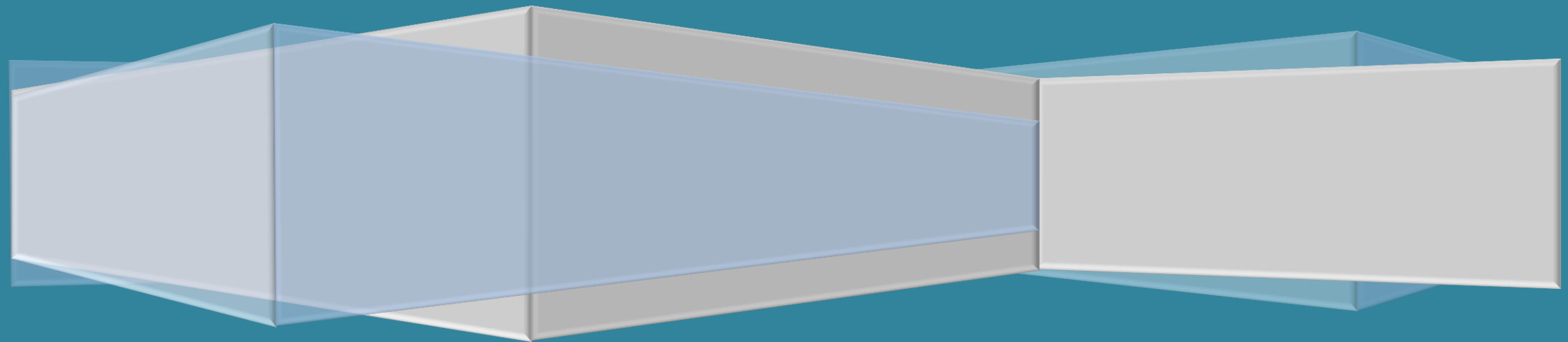


Sandwell Safeguarding Children Board

SSCB Learning and Improvement Framework

Revision Date: May 2016

Date of Review: May 2017



SSCB Learning and Improvement Framework

Introduction:

Sandwell Safeguarding Children Board (SSCB) is a learning organisation and through its statutory functions reviews, scrutinises and challenges local safeguarding arrangements and practice in order to improve services to safeguard and promote the welfare of children in Sandwell. To support this work SSCB has developed a learning and improvement framework.

Statutory safeguarding guidance, Working Together to Safeguard Children (DfE, 2015) states that professionals and organisations protecting children need to reflect on the quality of their services and that they learn from their practice and that of others in order to improve local safeguarding practice. In order to support this there is a requirement placed on LSCBs to develop and maintain a local learning and improvement framework. This framework is for SSCB, partner agencies and all local organisations who work with children and families. SSCB will maintain and develop this framework responding to local and national policies and agendas.

Monitoring and review of this framework:

This framework will be monitored via the SSCB and be reviewed on an annual basis (or sooner in response to delivery of this framework, governmental guidance, national agendas etc.)

Overview:

This framework seeks to promote continuous improvement via a feedback loop as described in Appendix 1. The building blocks to this framework are illustrated below and explained further on pages 3-6:



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Principles for Learning & Improvement

- 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** 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 must 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
- Final reports of SCRs must be **published**, including SSCB'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 SSCB annual reports and will inform inspections
- 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

Process

- The building blocks to SSCBs learning and improvement framework are:
 - **Learning from Experience**
 - Reviews of safeguarding practice
 - Identification of learning
 - **Improving Services**
 - Embedding learning in practice
 - Evaluation of learning

Scope

- The local framework should cover the full range of **reviews and audits** which are aimed at driving improvements to safeguard and promote the welfare of children
- Some of these reviews (i.e. SCRs and child death reviews) are required under legislation. It is important that SSCB understand the criteria for determining whether a statutory review is required and always conduct those reviews when necessary.
- SSCB should 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. 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.

Working Together 2015 states that LSCBs should maintain a local **learning and improvement framework** which is shared across local organisations who work with children and families. This framework should enable organisations to be clear about their responsibilities, to learn from experience and improve services as a result.

Roles and Responsibilities

- Partner agencies and all local organisations who work with children and families are expected to endorse this framework and embed it into their organisational and workforce learning and development policies.
- In addition, partner agencies and local organisations are responsible for:
 - Providing staff and other resources to deliver the framework
 - Contributing to reviews of practice undertaken by SSCB
 - Ensuring lessons learnt from these reviews of practice are disseminated widely within their organisation (e.g. internal training, policies/ procedures, implementing action plans)
 - Ensuring lessons learnt from these reviews of practice are embedded into practice (e.g. evaluation via auditing, staff surveys)

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Learning from Experience – Reviews of safeguarding practice

Learning opportunities from safeguarding practice arises from a variety of sources. This framework sets out the key practice reviews that SSCB, partner agencies and other local organisations undertake.

Type of Review	Description	Who	Reporting	2015-16 Activity
Serious Case Review (SCR)	Where abuse or neglect is known or suspected and either: 1) a child dies; or 2) a child is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child.	<ul style="list-style-type: none"> Partner agencies Relevant organisations Independent Reviewer SSCB Business Unit 	<ul style="list-style-type: none"> SSCB via the Learning Lessons from SCR and/or a serious case review panel. Publishing of SCR reports 	<ul style="list-style-type: none"> Child ES SCR completed and published Child GS SCR Undertaken
Multi-agency case review	Review of a safeguarding incident which falls below the threshold for a SCR.	<ul style="list-style-type: none"> Partner agencies Relevant organisations Possible Independent Reviewer SSCB Business Unit 	<ul style="list-style-type: none"> SSCB via SCR subcommittee 	<ul style="list-style-type: none"> Child FS Case Review completed and published
Individual management review	Review of a safeguarding incident which falls below the threshold for an SCR and where there are limited concerns about how organisations or professionals worked together to safeguard the child	<ul style="list-style-type: none"> Partner agency 	<ul style="list-style-type: none"> SSCB via SCR subcommittee 	-
Child Death Review	A review of all child deaths up the age of 18	<ul style="list-style-type: none"> Child death Overview Panel (CDOP) 	<ul style="list-style-type: none"> SSCB via CDOP subgroup 	<ul style="list-style-type: none"> 63 child deaths reviewed (2015-16 CDOP annual report under development)
Multi-agency thematic case audits	Audit of practice relating to a specific safeguarding issue (case sample)	<ul style="list-style-type: none"> Partner agencies Relevant organisations SSCB Business Unit 	<ul style="list-style-type: none"> SSCB via QPP subgroup 	<ul style="list-style-type: none"> June 2015 - External audit of the understanding and application of thresholds November 2015 - External Sandwell Early Help Review November 2015 - External CSE Assurance Review
Multi-agency case	Audit of practice relating to a child's	<ul style="list-style-type: none"> Partner agencies 	<ul style="list-style-type: none"> SSCB via QPP 	<ul style="list-style-type: none"> May 2015 - Multiagency

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audits	journey through the system (case sample)	<ul style="list-style-type: none"> • Relevant organisations • SSCB Business Unit 	subgroup	<ul style="list-style-type: none"> • Domestic Abuse Audit • November 2015 - Multiagency audit re Compliance with the Cross Border Protocol • February 2016 – Multiagency LAC Audit
Single agency audits	Audit of practice (case sample)	<ul style="list-style-type: none"> • Partner agency 	<ul style="list-style-type: none"> • SSCB via QPP subgroup 	<ul style="list-style-type: none"> • Process for scrutinising single agency audits established • Limited work undertaken in respect of implementing the process.
s.11 audits	Self-assessment of an organisation’s safeguarding arrangements and practice (Section 11 of the Children Act 2004).	<ul style="list-style-type: none"> • Partner agency 	<ul style="list-style-type: none"> • SSCB via QPP subgroup 	<ul style="list-style-type: none"> • Full Section 11 Audit undertaken across the partnership supplemented with a series of ‘scrutiny panels’ • Report presented at May 2016 SSCB meeting
s.175/157 audits	Self-assessment of a schools safeguarding arrangements and practice (s.175/157 of the Education Act 2002)	<ul style="list-style-type: none"> • Schools 	<ul style="list-style-type: none"> • SSCB via QPP subgroup/ Education Advisory Group 	<ul style="list-style-type: none"> • Full Section 175 Audit undertaken across all Sandwell Schools/ Academies supplemented by a series of ‘Assurance Panels’
National research, SCRs, etc.	Key messages from research, other LSCB’s SCRs.	<ul style="list-style-type: none"> • SCR Subcommittee 	<ul style="list-style-type: none"> • SSCB 	<ul style="list-style-type: none"> • Key messages highlighted in SSCB Newsletters
Analysis of the quantitative data collected	Key analysis of themes affecting safeguarding arrangements and practice	<ul style="list-style-type: none"> • All subgroups 	<ul style="list-style-type: none"> • SSCB via QPP subgroup 	<ul style="list-style-type: none"> • Performance reports and an accompanying dataset routinely provided to SSCB
Analysis of service user feedback	Identifying key themes affecting safeguarding arrangements and practice	<ul style="list-style-type: none"> • All subgroups • Partner agencies • Relevant organisations 	<ul style="list-style-type: none"> • SSCB via QPP subgroup 	<ul style="list-style-type: none"> • Workforce survey undertaken in February 2016 • Board Member Reviews

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undertaken in December 2015/ January 2016

- Board Member 'Walk the Floor' initiative undertaken between January - March 2016

Learning from Experience – Identification of Learning

- Identification of key learning is achieved through the function of the SCR Subcommittee.
- Reviews of practice are commissioned by two of the SSCB subgroups: the SCR Subcommittee and the Quality of Practice and Performance (QPP) subgroups.
- The SCR subcommittee may commission an SCR or a multi-agency case review in order to provide an analysis, lessons from the case and recommendations for any changes in policy or practice.
- The QPP subgroup having a responsibility for scrutiny and quality assurance of safeguarding arrangements and practice across Sandwell and exercises this responsibility by taking an overview of performance, conducting case audits, overseeing the s.11 and s.175/157 self-assessment process and receiving specialist reports
- The Learning & Development subgroup having responsibility to identify opportunities for training, both single and multi-agency and monitors and evaluates quality in delivery.

Improving Services – Embedding learning in practice

In order to improve safeguarding practice learning identified from reviews of practice must be embedded into current practice. This is achieved by:

How	What	Who	Reporting
Dissemination of learning	Multi-agency training programme	<ul style="list-style-type: none"> • Partner agencies • Relevant organisations • Learning & Development Subgroup • SSCB Business Unit 	<ul style="list-style-type: none"> • SSCB via the Learning & Development and QPP Subgroup

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	SSCB multi-agency 'learning lessons' workshops	<ul style="list-style-type: none"> • Partner agencies • Relevant organisations • Learning & Development Subgroup • SSCB Business Unit 	<ul style="list-style-type: none"> • SSCB via the Learning & Developments and QPP Subgroup
	SSCB briefings and communication strategy.	<ul style="list-style-type: none"> • Partner agencies • Relevant organisations • SSCB Business Unit 	<ul style="list-style-type: none"> • SSCB via SSCB Business Unit
	Publication of serious case review final reports	<ul style="list-style-type: none"> • SSCB 	<ul style="list-style-type: none"> • SSCB via SCR Subcommittee
	Single agency training	<ul style="list-style-type: none"> • Partner agencies 	<ul style="list-style-type: none"> • SSCB via the Learning & Development Subgroup
	Single agency briefings and other communication strategies	<ul style="list-style-type: none"> • Partner agencies 	<ul style="list-style-type: none"> • SSCB via QPP subgroup
Actions to improve practice	Single and Multi-agency actions plans from case reviews.	<ul style="list-style-type: none"> • Partner agencies • Relevant organisations • SSCB Business Unit 	<ul style="list-style-type: none"> • SSCB via SCR Subcommittee
	Single and Multi-agency actions plans from case audits.	<ul style="list-style-type: none"> • Partner agencies • Relevant organisations • SSCB Business Unit 	<ul style="list-style-type: none"> • SSCB via QPP subgroup
	Single and Multi-agency actions plans from s.11 audits/ s.175 and s.157 audits	<ul style="list-style-type: none"> • Partner agencies • Relevant organisations • SSCB Business Unit 	<ul style="list-style-type: none"> • SSCB via QPP subgroup
	Actions arising from reporting to SSCB from other subgroups	<ul style="list-style-type: none"> • Partner agencies • Relevant organisations • SSCB Business Unit 	<ul style="list-style-type: none"> • SSCB via SSCB Business Unit

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Improving Services – Evaluation of learning

The aim of the activity outlines in this framework is to make a positive impact on frontline practice and in turn improve outcomes for children and young people in Sandwell. This evaluation process identifies whether or not lessons have been learnt and can identify new issues. This process completes the learning lessons feedback loop outlined in Appendix 1.

What	Who	Reporting
Single and Multi-agency case audits	<ul style="list-style-type: none"> • Partner agencies • Relevant organisations • SSCB Business Unit 	<ul style="list-style-type: none"> • SSCB via QPP Subgroup
Case reviews	<ul style="list-style-type: none"> • Partner agencies • Relevant organisations • SSCB Business Unit 	<ul style="list-style-type: none"> • SSCB via SCR Subcommittee
Reporting on action plans	<ul style="list-style-type: none"> • Partner agencies • Relevant organisations • SSCB Business Unit 	<ul style="list-style-type: none"> • SSCB via SCR Subcommittee
Evaluation of training	<ul style="list-style-type: none"> • Partner agencies • Relevant organisations • SSCB Business Unit 	<ul style="list-style-type: none"> • SSCB via Learning & Development Subgroup

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Appendix 1: SSCB Learning Lessons Feedback Loop

