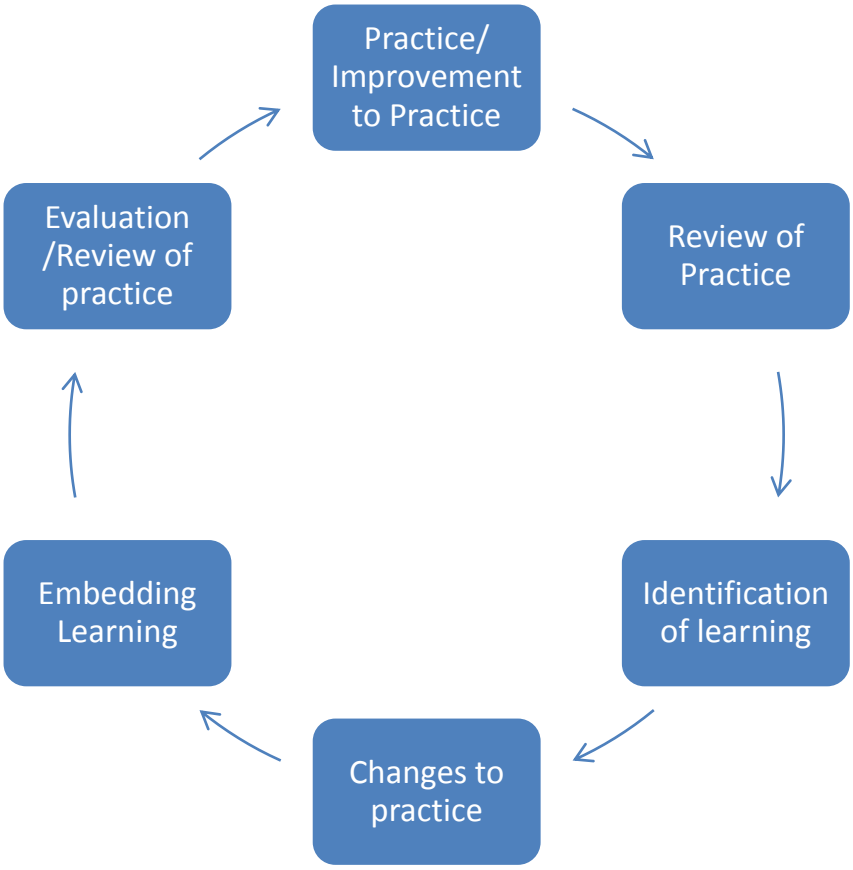
Roles and Responsibilities

Partner agencies and all local organisations that work with children and families are expected to endorse this framework and embed the framework 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	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 all agency practitioners Feedback from children and families National Learning OFSTED /regulator Improvement Actions Learning from CP Dissents

Identification of learning	Identification & dissemination 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
Changes to Practice	Organisational change to policy and practice Effective communication of changes Training for practitioners
Embedding learning	Dissemination of learning Practical support to practitioners through guidance, training and implementation
Evaluation/Review of practice	Review of the impact of changes to practice Impact assessment Reflective practice informs continuous learning

Principles for Conducting Reviews

The following principles will be applied by SSCB and partner organisations to all reviews:

- There should be a culture of continuous **learning and improvement** across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice;
- The approach taken to reviews should be **proportionate** according to the scale and level of complexity of the issues being examined;
- Reviews of serious cases should be led by individuals who are **independent** of the case under review and of the organisations whose actions are being reviewed;
- Professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- Families, including 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 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.

Initiation of Case Reviews

All LSCBs must conduct SCRs in line with requirements in paragraphs 12 to 18 and the checklist on pages 70 to 72 of Chapter 4, Working Together to Safeguard Children (2013).

"Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 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".

The SSCB Strategic Case Review Group make recommendations about cases meeting the criteria for a serious case review, or partnership review and identify themes for practitioner forums and audits.

The final decision if a case meets the serious case review criteria will rest with the SSCB Independent Chair.

Decisions on whether to initiate a serious case review should be made within one month of the LSCB being notified of the incident triggering the threshold. SCRG Form A is completed to make a referral (Appendix A)

Appendix A. Contains the case review threshold flowchart and form SCRG Form A. **Serious Case Reviews** (SCR) **Partnership Reviews** and **Child Death Overview Panel** (CDOP) 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 **Appendix B** provides details of review methodologies which the SSCB may consider

The National Panel of Independent Experts on serious case reviews will be notified within 14 days of the SSCB Chair's decision on whether a Serious Case Review is to be initiated. Where a case is considered for a Serious Case Review and the SSCB Chair decides the threshold is not met, additional information to justify the decision will be required to be provided to the National Panel of Independent Experts on Serious Case Reviews. Where the notification to the National Panel of Independent Experts on Serious Case Reviews is to initiate a Serious Case Review, the notification information should also contain the name(s) of the independent Lead Reviewer(s) appointed by the SSCB

CHILD DEATH OVERVIEW PANEL

The LSCB is responsible for ensuring that a review of each death of a child (aged under 18 years of age), normally resident in the LSCB'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 LSCB 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 particularly 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 any death of a child.

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 and anonymised 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 and to whom they should be addressed
- 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 back to the LSCB Chair 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

Recommendations from CDOP relating to case reviews, are taken to the LSCB for further discussion and action to prevent future such deaths where possible.

Principles for Conducting Audits

The SSCB has adopted the standards applied by Surrey County Council when conducting multi-agency audits and case file reviews . **Appendix C** contains the guidance and standards applied by the SSCB when conducting audits.

Working Together 2013 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 Learning, Development and Communication 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.

Training will be evaluated using tools 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.

SSCB are developing a participation strategy to ensure that children, their families, carers and practitioners inform the work of the SSCB and its partners.

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Dissemination of Learning

Wide dissemination of Learning Outcomes will be a key part of embedding learning into practice.
The SSCB will:

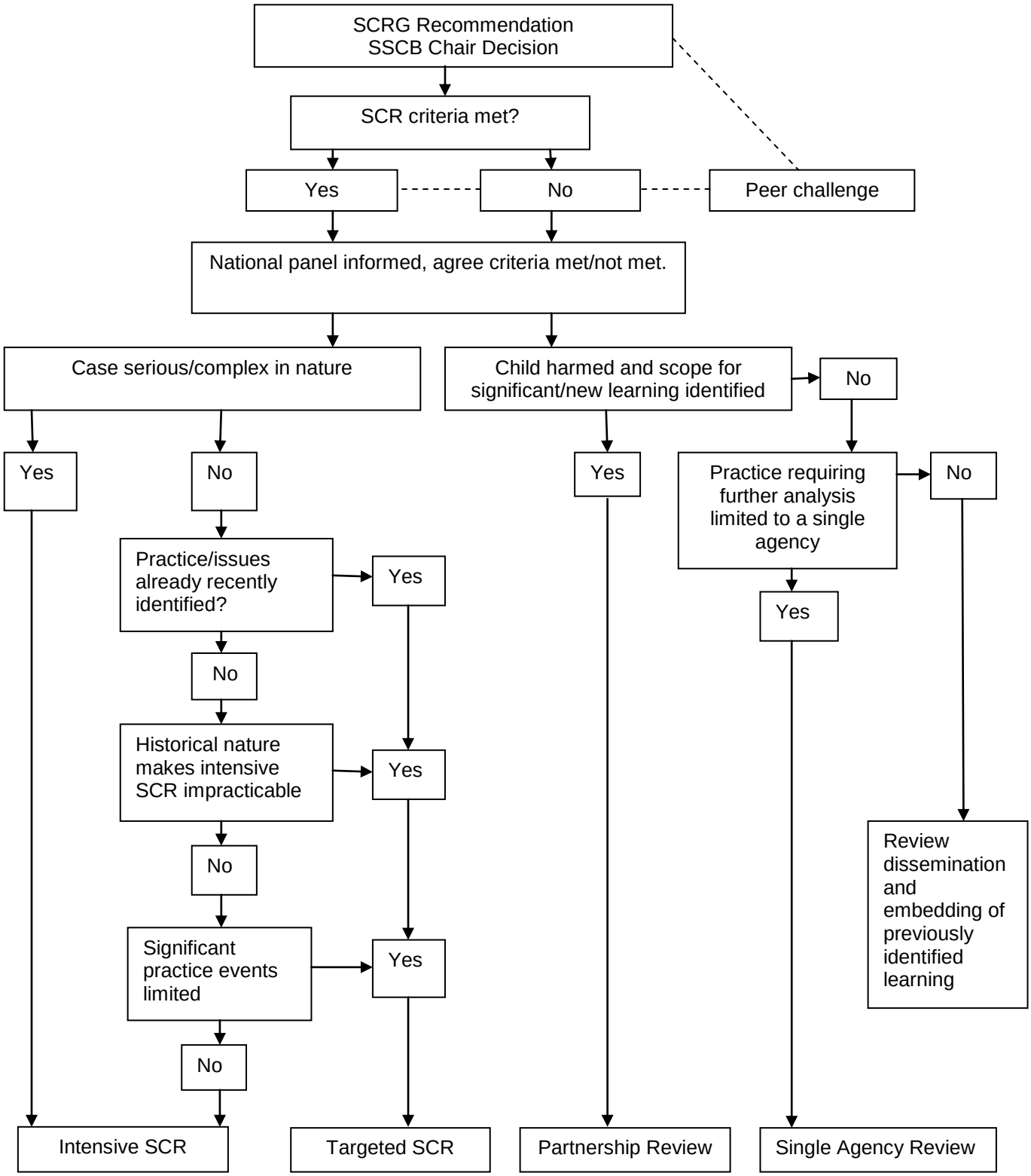
- Facilitate multi-agency learning events for professionals involved in specific cases
- Provide targeted workshops to support partners in embedding learning into practice change and development
- Provide briefings, newsletters and communications to partner agencies and relevant organisations
- Publish learning leaflets following completion and publication of Serious Case Reviews
- Publish Serious Case Review Reports in line with the requirements of Working Together (March 2013)
- Deliver a multi-agency training strategy and training programme
- Map themes from Serious Case Reviews, Partnership Reviews, Domestic Homicide Reviews and audit to inform planning and service development to identify and address regularly occurring themes

Partner organisations will:

- 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

Appendix A

Case Review Threshold Flowchart



	SURREY SAFEGUARDING CHILDREN BOARD **STRATEGIC CASE REVIEW GROUP** ***Referral Form*** **Consideration of Case for Serious Case Review**

Referrer	
Name:	
Email:	
Date of referral:	
Agency:	
Phone No:	

Child and Family	
Name of child (include any aliases):	
Date of Birth:	
Date of Death (if applicable):	
Date of Critical Incident:	
Home Address:	
Ethnic Origin:	
Is the child subject to a child protection plan?	
Child's whereabouts at time of critical incident/death:	
Who was caring for the child at the time of critical incident/death?	

Family Composition/Significant Others (including siblings):						
Name	Relationship to subject child	Date of Birth	Address	Legal Status	Ethnic Origin	Is/Was name on CP Plan

Other agencies involved			
Name	Agency	Contact details	Are they still involved?

Circumstances that triggered the referral (please tick all that apply):
- a child sustains a potentially life-threatening injury or serious and permanent impairment of physical and/or mental health and development through abuse or neglect ☐

- a child has been seriously harmed as a result of being subjected to sexual abuse ☐
- a parent has been murdered and a domestic homicide review is being initiated under the Domestic Violence Act 2004 ☐
- a child has been seriously harmed following a violent assault perpetrated by another child or an adult X☐
Information for panel:
Concerns about interagency working: Please say what concerns you have about the way agencies worked together in this case, that would indicate the need for a case review (Working Together 8.11) Include events and circumstances relevant to the above category.

Has a serious incident notification been made to OFSTED (if yes please include date)	Yes	No

Signed:

Note: Agencies are reminded of the need to secure their files as soon as they become aware that a Serious Case review might take place.

Appendix B- 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.

Appendix C

UNDERTAKING AN AUDIT AS PART OF THE SURREY SAFEGUARDING CHILDREN BOARD AUDIT/LEARNING & IMPROVEMENT PROGRAMME

Working Together 2013 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

Audit is a quality assurance process. It provides a means of finding out whether the service is following guidelines and or applying best practice in a particular area. It is a systematic process that involves: defining standards and criteria, collecting data and analysis the findings.

Audit is undertaken to ensure that policy and procedures are being followed and to measure the impact of changes to practice. It provides evidence of best practice and can demonstrate the quality of work to external bodies and inspectors. It also allows areas of weakness to be identified and acted upon.

The process of doing the audit can be as beneficial as the outcome because it provides staff with the time and space to reflect critically upon practice and, in the multi agency audits carried out by the Surrey Safeguarding Children Board (SSCB), the opportunity for agencies to learn from each other.

The majority of agencies who constitute the Board and the area groups are signed up to the multi agency sharing information sharing Agreement

Quality & Assurance Group

The Quality Assurance Sub Group (QA Group) of the SSCB has an annual programme of audits that seek to assure quality in key areas of safeguarding activity. The area safeguarding groups may be asked to suggest and support audits in the same way as the QA Group.

The topics for audit are selected by issues/questions raised by:

- Inspection/review processes
- Complaints
- Serious Case Reviews/Case reviews
- Learning and Improvement framework
- SSCB priorities

The QA Group (and, where it has been agreed, the Area Safeguarding Groups) will oversee each audit by:

- Commenting upon and approving the scope for each audit to be undertaken
- Commenting upon and approving the report for each audit before a summary is submitted to the Board as part of the QA Officer's quarterly report. Where the audit has been commissioned by the Area Safeguarding Groups the audit will also be presented to the QA group who can so that they can quality assure the work.
- Quality assuring the action plans arising from audits to ensure that they are SMART and there is a clear understanding about what actions will be taken forward, by whom and when

- Reviewing the action plans
- Agreeing if re audit is required and the timescales for this
- Ensuring, through the Quality Assurance Administrator, that a record of all audits, re audits and action plan reviews is maintained until the audit is signed off.

SSCB Audit Standards

The QA standards from Surrey Children's Services have been adopted by the SSCB to ensure that:

- The Child is the central focus of our work
- The wishes, feelings and views of the child underpin and inform all the work we undertake
- Work with children, families and carers acknowledges and respects diversity and difference, and considers the impact of their culture and background
- Children are safeguarded and protected in a timely manner through a balanced analysis of risks and strengths. Particular attention is paid to safeguarding children with a disability
- Corporate parenting responsibilities will ensure safety, security and stability of care where possible within the child's family network and community. Particular attention will be given to good quality care planning and achieving permanency for a child without delay
- Active engagement in partnership working with community networks and partner agencies to achieve optimum outcomes for children
- Staff are supported, trained, managed and provided with reflective supervisions to ensure the best possible outcome for children and young people
- Managers lead staff to deliver quality and excellence, have an understanding of relevant processes and resources, and provide a clear direction to constantly improve service delivery

The standards provide the framework for the questions used in the audit tool. Audit is conducted by a multi agency group which is formed as a short task and finish group. The role of the group is to:

- Agree the scope of the audit, the standards and aims
- Decide on the best way to conduct the audit which should include case review, including an agreed audit tool, consultations with the work force and where possible ascertain the views of children and families. This can be done through focus groups, questionnaires, structured interviews and surveys
- Agree the sample size

Information Governance/ Data Security

The majority of agencies that constitute the Board have signed up to a Multi Agency Information Sharing Protocol.

Each individual agency is responsible for their own information security once the SSCB audit information has been received by them. Audit information is sent by the SSCB to secure email addresses or encrypted.

Completed audit forms should are kept securely by the SSCB until the audit report is completed and agreed by the QA group, after which time they are destroyed by shredding.

Dissemination of Findings

In order to be effective the SSCB will share findings in accordance with the Learning & Improvement Framework. Each individual agency take responsibility for the distribution of the findings of the audit as relevant to their area of practice.

Where the audit has involved contributions from parents and children's the relevant outcomes and actions should be shared with them.

The SSCB Learning & Improvement Framework is reviewed annually by the SSCB Policy & Procedures Group. The next review date is February 2015