Norfolk Safeguarding Children Board

# Norfolk Safeguarding Children Board

# Learning and Improvement Framework

**V 3_Final Draft: March 2016**

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**Disclaimer and Acknowledgement:**

NSCB learning and improvement framework is built on the ethos of learning from good examples and practices. In the process of developing NSCB LIF we have searched far and wide across the country to learn from good examples of other LSCBs. As a result, NSCB LIF has been informed and influenced by many examples of good practices across the country. Our special thanks to North Yorkshire LSCB, Sheffield LSCB, Suffolk LSCB, Plymouth LSCB and Wolverhampton LSCB, as we have been inspired by aspects of these LSCB's LIF.

## Context

As per **Working Together 2015** (Page 72) - Local Safeguarding Children Boards 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 their partners so that

- Reviews are conducted regularly, not only on cases which meet statutory criteria, 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, why it happened, and what action will be taken to learn from the review findings
- Actions result in lasting improvements to services which safeguard and promote the welfare of children and help protect them from harm
- 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.

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.

Working Together (2015) also highlights that LSCBs 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 LSCB partners are fulfilling their statutory obligations set out in Chapter 2 of this guidance
- quality assure practice, including through joint audits of case files involving practitioners and by identifying lessons to be learned
- monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children.

Learning and improvement activities are key to any well performing partnership and its member agencies. The Norfolk Safeguarding Children Board (NSCB) Learning and Improvement framework presents NSCB's approach to learning and monitoring activities and its approach to the evaluation of embedding learning. It aims to use these to assure itself of the quality and effectiveness of the safeguarding provision for children across Norfolk.

# Principles for learning and improvement

Working Together 2015 states the key principles which should be applied by LSCBs and their partners to all reviews

(WT 2015, page 74 section 10-13)

• 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 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. 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

• 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.

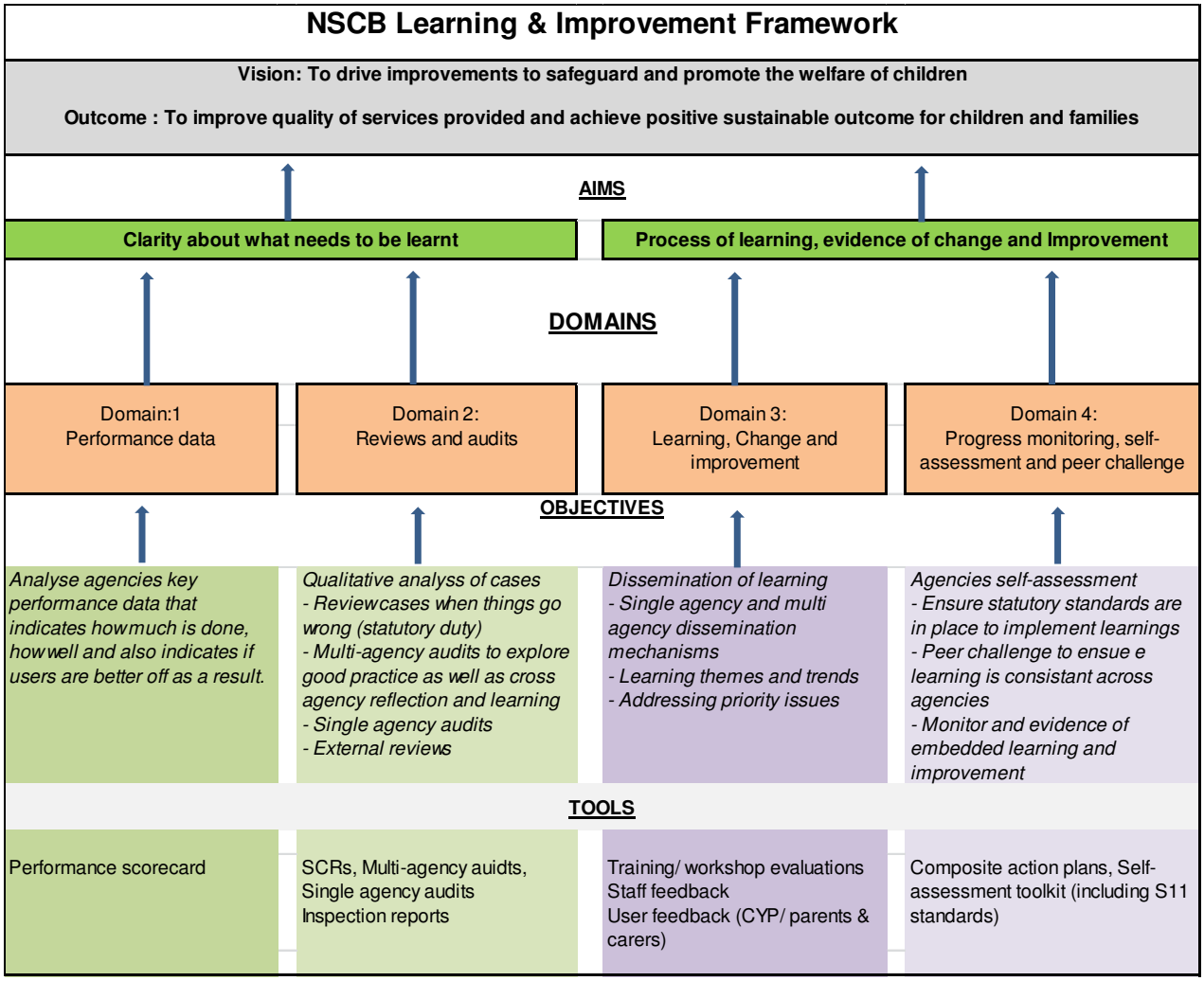
## NSCB Learning and Improvement Framework

The vision of the NSCB Learning and Improvement framework is to drive improvement by encouraging and embedding positive outcomes for children, young people and their families in Norfolk.

The framework has four key domains. The first two aim to clarify what needs to be learnt, based on quantitative and qualitative evidence, and the remaining two to evidence how learning should lead to change and improvement while agencies demonstrate full commitment and opportunities for peer challenge. The four domains are laid out in the rest of this document, which also details how these are intended to be implemented.

Diagram 1 presents the domains with objectives, tools and relative links.

## Diagram 1: The Framework



## Learning and Improvement Cycle

**Reviews:** Learning and Improvement is an on-going and cyclical process, as presented in the learning and improvement cycle. Information is gathered by conducting reviews, including both single and multi-agency audits and analyses of relevant data and trends.

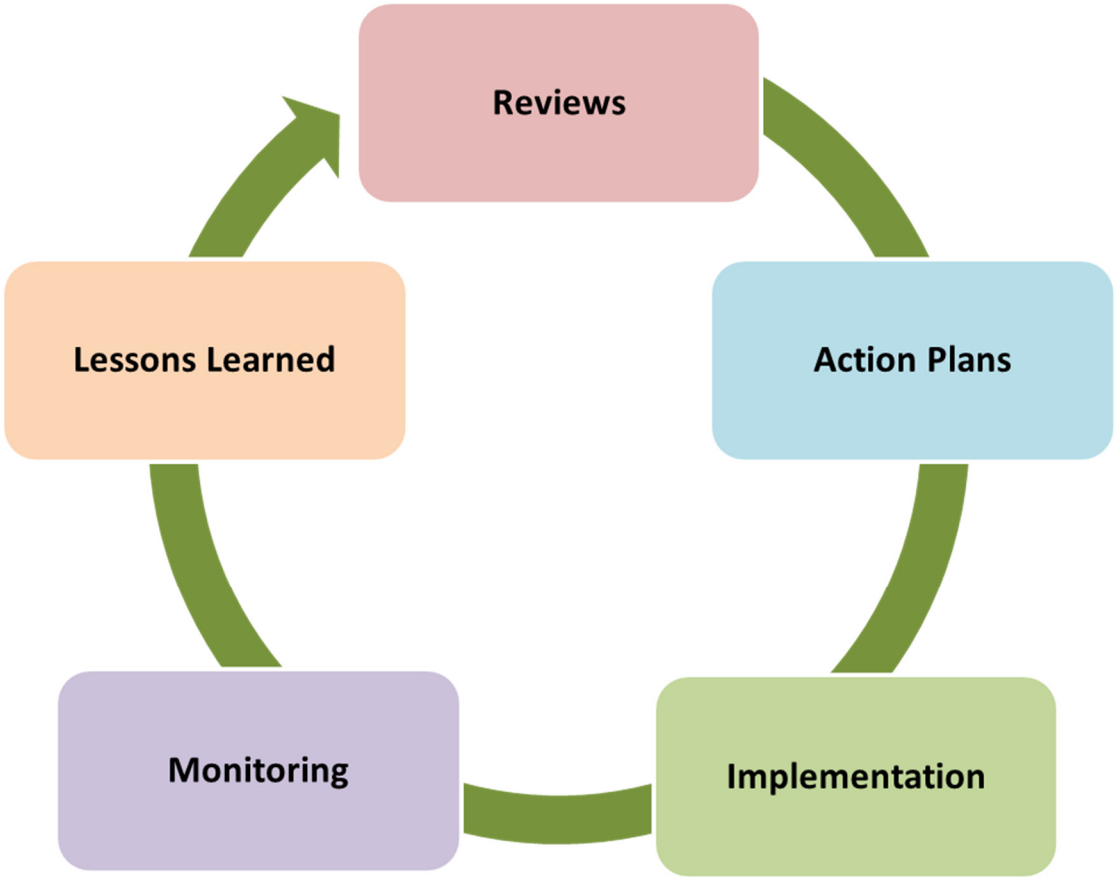
**Action Plans:** Following the review, activity reports are produced along with action plans which are presented to the NSCB Board and to other subgroups (as deemed appropriate) for approval.

**Implementation:** A programme of implementation is produced with clear identification of actions, and organisations responsible for implementation are identified. Actions are disseminated via the workforce development group, local safeguarding children groups and single agencies' own initiatives.

**Monitoring:** Learning, improvement and impact are monitored by the Performance Improvement & Quality Assurance Group (PIQAG), on behalf of the NSCB Board. The monitoring of the actions and progress on recommendations is done using a composite action plan. A composite action plan is a monitoring tool which connects an overall plan with relevant recommendations and the progress status of actions taken by agencies.

**Lessons Learned:** The impact of actions and implementation will be evidenced, once information has been gathered, by conducting further reviews, audits by single and multi-agency organisations, and when relevant data and trends have been analysed.

## Diagram 2: The Learning and Improvement Cycle



# Domain 1: Performance Data

## 1. NSCB Performance Reporting

This NSCB has a performance-reporting mechanism which outlines how the Board and the partners aim to fulfil its key function in relation to performance monitoring.

The board monitors data at three different levels, as below:

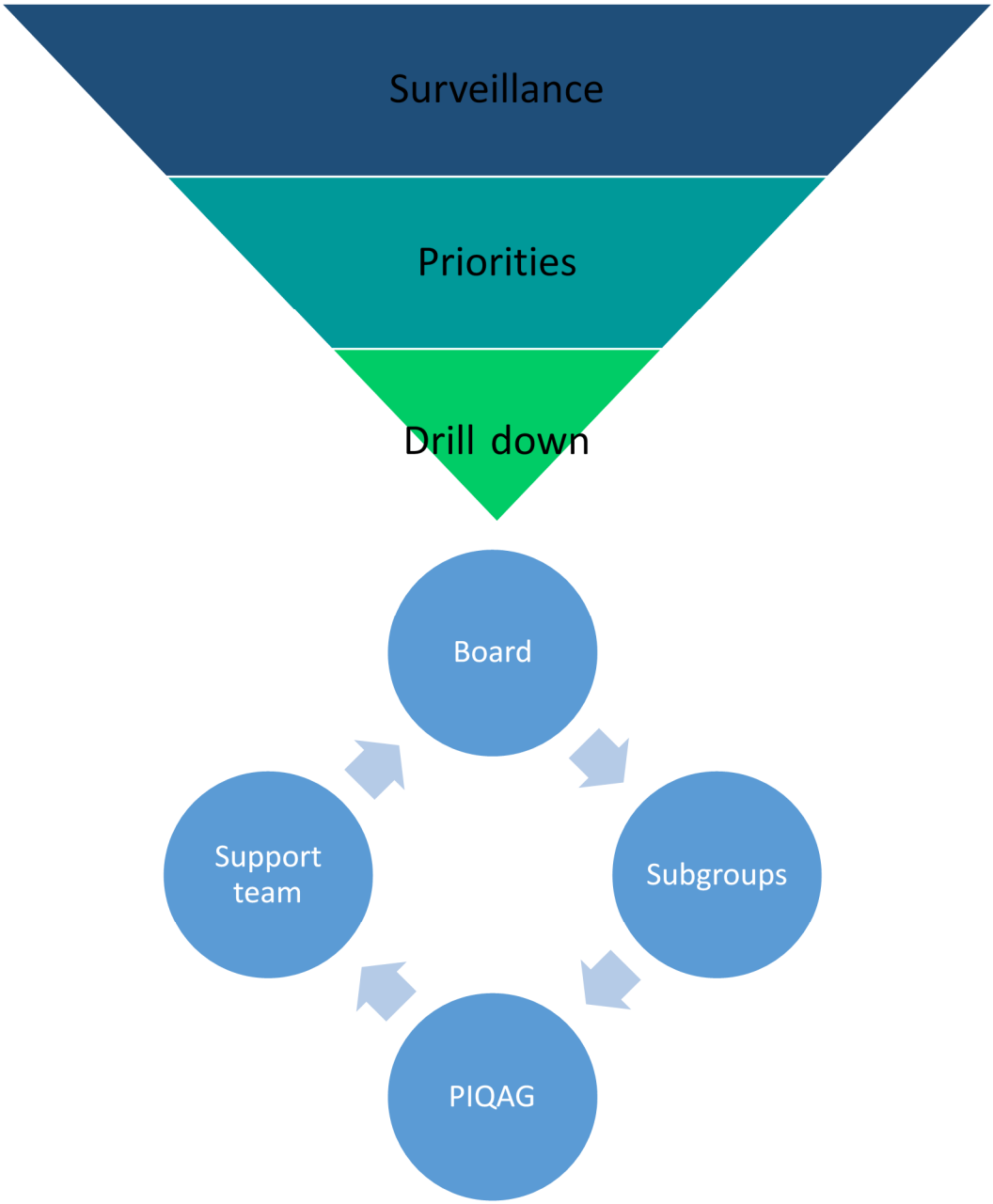
**Surveillance** – this includes a set of performance data providing an overall picture across agencies in Norfolk around children's safeguarding. This is a set of performance indicators that partner agencies agreed to be appropriate for surveillance and reassurance for the Board. The Board maintains a dashboard for its surveillance data.

**Priorities** – this includes a set of performance data which relates to the NSCB's current priorities, e.g. child neglect, child sexual exploitation and child sexual abuse.

**Drilldown** - the NSCB data drilldown reports are initiated by the Board in response to issues raised by the performance data. The reports provide information on the current safeguarding arrangements and raise questions which are directed to the appropriate subgroup for further enquiry, e.g. Local Safeguarding Children Groups and/or sector specific Advisory Groups (Health, Education and District Councils). The subgroups report back to PIQAG for ongoing analysis of actions and services to measure the impact on, and outcomes for, service users. From PIQAG, the NSCB Support team collate the responses to the questions raised and report back to Board, in coordination with the key stakeholders, to complete the cycle of reporting.

The process is constantly under review to improve up-to-date intelligence.

## Diagram 3: NSCB Performance reporting Process



# Domain 2: The reviews and case audits

'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.' (WT 2015, p-72)

To fulfil its statutory functions, NSCB is responsible for:

- carrying out serious case reviews (SCRs) where the criteria are met
- carrying out other reviews of serious incidents where the SCR threshold is not met but lessons remain to be learnt
- carrying out reviews of all child deaths under the age of 18
- evaluating the quality and effectiveness of help being provided to children and families, including early help
- evaluating practice through joint audits to identify good practice as well as to identify priorities that will improve multi-agency working with children and families
- coordinating what is done by each person or body represented on the Board for the purpose of safeguarding and promoting the welfare of children in the area

**This section outlines:**

- **Statutory reviews that are carried out by NSCB**
- **Multi-agency audits either carried out or commissioned by NSCB**
- **Single agency audits – reporting and evaluations**

## 2. Case reviews and audits:

Working Together (2015 p.72) states, the local framework (e.g. the local learning and improvement 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.

LSCBs 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. Such reviews may be conducted either by a single organisation or by a number of organisations working together. LSCBs should follow the principles in the Working Together guidance when conducting these reviews.

### 2.1 Statutory reviews

#### 2.1.1 Serious Case Reviews

These will be undertaken as defined in Working Together 2015:

A Serious Case Review (SCR) will be undertaken where:

- Abuse or neglect of a child is known or suspected
- The child has died, or
- 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

Cases which meet one of these criteria above **must always** trigger an SCR. In addition, an SCR **should always** be carried out when a child dies in custody, in police custody, on remand or following sentencing, in a Young Offender Institution, in a secure training centre or a secure children's home, or where the child was detained under the Mental Health Act 2005. The regulation also includes cases where a child died by suspected suicide and abuse or neglect is known or suspected.

The Serious Case Review Group (SCRG), one of the Board's subgroups, is responsible for commissioning such reviews. The group has published an SCR process and guidance document which gives further details on criteria for SCRs, referrals processes, system methodology and approaches for learning together, including the roles and responsibilities of reviewers, review panels and professionals involved, processes and timelines.

Further details - NSCB Serious Case Review Process & Guidance notes (October 2013).

The full document is available to download from NSCB website:
http://www.nscb.norfolk.gov.uk/Serious%20Case%20Reviews.asp

### 2.1.2 Child Death Reviews

The NSCB is responsible for reviewing every death of a child normally resident in Norfolk. All child deaths are recorded by the NSCB and reviewed by the Norfolk Child Death Overview Panel (CDOP). The CDOP meets monthly to review all child deaths, and to establish classifications of death and consider whether the causes of death had any modifiable features, i.e. were preventable. The CDOP Chair provides an Annual report to the NSCB Board including the panel's recommendations.

## 2.2 Multi-Agency Audits

Multi-Agency Audits are a critical element in learning and improvement to safeguard children. Audit themes and scope are informed by a range of sources which include scrutiny of performance data, and any emerging concerns from one or more partner agencies.

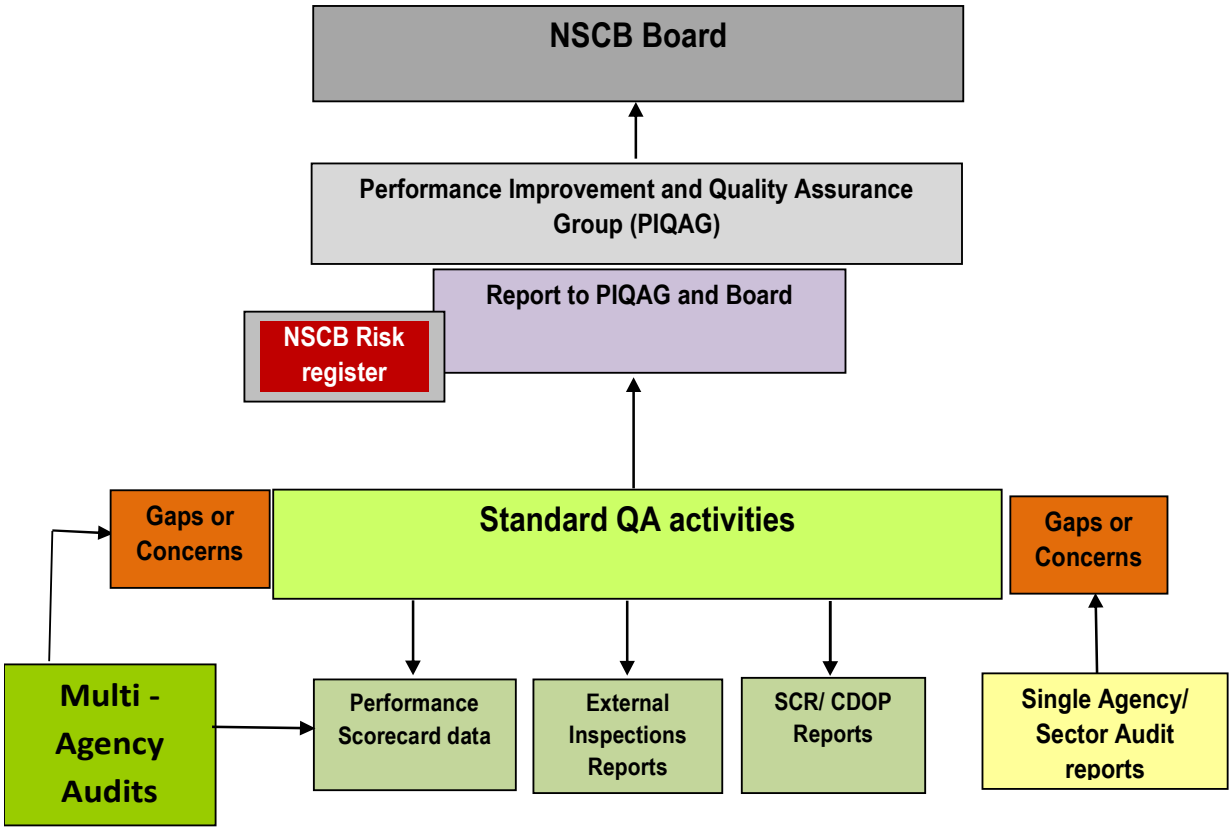
Depending on the nature of the scrutiny, a number of cases are selected by using either random or purposive sampling methods. Case files are checked for consistency and effectiveness in multi-agency practice and impact on children and young people and families. Wherever possible, practitioners and managers are involved in these audits. This offers an opportunity to reflect and to discuss the child's journey through the safeguarding system, in order to identify good practice as well as where lessons need to be learnt.

### 2.2.1 Audit Triggers

Multi-agency audit activities that are carried out by NSCB are based on the NSCB priorities identified by the Board, PIQAG or any other subgroups. Any of the Board subgroups or a single agency may request a multi-agency audit from PIQAG, however, the decision to carry out a multi-agency audit and its overall governance remains with PIQAG.

Information and intelligence gathered by NSCB and /or provided by single agencies should assure the Board about the standard and quality of front line practices. However, depending on what is known to the Board and where the identified gaps and concerns are, NSCB multi-agency audit activities can be commissioned. While audit activities are complementary to single agency intelligence, both performance data and any review activities may trigger a request for further single agency audits as well. The diagram below shows the relationship between multi-agency audits and other activities.

## Diagram 4: NSCB Audit Triggers




## 2.3 Single Agency Audits - Reporting and Evaluation

### 2.3.1 School Self-Assessment Audit

The aim of the school self -audit is to provide evidence that both the governing body and the Head Teacher/Principal are fulfilling their statutory responsibilities under the Education Act 2002 (section 175 and 157) and are modelling good practice in safeguarding and promoting the welfare of children. The school self-audit is designed and intended as a supportive tool to assist schools/colleges in reviewing their current safeguarding policies and practice, identifying areas for improvement and action. It can also be used to support the school/college's Ofsted inspection as evidence of good safeguarding practice.

The school self-audit is coordinated by the Education Safeguarding Advisor and the process is undertaken on a biennial basis. An audit report is presented to Education Advisory Group and PIQAG.

### 2.3.2 Early Years Childcare Settings Self-Audit

The Early Years Childcare settings self-audit is designed to provide evidence that early years childcare providers can demonstrate how they are fulfilling their statutory requirements and duty under section 40 of the Childcare Act 2006, to comply with the welfare requirements of the Early Years Foundations Stage, as well as local codes of practice. The early year's audits are periodically coordinated by the early year's team and reported to PIQAG annually.

### 2.3.3 Children's Services Quality Assurance Audits

The Children's Services Quality Assurance team carries out a range of social care case audits throughout the year and reports to the Children Services Leadership Team (CSLT). To ensure Children's Services social care audit and NSCB's multi-agency audits can effectively inform each other of their activity, the quality assurance manager presents completed audit reports to the PIQAG quarterly with particular focus on multi-agency working.

### 2.3.4 Public Health/ DAAT Audits

Public Health Drug and Alcohol Team carries out a number of contract monitoring and audit activities. These include an annual progress report from contractors regarding achievements on standards of 'safety'. This includes:

- Systems to ensure learning from safety/other incidents
- How child protection guidance is followed in both its own activities and when working with other organisations
- Systems which keep service users, staff and visitors safe

Another safeguarding audit is carried out 6-monthly by the Safeguarding lead within the Matthew Project Under 18 and reported to the Matthew Project Young People's Service Governance Group. There is also an adult substance misuse service and Norfolk Recovery Partnership (NRP) carries out annual care plan audits which are reported to the senior management team within Public Health and (where necessary and/or relevant) escalated to the Norfolk Drug and Alcohol Partnership (N-DAP) Board and/or NSCB. Audits are reported annually.

### 2.3.5. Health Services Quality Assurance Audits

The NHS designated safeguarding team carries out a range of audits throughout the year. The audit outcomes are presented in a health quality assurance dashboard. To ensure health audits and NSCB's multi-agency audits can effectively complement each other, the designated health team members present completed audit reports and dashboard to the PIQAG quarterly.

### 2.2.1 Others

PIQAG may request any other NSCB partner agencies to present their internal audit reports which relate to safeguarding children's practices and outcomes as are required including health, district councils, probation services, police and others.

The NSCB /PIQAG reporting calendar in this document presents the Board's expectation and planned timescale for single agencies audit reports (see page 32).

**NSCB Mandate for Evidence:**

Depending on the evidence and level of concerns NSCB Board may call for evidence from any of its partner agencies at any time. While the reasons for concern are expressed clearly, the Board, via PIQAG, may request any agency to carry out single or joint audits on selected cases/ topics/ issues/ themes. All NSCB partner agencies will be expected to provide evidence and/or an outcome of an audit as and when requested.

# Domain 3: Change and Improvement

Working Together 2015 (p – 73) states, Reviews are not ends in themselves. The purpose of these reviews is to identify improvements which are needed and to consolidate good practice. LSCBs and their partner organisations should translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children.

**This section outlines:**

- **Mechanism and arrangements for dissemination of learning**
- **Methods for learning and evaluation**

## 3. Change and Improvement

It is important that learning and improvement work undertaken is not seen as an end in itself but as a progression work to safeguard children and young people for all agencies. It is expected that all agencies will effectively disseminate and take necessary actions to improve their practice to achieve better outcomes for children and young people.

### 3.1 Dissemination of learning

#### 3.1.1 Learning from SCRs

**Guide for Disseminating and Embedding Learning from Serious Case Reviews**

The following guide sets out the process through which learning from Norfolk and national Serious Case Reviews (SCR) should be disseminated and embedded in practice. It details responsibilities for NSCB partner agencies and practitioners to ensure lessons and good practice identified during the course of the SCR have long lasting effects and lead to practice and service improvement.

**Norfolk Serious Case Reviews**

**1. Review Team Responsibilities**

Following the decision to conduct a Serious Case Review the NSCB will set up a Review Team including an independent lead reviewer to carry out the SCR. For the purposes of this Guide the Review Team have two key responsibilities which focus on the identification and presentation of learning :

- The Review Team will analyse all of the information gathered during the review. This analysis will lead the Review Team to formulate its key findings and issues for the NSCB to consider
- The Review Team with the lead reviewer will produce a report detailing its findings and issues for the Board
- The review team will liaise with front line staff and ensure they are engaged, supported and challenged as appropriate

**2. NSCB Responsibilities**

The NSCB will receive the Review Team's report and examine the findings and issues raised. Consequently, the NSCB will

- Formulate a response to the findings and issues raised into improvement action. This will be done in collaboration with the Serious Case Review Sub Group
- Publish the SCR Review report on the NSCB website and notify partners of its availability
- All relevant findings and NSCB actions will be shared with the Performance Improvement and Quality Assurance Sub Group. The PIQAG will timetable a specific agenda item to consider implementation and progress monitoring activity

This will include as a minimum:

a) Review of NSCB multi-agency and single agency SAFER training programmes and where necessary integration of key SCR learning into course content

b) Awareness-raising road show events, a poster campaign aimed at practitioners promoting key messages from the SCR
c) Where necessary delivering multi-agency practice briefings
d) Enabling single agencies to disseminate learning by publishing power points summarising the key practice episodes and systemic learning from each case alongside the publication of the report in full.

**3. Individual Agency Responsibilities**

Agencies involved in an individual SCR may have specific actions to take. However all agencies, as a minimum, should respond to the publication of a Norfolk SCR in the following way :

- Having received notification from the NSCB that a SCR has been published the Manager/Designated Child Protection Lead should disseminate the report within the organisation
- Agency managers should consider the content of the report, identify implications for their service and implement any action or change required in light of the SCR learning
- Team meetings and individual supervision sessions should include an agenda item on the publication of a Norfolk Serious Case Review. This will give teams the opportunity to discuss learning, practice and suggest areas for service improvement. Individual supervision sessions will give another opportunity for a one-to-one analysis of the SCR and how individuals can adopt the learning into their everyday practice
- Share any NSCB provided materials within their organisation
- Review recommendations and if any concerns are identified in relation to not being able to implement any of the recommendations the Board / SCRG must be informed about what will be done to address the issue.

**4. Practitioner Responsibilities**

Everyday reflective practice is important to help gain an accurate picture of a child's situation. Practitioners should engage in Serious Case Review learning in the following ways :

- Read SCR publications
- Read LSCB Briefings
- Attend single agency and multi-agency training
- Contribute to agency development through team meetings and supervision discussions
- Case conversations with colleagues
- Incorporate findings into assessments as a means of evidence-based practice

**National Serious Case Reviews**

In addition to Norfolk Serious Case Reviews, LSCBs across the country publish their own reviews following the death or serious injury of a child. These national SCRs also serve as important sources of learning, some of which achieve higher prominence through national and widespread media coverage.

### 3.1.2 Learning from other reviews and audits

**Guide for Disseminating and Embedding Learning from other reviews and audits**

The following guide sets out the process through which learning from other reviews and audits should be disseminated and embedded in practice. It details responsibilities for NSCB partner agencies, subgroups and practitioners to ensure lessons are learnt and good practice is identified during the course of the audits and that reviews have lasting effects which lead to practice and service improvement.

**1. Review/ Audit Team Responsibilities**

Following the decision to conduct a multi-agency audit or any other reviews audit team members will be identified to carry out the Audits. The Review Team will have two key responsibilities which focus on the identification and presentation of learning and areas of concern in a fair and neutral way:

- The Review Team will analyse all of the information gathered during the review. This analysis will lead the Review Team to formulating its key findings and issues for the PIQAG to consider
- The Review Team will produce a report detailing its findings and issues

**2. NSCB/ PIQAG Responsibilities**

The PIQAG on behalf of the Board will receive the audit/ review report and examine the findings and issues raised. Consequently:

- NSCB will share all relevant findings and NSCB actions with the Performance Improvement and Quality Assurance Sub Group. The PIQAG will timetable a specific agenda item to consider implementation and progress monitoring activity
- PIQAG will also formulate a composite action plan and notify the respective agencies and/ or NSCB subgroups that are expected to take any improvement actions forward.

**3. Individual Agency Responsibilities**

Individual agencies may have specific actions to take forward. However all agencies, as a minimum, should review the findings and check what they can take from the review to improve practice in their own agencies. This may include

- Manager/Designated Child Protection Leads disseminating the audit/review report within the organisation
- Agency managers considering the content of the report, identifying implications for their service and implementing any action or change required in light of the audit/review
- Team meetings and individual supervision sessions to include an agenda item on the publication of an audit or review report. This will give teams the opportunity to discuss learning, practice and suggest areas for service improvement.
- The sharing of any NSCB-provided materials within their organisation

- Each agency reviewing recommendations and if any concerns exist about not being able to implement any of the recommendations the Board / PIQAG must be informed about what will be done to address the issue.

**4. NSCB Sub-group responsibilities**

- To review NSCB multi-agency and single agency training programmes and where necessary integration of key learning into course content Including examples of good practice
- To monitor progress on relevant recommendations and provide periodic progress updates to the PIQAG

**5. Practitioner Responsibilities**

Everyday reflective practice is critical to help gain an accurate picture of a child's situation. Practitioners should engage in multi-agency audits and reviews in the following ways

- Participate when invited to take part in the audits
- Provide information as requested for the reviews/ audits
- Disseminate findings afterwards within their team and agencies
- Contribute to agency development through team meeting and supervision discussions
- Conduct Case conversations with colleagues
- Incorporate learning into assessments as a means of evidence-based practice

**6. Children and Young People's Strategic Partnership Board's Responsibilities**

- To review NSCB multi-agency audit findings and recommendations
- To take appropriate actions to address any issues raised and implement any relevant recommendations
- To provide periodic progress updates to the NSCB Board/ Leadership Group

# Domain 4: Self-assessment and peer challenge

Working Together 2015 (p.9) states, safeguarding is everyone's responsibility: for services to be effective each professional and organisation should play their full part.

**This section outlines:**

- **NSCB partner agencies' responsibilities to fulfil statutory standards and good practice**
- **Mechanisms for 'challenge' on falling standards and to learn lessons**

# 4. Self-Assessment and Peer Challenge

## 4.1 Single agency self-assessment

Working Together to Safeguard Children (2015) requires LSCBs to gather data to assess whether *partners are fulfilling their statutory obligations*, this includes compliance with Children Act 2004 Section 11 standards.

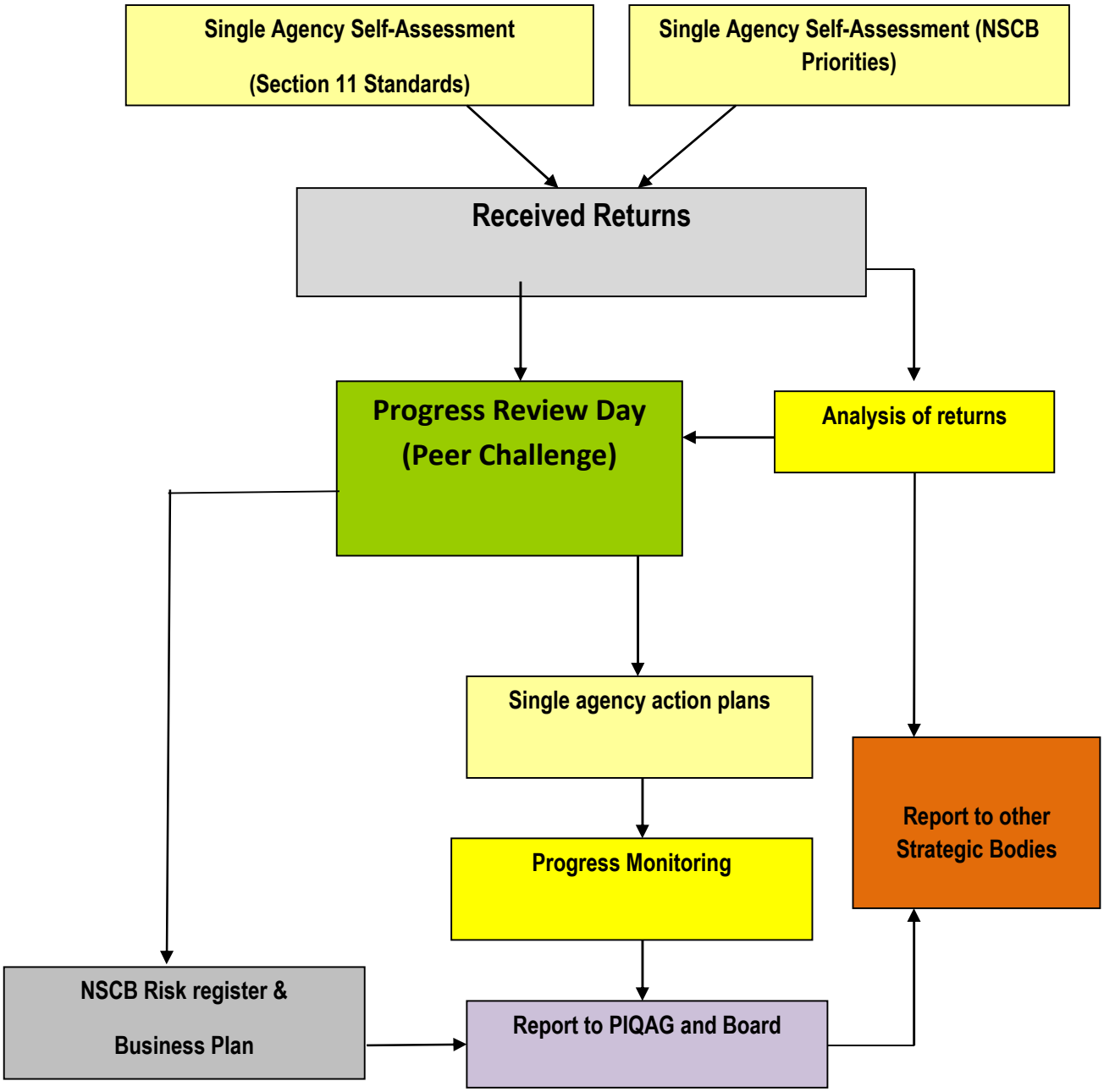
The NSCB single agency self-assessment tool focuses on not only the S11 standards but also a wider range of issues and concerns that may come to light as a result of internal or external scrutiny or inspection. The self-assessment tool is revised every year to incorporate new areas for scrutiny and agreed by PIQAG. The process seeks to ensure the S11 standards are complied with, and show evidence of single agencies having taken on board lessons and issues identified by any of the reviews and audits.

The self-assessment tool aims to simplify the process for NSCB statutory partners, while strengthening the ability of the Board to assess the adequacy of safeguarding arrangements locally. These include:

- Ensuring that contracting/ commissioning arrangements with third parties are incorporated as a key area for assessment
- Learning from case reviews (serious case review or multi-agency reviews) and ensuring they have been incorporated into the self-assessment toolkit.
- Ensuring that the scope of the self-assessment is clearly focused and concentrates on those areas of work which are deemed essential for safeguarding children.
- Ensuring areas for improvement are identified by external inspection e.g. HMIC, CQC, OFSTED

## Diagram 5: The Self-Assessment Process

**NSCB Partner Agency Self - Assessment and Monitoring Process Diagram**



## 4.2 Progress Review & Peer challenge day

NSCB has also introduced a peer 'challenge day' from 2014 where partners are invited to come together, present and question each other's standards and any shortfall (if needed). This is not only provides a unique opportunity for learning from each other but also hold each other to account. The process is further monitored, where actions are agreed, for the respective agencies to implement as a result of the self-assessment and peer challenge.

## 4.3 What does 'good' look like across NSCB partnership?

Success criteria of the NSCB partnership can only be measured if the improved quality is sustained and results in positive outcomes for children and young people. Each agency and partner working together will identify and determine what 'good' looks like for their service and what standards are in place to define these. However, quality can only be measured if there is a 'desired picture' for each service which can be compared against performance data. Measures of quality should result in **sustained improvement**.

Some examples below show what 'good' may look like in terms of outcomes/Impact across NSCB partner agencies:

| Examples of outcome statements | Examples of Impact measures |
|---|---|
| **Children's Services**<br><br>• Child protection plans result in objective, tangible, and sustainable improvements in the wellbeing and safety of children and their families<br>• Parents feel empowered and more confident as a result of the involvement of the service<br>• Young people are reporting that they feel safe to walk the streets of the estate<br>• 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<br>• Young people are reporting that as a result of the intervention their mental health has improved and consequently their risk-taking behaviors have decreased. | • Episodes of re-referral decreasing<br>• Incidents of assault on the location have decreased<br>• The number of children reported as 'missing' has decreased<br>• Young people feel safe at home, school and in the community |
| **Police**<br><br>• Families are reporting that Police attending domestic violence incidents treat them with respect, involve the children and provide clear information | • The number of Domestic Violence/ Domestic Abuse incidents reported to the police has decreased |

| | |
|---|---|
| • Staff feel more confident in dealing with domestic incidents<br>• Staff feel more confident in dealing with sexual exploitation/sexual abuse incidents | • Referrals to social care arising from Domestic Violence incidents have decreased |
| **Health**<br><br>• Learning from serious incidence reviews/ never events reviews (commonly used by health services) involving children and young people being embedded<br>• Antenatal midwifery services are effective in identifying potentially vulnerable mothers thereby reducing their concerns<br>• Parents report that they are treated empathetically by staff | • The number of serious incidence decrease-<br>• The number of complaints from Parents decrease |
| **Safeguarding Training (All agencies)**<br><br>• Staff who have received safeguarding training report that they feel more confident in dealing with particular family interventions.<br>• Professionals in the service are operating at a required level of safeguarding children practice competence | • The numbers of people attending courses increases<br>• Delegates consistently evaluating training quality to be good and standards excellent<br>• Training impact assessments finding evidence of improvement practice |

## 4.4 Methods of Learning

The following table sets out the various methods of learning employed by NSCB.

| Where (Source of Learning) | What (Learning) | How (Methods) | Who (Stakeholders) | Outcome for Improvement |
|---|---|---|---|---|
| Serious Case Reviews and subsequent briefing and learning events | We will use these processes to identify:<br>• Multi-Agency Lessons<br>• Single-Agency Lessons<br>• Risk assessment Information | • SCR Challenge Events<br>• SCR professional days<br>• Audit and Quality Assurance<br>• Participant feedback from family/carers<br>• Progress on recommendations | • NSCB Board and all member agencies<br>• SCRG<br>• WDG<br>• PIQAG | • Evidence of timely completion of action plans Evidence of improved practice via audits |
| Child Death Reviews (CDOP) | We will use this process to identify:<br>• Themes and Trends<br>• Modifiable Factors | • CDOP analysis of child death<br>• Annual overview report | • NSCB and CDOP<br>• CDOP chair | • Evidence of identified trends/ themes incorporated into Board's plan |
| S11 Audit and agency self-assessment | We will use this process to identify:<br>• Compliance with S11 and statutory provision<br>• Progress and improvement on identified areas for improvement | • Individual Agency Self-Assessment<br>• Peer challenge day<br>• Assessment and Evidence Provided<br>• External inspections (CQC, OFSTED, HMIC | • NSCB Board and all member agencies<br>• PIQAG | • Evidence of progress on action plan |
| Guidance and Policy | We will use these processes to identify:<br>• Government priorities | • Single and Multi-Agency audits which evidence | • NSCB Board and all member agencies | • Evidence of up to date NSCB policies |

| Where (Source of Learning) | What (Learning) | How (Methods) | Who (Stakeholders) | Outcome for Improvement |
|---|---|---|---|---|
| | • Practice guidance<br>• National perspectives<br>• Local policies | compliance with policy and procedure | | • Evidence of consistency in practice across NSCB partnership |
| Single agency audits | We will use these processes to identify:<br>• Quality of practice<br>• Trends<br>• Quantitative data | • Review of audit findings reported to NSCB | • NSCB Board and all member agencies<br>• PIQAG | • Evidence of quality and effectiveness of single agency practice |
| Multi-agency practice audit | We will use these processes to identify:<br>• Organisational performance trends<br>• Quality of practice<br>• Theme specific deep-dive<br>• Outcome for children and families | • Bespoke tools and techniques<br>• Review of progress against action plans | • NSCB Board and members agencies<br>• PIQAG<br>• LSCGs | • Evidence of quality and effectiveness of multi-agency working<br>• Identify and act upon areas where practice needs to be strengthened |
| Safeguarding Performance data | We will use these processes to identify:<br>• Quantitative data<br>• Trends analysis<br>• Emerging issues | • NSCB scorecard/ Dashboard with analysis | • NSCB Board and member agencies<br>• PIQAG<br>• LSCGs | • Evidence of overall picture of risks across partnership<br>• Evidence of improvement from trend analysis |

| Where (Source of Learning) | What (Learning) | How (Methods) | Who (Stakeholders) | Outcome for Improvement |
|---|---|---|---|---|
| Users Feedback | We will use these processes to identify:<br>• Greater understanding of service user experience<br>• Service Improvements<br>• Key themes for improving quality and service user experience | • Children and young people shadow Board<br>• Parent/Carer Engagement Group<br>• Bespoke evaluation tools | • NSCB Board and partner agencies<br>• Service Users, including children, young people and their families | • Evidence of quality and effectiveness of services from users experience |
| Workforce feedback | We will use these processes to identify:<br>• Greater understanding of workforce experience<br>• Service Improvements<br>• Key themes for improving quality and workforce experience | • Bespoke evaluation tools<br>• Discussion at LSCGs | • NSCB Board and partner agencies<br>• WDG<br>• PIQAG<br>• LSCGs | • Evidence of experience of the workforce delivering services across partner agencies |
| Local Authority Designated Officer's (LADO) reports | We will use this to identify:<br>• Safe recruitment process and practice<br>• Whistleblowing policy | • LADO reports to PIQAG | • NSCB Partner agencies | • Evidence of issues and concerns and appropriate actions to address issues |
| Children and young people strategic partnership | We will use this to identify:<br>• Operation risks to coordinating safeguarding arrangements | • Reporting arrangements defined through a Memorandum of Understanding( MoU) between Children and | • NSCB chair and CYPSP chair (DCS) | • Effective link between operational and strategic priorities |

| Where (Source of Learning) | What (Learning) | How (Methods) | Who (Stakeholders) | Outcome for Improvement |
|---|---|---|---|---|
| | • Specific issues related to vulnerable young people | Young People's Strategic Partnership Board (CYPSP) and NSCB | | |
| Risk Register | We will use this to:<br>• Monitor significance of each of the areas risks and resilience factors<br>• Monitor changes | • Regular monitoring by Leadership Group | • NSCB partners<br>• LG | • Effective risk and resilience management by NSCB Board |

## NSCB/ PIQAG Reporting Calendar

| January | February | March |
|---|---|---|
| NSCB themed Audit<br>Early years Audit<br>LADO report | | Section 11 audit<br>NSCB themed audit |
| **April** | **May** | **June** |
| LADO report<br>Training Impact assessment | NSCB themed audits<br>Public Health/ DAAT report<br>YOT Report/ Audit | |
| **July** | **August** | **September** |
| LADO report | NSCB Themed audit<br>Private Fostering Report | Schools - S 157 audit<br>CDOP report |
| **October** | **November** | **December** |
| NSCB Themed audit<br>LADO report<br>Health – single agency audit | Public Health/ DAAT report<br>YOT Report | |

**(Note: this calendar is updated on a regular basis)**

## 4.5 Training Evaluation

LSCBs should 'Monitor and evaluate the effectiveness of training, including multi-agency training to safeguard and promote the welfare of children' (Working Together, 2015)

The NSCB goes beyond this minimum requirement by not only monitoring and evaluating training provided by partner agencies, but by developing and delivering a substantial programme of training and learning events that

- Ensure a comprehensive programme of high quality multi-agency training that is linked to and shaped by local priorities, learning from Reviews, Thematic Audits and the NSCB Business Plan
- Ensure that training meets the needs of a wide range of professionals
- Actively and effectively promotes the availability of training and adopts measures to increase its accessibility, including employing a range of delivery methods e.g. whole day courses, seminars and workshops, best practice events, conferences and e-Learning
- Offer an extensive and responsive programme of short seminars and other learning events that are able to respond efficiently to training needs or to disseminate learning from reviews, audits etc.

In addition, the NSCB seeks to assess the impact of training, over a period, in order to measure changes in practice resulting from attending training. The focus of each of the training impact assessment and the methodology for the assessment is discussed and agreed at the workforce development group. Training evaluation and assessments are overseen by the workforce development group and reported to PIQAG and to the Board.