Redbridge LSCB Local Safeguarding Children Board

London Borough of Redbridge

Independent Chair: John Goldup

REDBRIDGE

LOCAL SAFEGUARDING CHILDREN BOARD

LEARNING AND IMPROVEMENT FRAMEWORK

2nd Edition

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1. Introduction

This Learning and Improvement Framework sets out how Redbridge Local Safeguarding Children's Board (LSCB) meets its responsibilities as set out in *Working Together to Safeguard Children 2015* to create, maintain, review and measure a framework of continuous learning and improvement.

This document is based on the principle that 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.

Redbridge LSCB is committed to continuous improvement in the way it works and in the outcomes for safeguarding practice. This framework outlines the method by which lessons are learned from the different activities of the Board and how they can best be disseminated and embedded in practice. The aim is to meet the challenges of a changing environment and to further improve safeguarding practice across all agencies. The framework is therefore flexible, responsive to changes and makes an integral contribution to the development of the annual business plan.

Redbridge LSCB Sub-Group chairs are members of the Board and the LSCB Executive. They report to the Board and Executive meetings. This helps to ensure that leaning from all aspects of the LSCB's work is brought together and shared in one place. Members of the Board are encouraged to model a commitment to ongoing learning and improvement to their different agencies and this is facilitated via networking events and Board development days during the year.

The Board is also committed to continuing to work with other LSCBs and Boards such as the Redbridge Children Trust Partnership Board, Safeguarding Adults Board, the Health and Wellbeing Board and the Clinical Commissioning Group to share practice and learn from others.

The Framework sets out:

- The statutory duties of the Board and its partner agencies in terms of learning and improvement

- Approaches, methods, and mechanisms used to promote and ensure learning and improvement

2. Statutory Duties of the LSCB:

Working Together to Safeguard Children 2015 sets the framework for the work of the LSCB. There is an underpinning requirement that in all its work the LSCB continues to learn and improve. *Working Together* sets this out as follows:

- *"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. This framework should enable organisations to be clear about their responsibilities, to learn from experience and improve services as a result."

Each local framework should support the work of the LSCB and its partners so that:

- Reviews are conducted regularly, not only on cases which meet statutory criteria of Serious Case Reviews (SCRs), 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. SCRs will be conducted by an independent professional and will invite contributions from children and families.

- 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 for accountability and engagement.

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 LSCBs understand the criteria for determining whether a statutory review is required and always conduct those reviews when necessary.

3. Approaches, methods, and mechanisms used to promote and ensure learning and improvement:

As a 'learning organisation', the LSCB demonstrates a learning culture through its training, scrutiny and challenge functions which contribute to a significant amount of multi and single agency learning.

Learning and improvement are promoted and ensured through:

- Training and Development supported by Redbridge LSCB Training Programme

- The evaluation of training and its impact

- Serious Case Reviews (SCRs) and Independent Management Reviews (IMRs) and learning from SCRs carried out by other LSCBs

- Multi-agency 'Learning Lessons' reviews carried out by the Learning and Improvement sub group on individual cases

- Multi agency and single agency audits

- Section 11 Audits

- Learning from Inspection
- Consideration of cases at the Child Death Overview Panel (CDOP).
- Scrutiny of performance data
- Consultation with young people

Feedback from the various learning activities described above will inform improved policies and procedures, the development of appropriate training programmes, and most importantly, improvements in practice and in outcomes for children. Individual agencies are responsible for integrating learning into their own practice and will be held to account by the LSCB for this. The LSCB is responsible for ensuring that system-wide learning is appropriately integrated into practice.

The work of the Learning and Improvement and Training Sub-Groups:

The LSCB has a multi-agency Learning and Improvement Sub-Group which drives much of this activity. Specifically, the group is responsible for:

(i) Overseeing the development and delivery of the LSCB's multi-agency audit programme, identifying and disseminating learning, and making recommendations on action required to the LSCB Executive and / or individual partner agencies, as appropriate.
(ii) Commissioning and overseeing Learning Reviews on cases of concern (including child protection incidents which fall below the threshold for a Serious Case Review) or cases referred by individual partner agencies from which lessons may be learned about the way organisations are working together to safeguard and promote the welfare of children.
(iii) Identifying and disseminating the learning from such reviews, and making recommendations on action required to the LSCB Executive and / or individual partner agencies, as appropriate.
(iv) Considering case reviews / learning reviews conducted by partner agencies on individual cases and identifying learning for the partnership.
(v) Maintaining an overview of key lessons to be learned from national research and publications, including Serious Case Reviews undertaken by other LSCBs, and, in conjunction with the Training Sub Group, ensuring the effective dissemination of this learning across partner agencies.
(vi) Reviewing all serious incidents notified to Ofsted, in relation to which a Serious Case Review is not to be undertaken, and determining whether a Learning Review should be undertaken.
(vii) Contributing an evaluation of learning and improvement activity and its impact to the LSCB Annual Report

It works closely with the Training Sub Group which is responsible for:

(i) Conducting an annual multi-agency training needs assessment to inform the development of the annual training programme

(ii) Collating and maintaining information identifying all single agency safeguarding training provided by LSCB partners
(iii) Ensuring effective monitoring and evaluation of all safeguarding training provided in the borough, whether by the LSCB or by individual partner agencies, ensuring that training is of a consistently high standard, meets the identified learning outcomes and is linked to the overall training strategy.
(iv) Preparing an annual training programme of LSCB multi-agency training, linked to Business Plan priorities, for approval by the LSCB Executive.
(v) Managing the planning, design, commissioning, publicising and delivery of the multi-agency LSCB Training Programme.
(vi) Developing and implementing effective arrangements for evaluating the impact of training
(vii) In conjunction with the Learning and Improvement sub group, ensuring the effective dissemination of learning from Serious Case Reviews, learning and management reviews, and multi-agency audit work
(viii) Making an annual report to the LSCB outlining training provided and attendance, and evaluating the effectiveness and impact of such training with recommendations for further development
(ix) Contributing to the LSCB Annual Report

Training and Development:

Redbridge LSCB has an annual training programme which is agreed via the Training Sub-Group. The training programme is designed to support the priority areas for improvement identified in the LSCB Business Plan for the year, but it is also flexible enough to respond to issues arising during the year from practice audit, local or national policy developments, emerging concerns etc. The programme is varied and incorporates courses, workshops, conferences, briefings, a LSCB development day and online e-learning. External trainers are commissioned where necessary, but the LSCB is also committed to making full use of expertise and knowledge within the multi-agency, multi-professional Redbridge workforce as a training resource. This is an important way of supporting both organisational and personal development and learning. Train the trainer courses are commissioned and course cascade materials provided in order to facilitate partner agencies and their managers to deliver briefings, workshops and bite- sized training sessions in settings and times that are convenient for their workforce. This method of cascade training supports the dissemination of safeguarding awareness and messages across wider workforce.

As well as the LSCB, a substantial amount of safeguarding training is also provided by individual partner agencies. The LSCB has clarified the different levels of responsibility for training as follows:

1. Employing agencies are responsible for ensuring that all their staff who come into contact with children receive basic and induction safeguarding training (Level 1)
2. The LSCB will provide core training on a multi-agency basis for all staff whose work with children may involve their contributing to assessing, planning, intervening, and reviewing the needs of a child and parenting capacity where there may be safeguarding concerns (Level 2); and specific briefings for staff in this group, which may be on a multi or single agency basis, on identified priority topics.
3. The LSCB may provide specialist multi-agency training (Level 3) commissioned by partner agencies for staff working in specialist child protection roles. This training will be fully funded by those agencies involved.

The 2015/16 training programme is set out in the Redbridge LSCB Multi-Agency Training Programme and Policy, the most recent edition of which was published in September 2015.

The Evaluation of Training and its Impact:

The LSCB, through its Training Sub Group, is responsible for monitoring and evaluating the effectiveness of all training provided to safeguard and promote the welfare of children. This includes, not only multi-agency training provided under the auspices of the LSCB, but also single agency training provided by individual partner agencies.

Traditionally, the evaluation of training has primarily measured customer satisfaction through the feedback and evaluation forms completed by attendees at the conclusion of a training event. However, the LSCB is committed to more rigorous evaluation of the impact of training on quality of practice and improved outcomes for children – what difference has training made? This has been primarily sought through feedback requested from line managers and participants on the difference training ahs made to their practice. This is not however enough. The Training Sub Group will be developing new strategies for evaluating the impact of training. This is likely to involve direct questioning of a sample of participants and their managers three months after attendance on training, to seek direct evidence of how the learning has been taken back into the worker's practice and agency, and of its impact on practice. The LSCB in 2015/16 is creating a new post of Training Co-ordinator to strengthen its evaluation of training and its impact.

Serious Case Reviews (SCRs), Independent Management Reviews (IMRs), Learning from SCRs carried out by other LSCBs and Homicide Reviews:

Redbridge LSCB will carry out any SCR in line with the statutory guidance contained in *Working Together*. Independent Management Reviews are carried out in cases that cause some concern and where there is useful learning but which do not necessarily meet the threshold for a SCR. There is also representation from CDOP on the Learning and Improvement Sub-Group that ensures that cases from CDOP are brought to the attention of the Sub-Group for consideration.

All serious incidents notified to Ofsted are referred to the LSCB Chair for a decision on whether a Serious Case Review should be commissioned. The Chair will ensure that s/he has full information available on which to make a decision. This may involve convening a multi-agency meeting to share information on the case. This meeting may offer advice to the Chair, but the decision on whether or not a SCR should be held is the Chair's alone. The Chair will inform the National Panel of Independent Experts on Serious Case Reviews of all cases considered and his/ her decision, and enter into dialogue with the Panel as necessary.

All SCRs will be carried out in line with the guidelines in *Working Together* to ensure an approach that is proportionate to the case, that is focused on learning, and which uses a methodology customised to the particular requirements of the case. This may include use of the SCIE systems approach.

Learning from SCR locally and nationally is cascaded via briefings and workshops and promoted on the LSCB website. Action plans arising from local cases or ones the LSCB has been involved in are monitored and followed up and implemented across different agencies as appropriate.

Redbridge LSCB and Community Safety Partnership Board have an agreed process for considering whether a domestic homicide review and a serious case review should be conducted separately or jointly as listed below:

The Chair of the CSPB decides when a domestic homicide review is needed. The LSCB chair has the same role for serious case reviews, although for serious case reviews there is now a national panel of independent experts that must be consulted on any serious incidents which are assessed locally as not meeting the serious case review criteria.

When an incident involves the murders of an adult and a child and meets the criteria for both a Domestic Homicide Review and a Serious Case Review, the Chairs of the CSPB and the LSCB will determine the arrangements for co-ordinating the reviews without unnecessary duplication. This may involve establishing a joint panel to oversee both reviews. It may be appropriate to produce a joint review report, with a single set of recommendations and a joint action plan. Alternatively, separate authors may be commissioned to write separate reports, but with maximum co-ordination of agency input in terms of chronologies and analysis of lessons to be learned.

If separate reports are commissioned, the Panel will consider the appropriateness of joint recommendations and action planning. The joint Panel will monitor implementation of the actions plan(s) arising from both reviews, reporting to the six monthly joint meeting of the CSP and the LSCB Executive.

Multi Agency Learning Lessons Reviews:

These are multi-agency reviews carried out by the Learning and Improvement Sub Group of cases where, while not meeting the criteria for a Serious Case review, it appears that there may be lessons learned for the improvement of multi-agency practice and working through an evaluative and collaborative review process. A range of methodologies may be used. The LSCB has agreed a protocol for referral pathways from the different agencies for cases to be considered for a Learning Lessons review. This may include referrals from the Child Death Overview Panel, from the LSCB Chair following a decision not to commission a SCR, or from single or multi-agency audits.

Multi-Agency and Single Agency Audits:

The LSCB has an annual programme of thematic multi-agency audits. Themes considered in 2014/15 or planned for 2015/16 include:

- practice in cases where adolescents have experienced abusive relationships with partners of their own age
- multi-agency practice with children missing from education
- practice and planning with children who had been subject to a child protection plan on the grounds of neglect where the plan had ended and the child had been stepped down to support under a Child in Need plan
- multi-agency identification and protection of children at risk of sexual exploitation
- the outcomes of early help – was early help helpful?
- understanding and application of thresholds

For each audit, a small number of key lines of enquiry are identified, focused on the quality of practice, on multi-agency working, and on the outcomes achieved for children. Practitioners in each involved agency, without previous involvement in the case, audit their own agency's work. The outcomes are then brought together in a workshop, for discussion and challenge, from which an overview report, identifying themes, strengths, and areas for improvement, is produced. Each audit is reported to and discussed at the LSCB. Audit findings are disseminated throughout partner agencies, in order to ensure that the lessons learned feed through to improvements in practice and in outcomes.

In Children's Social Care, there is a regular programme of case audit, undertaken both on an offline basis by Quality Assurance staff and on a peer audit basis by Team Managers. Findings and recommendations are reported to the Senior Management Team and improvement actions agreed. Feedback, both on strengths and areas for improvement, is given to individual workers and managers on cases audited.

Section 11 Audits:

Section 11 (4) of the Children Act 2004 requires every LSCB partner to have arrangements in place to ensure that "their functions are discharged having regard to the need to safeguard and promote the welfare of children". Every partner is required by the LSCB to conduct a self assessment or "Section 11 audit" on a regular basis to ensure compliance with this requirement. In Redbridge the process is about more than compliance. It is expected to be a rigorous and transparent scrutiny, which identifies areas where improvement is needed to ensure best practice in the safeguarding of children, with a clear action plan with timescales within which those improvements will be made. Increasingly, agency self assessments are scrutinised by a "peer challenge" panel, including lay members of the LSCB. The rigour of the process, and the delivery of the action plans, is closely monitored by the LSCB.

Section 11 audits are completed every two years. Audits are completed against the standards set out in the Pan London Section 11 Self-Assessment tool. The standards are:

- Standard 1: Senior management have commitment to the importance of safeguarding and promoting children's welfare;
- Standard 2: There is a clear statement of the agency's responsibility towards children and this is available to all staff;
- Standard 3: There is a clear line of accountability within the organisation for work on safeguarding and promoting welfare;
- Standard 4: Service development takes into account the need to safeguard and promote welfare and is informed, where appropriate, by the views of children and families;
- Standard 5: There is effective training on safeguarding and promoting the welfare of children for all staff working with or, depending on the agency's primary functions, in contact with children and families;
- Standard 6: Safer recruitment procedures including vetting procedures and those for managing allegations are in place;
- Standard 7: There is effective inter-agency working to safeguard and promote the welfare of children;
- Standard 8: There is effective information sharing

An overview report on the audit programme and key areas for improvement identified is considered at the LSCB. Agencies' progress against their individual action plans is monitored, and six months after receiving the overview Section 11 report any outstanding actions for improvement will be reported to the LSCB. Where necessary, the Chair will pursue outstanding improvement actions with senior management in the relevant agency.

Learning from Inspection:

The LSCB receives the report of any inspection carried out with a partner agency, and the action plan drawn up to address its recommendations. Progress against the action is monitored at regular intervals by the Board.

Child Death Overview Panel (CDOP):

Redbridge LSCB carries out Child Death Reviews as set out in *Working Together 2015*. Lessons and trends arising from these reviews are compiled and reported to the main Board.

Campaigns are carried out as appropriate. A major ongoing concern that has triggered both training workshops and a public health awareness drive in Redbridge is the issue of consanguinity, working closely with faith groups and community organisations in the Borough to reduce the number of child deaths and the number of children born with abnormalities and disabilities.

Redbridge CDOP takes part in national research projects and participates in Pan London meetings to share good practice. It produces newsletters, leaflets and other publicity for both professionals and the public to raise awareness of some of the avoidable causes of child deaths. The CDOP Co –ordinator sits on both and the Learning and Improvement and Training Sub-Groups. This facilitates the sharing of learning and the dissemination of information about preventable deaths.

Any recommendations made by the CDOP to individual agencies as a result of its consideration of a case are reported to and tracked by the LSCB through the Chair. The CDOP will refer appropriate cases to the Chair for consideration of a Serious Case Review, or to the Learning and Improvement Sub-Group for consideration of a Learning Lessons Review.

The CDOP produces an Annual Report, summarising learning from its work over the year. The report is brought to the LSCB.

Scrutiny of Performance Data:

The LSCB has agreed a multi-agency dataset for consideration at each Board meeting. The dataset is a 'live' document and continues to develop. To focus challenge and scrutiny, the LSCB Executive identifies for each Board meeting an area for particular scrutiny, and commissions detailed analysis and presentations to be brought to the Board.
As an example, in 2014/15 the Board scrutinised and challenged performance in the following areas:

- Low performance by North East London Foundation Trust in meeting the target for universal post-birth visits within 14 days of birth
- High health visitor caseloads
- Low rate of Section 47 inquiries compared to national and statistical neighbour averages
- Social work capacity and caseloads
- Low police charge rates for sexual offences in Redbridge, compared to London as a whole

Consultation with Young People:

It is a priority for the LSCB to ensure that the voices of children and young people are clearly heard in all its work, and that safeguarding practice takes full account of the views, wishes, feelings and priorities of young people. The LSCB Youth Forum is a group of young people, supported by the LB Redbridge Positive Activities (Youth) Service, who work to raise awareness of safeguarding issues among young people in the borough and to make **sure that young people's voices are heard and acted upon by the LSCB.** The LSCB Chair meets with the Youth Forum at least once a term, and Forums members make an annual presentation to the full LSCB on their work and the issues that concern young people about their safety. The Youth Forum also aims to run three information, engagement and consultation events a year, supported by the LSCB, for and with young people of different ages. Recent themes for these events have included cyber bullying, gangs and knife crime, and child sexual exploitation.

It is an integral part of every multi-agency audit that the views of a group of children and young people are sought on the topic, themes and issues being explored. The responses from young people greatly enrich the audit reporting and recommendations.

4). Document References:

Working together to safeguard children - March 2015, HM Government

London Child Protection Procedures 5th Edition - London Safeguarding Children Board, 2013

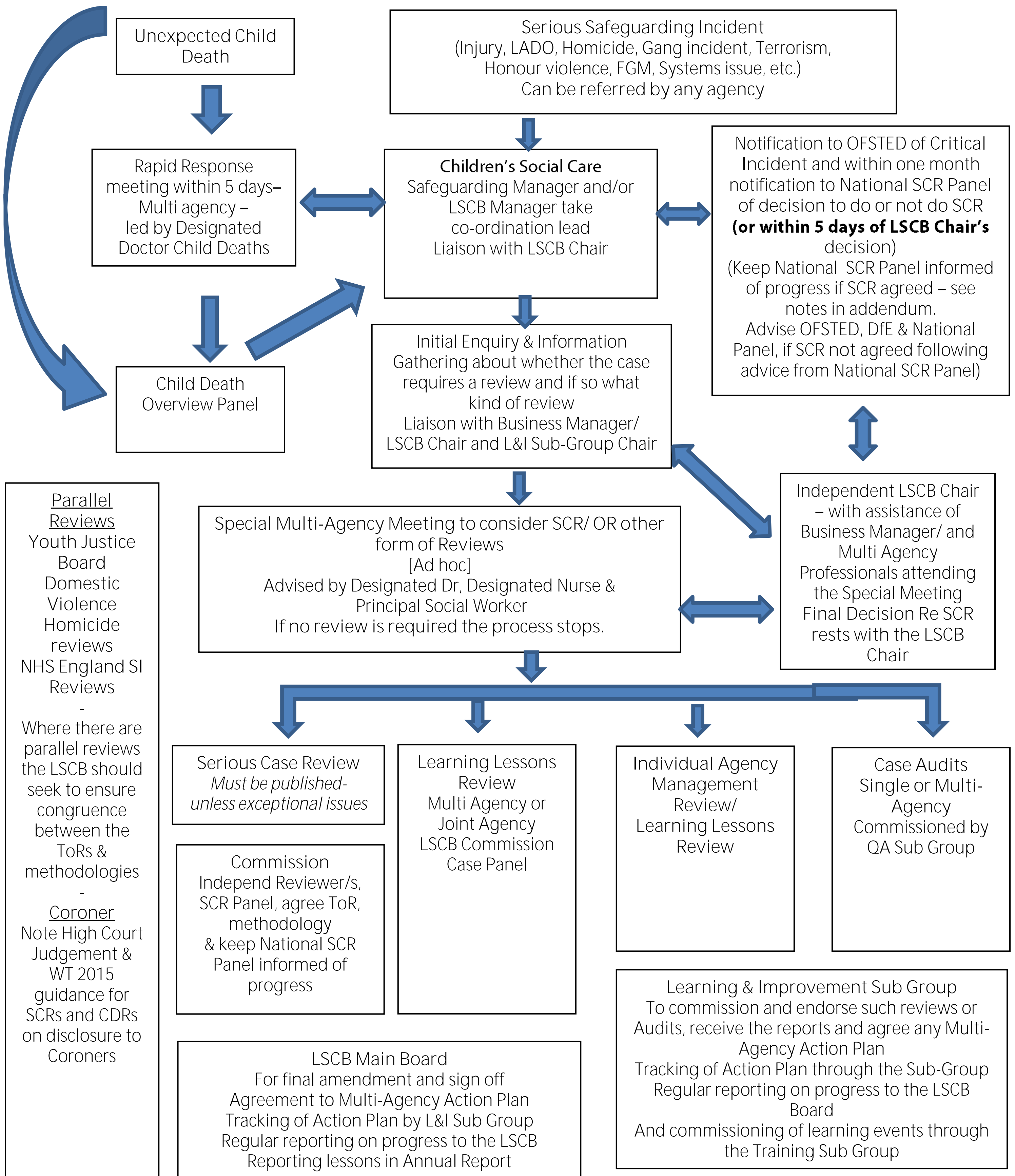
The Munro Review of Child Protection: Final Report
Professor Eileen Munro, May 2011, Department for Education (DfE)

A child-centred system: The Government's response to the Munro review of child protection - July 2011, Department for Education (DfE)

Social Care Institute for Excellence www.scie.org.uk

A study to investigate the barriers to learning from SCRs and identifying ways of overcoming these barriers - July 2014, Department for Education (DfE)

Appendices:



2). National SCR Panel Initiation of Serious Case Reviews

Serious Incident occurs where:
a child has sustained a potentially life-threatening injury through abuse or neglect, serious sexual abuse, or sustained serious and permanent impairment of health or development through abuse or neglect.
OR
a child dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in the child's death

LSCB considers whether and how to proceed with an SCR
If the child has died, the criteria for an SCR will most likely be met.

Questions to consider include:
If the child has not died, are there concerns about how agencies or professionals worked together to protect the child?

- What is the scope of the review and who needs to be involved?
- Are there any criminal proceedings or other reviews of the case which will impact on the SCR?

Once an LSCB has made a decision on whether to/ or not to initiate an SCR, the LSCBs should inform the panel by emailing the secretariat at: Mailbox.SCRPANEL@education.gsi.gov.uk

YES
Initiation - If an LSCB has decided to initiate an SCR, the LSCB should let the panel and Ofsted know of their decision for information. The LSCB will be asked to confirm that the report of the SCR will be published.
Appointing reviewers
LSCBs should also let the panel know:

- name(s) of the reviewer(s) appointed to conduct the SCR and why you have chosen them
- the type of review you will be conducting

This will be for information. The panel has no formal role in vetting reviewers.

NO and WHY

Initiation - If an LSCB has decided not to initiate an SCR, the LSCB should let the panel know their decision, providing a copy of the local authority's Serious Incident Notification and an explanation why the LSCB has decided the case does not meet the SCR criteria.

3). Publication of Serious Case Reviews:

LSCB considers publication of the SCR report.
Questions the LSCB should consider as a minimum are:

- The public interest in seeing the report and understanding the issues raised by the case;
- The importance of ensuring that lessons are learnt and shared widely to improve services to children and families;
- How these public interests can be balanced with those of any children and vulnerable adults involved in the case;
- Whether the style and content of the report make it fit for publication and, if not, how it can be improved;
- Whether there are any legal restrictions on releasing certain information in the report;
- What expert advice is needed e.g. from lawyers or medical or communications professionals; and How best to manage media interest in the case.

Once an LSCB has decided whether or not to publish SCR report, the LSCB should inform the panel by emailing the secretariat at: Mailbox.SCRPANEL@education.gsi.gov.uk
If at any time during the course of the SCR the LSCB comes to a view that publication of the report may not be possible, the LSCB should alert the panel to its concerns.

YES
Publication - If an LSCB has decided to publish an SCR, the LSCB should send a copy to the panel mailbox at least one week before publication.

NO and WHY
Publication - If an LSCB has decided not to publish an SCR report, the LSCB should let the panel know their decision, providing an explanation of how they have considered the questions above.

Panel meetings
The panel now meets every month to review the details of cases submitted. The panel may request a meeting or further information from the LSCB before being in a position to advise about a case. If so the panel will contact the LSCB direct.