

Norfolk Safeguarding Children Board: Lead Reviewer Brief on Learning from Serious Case Reviews & Key themes and 'Practice Standards'

Background and context

Norfolk has commissioned a number of SCRs under the statutory guidance set out in [Working Together](#) 2013 and 2015. It is crucial that the Board makes sense of the learning so we can plan, action and evidence improvement within a clear structure.

The SCR process includes regular review and analysis of the recommendations from the reports. Over the years, we have pulled together a Thematic Learning Framework, to enable us to think about the recurring issues and barriers to effective working together. This has moved us from a position where we are looking at over 100 individual and sometimes repetitive recommendations to a point where we can think about SMART actions to move us forward on a continuous journey of learning and improvement.

This framework has been presented to the NSCB's SCR subgroup and Norfolk's Public Protection Forum (PPF). Through PPF, the Thematic Learning Framework has been adopted by the Adult Safeguarding Board and the Countywide Community Safety Partnership in their work on safeguarding adult reviews and Domestic Homicide Reviews.

Thematic Learning Framework

Learning from Serious Case Reviews: Emerging Themes



At the heart of all learning is the child or young person, understanding their experience and what they expect from the adults in their lives: does this align with the Norfolk vision, i.e. that all children are loved, valued and respected, happy, healthy and safe and have high aspirations for their future. The central focus is that all learning is child centred and we need to be anchored to the premise that we are working to get the best outcomes for children: remembering what it is like to be a child in Norfolk and asking ourselves what can and should they expect from the adults in their lives who should be keeping them safe.

The thematic learning framework, focuses on four key learning areas:

1. **Professional curiosity** – how can the Board encourage and support appropriate curiosity with families, and between professionals?
2. **Information Sharing and Fora for discussion** – how can the Board ensure that we use opportunities for discussion effectively, include all relevant parties, act promptly and clearly; and share information well?
3. **Collaborative Working, Decision making and Planning** – how can the Board improve timely and collaborative planning and get strong and shared decisions?
4. **Leadership: Ownership, Accountability and Management Grip** – how does the Board give effective leadership and champion better safeguarding, locating clear accountability?

Sitting underneath everything we do is the recognition that safeguarding requires people at all levels to manage risk and uncertainty.

While this framework attempts to distil the recurring challenges around effective safeguarding, we recognise that the themes will cross over and interlink, for example effective communication and information sharing is intrinsic to collaborative working and the ability to be professionally curious and reflective is dependent on management support and organisational culture.

More specifically, under each of the four quadrants we have started developing headline outcomes that we need to work towards to assure ourselves that Norfolk safeguarding arrangements are co-ordinated and effective. We propose to use this framework to review our approach to practice standards, with reference to our Threshold Guide and multi-agency commitment to working within the Signs of Safety framework. The detail of these headline outcomes is included at Appendix 1.

KEY THEMES:

Analysis of the recommendations show additional themes linked to specific and recurring safeguarding issues and/or areas of practice.

Recurring safeguarding issues:

- Domestic Abuse
- Challenge and Escalation (use of the Professional Disagreements Policy)
- Engaging fathers
- Neglect

Recurring areas of practice

- Information-sharing
- Returning children home
- Disseminating learning from SCRs
- Quality of engagement with children and young people
- Quality of referrals to CSC and feedback mechanisms
- Early Help practice
- Practitioner confidence re Child Sexual Abuse
- Core standards for supervision
- Use of historical information in assessments

Learning in Practice

The NSCB Monitoring & Evaluation Officer works with members of the SCRG to:

- Gather evidence that any agency specific recommendation has been implemented and if not, what establish any barriers to improvement
- Shape the high level actions that will help Norfolk to achieve SMART outcomes against each quadrant of learning, including identifying owners

The NSCB Business Manager ensures that at the point of commission all Lead Reviewers are aware of this framework and can contribute to supporting its development by:

- Acknowledging any current work being undertaken to improve practice
- Ensuring that future recommendations are SMART and can be mapped within the framework as appropriate
- Alerting the Board to any case/child specific learning and/or the need to review the framework as learning from SCRs emerge

The NSCB Chair also chairs the PPF and is working with Chairs of other partnership boards, including Adults, DASVB (responsible for DHRs) and MAPPA to ensure that our combined learning is managed strategically.

More specifically, all partners need to consider the learning from SCRs and how that is fed into the domestic abuse change programme: domestic abuse-related themes have

emerged from a number of different Serious Case Reviews in Norfolk with specific recommendations on this theme featuring in five separate cases. The key points emerging from child SCR in Norfolk have ranged from the overarching need to ensure professionals recognise and respond to concerns in relation to domestic abuse, to more specific recommendations regarding information-sharing between the Police and other agencies, use of specific risk assessment tools and the importance of professionals offering to speak to women alone where domestic abuse issues are suspected. Further development areas identified include better understanding across agencies of the role of IDVAs and the MARAC process.

SCR Publication & Media Management

Previously, we have published an action plan and summary powerpoint alongside the report as part of a comprehensive publication plan, including press statements from the NSCB Chair. With the revised approach to learning, the NSCB has agreed that the benefit of having a more coherent approach to learning outweighs the risks of not addressing each individual recommendation. Therefore, our approach to publication is to:

- Continue to ensure that the press statement recognises the harm caused to each individual child involved in the SCR
- Refine the summary learning powerpoints and link the messages back to the thematic learning framework and address any case specific recommendations

The NSCB Business Manager will continue to liaise with media partners prior to any SCR publication and the Chair will keep key partners, including NCC's Managing Director, advised of all publication plans.

Dissemination of Learning

SCRG has also suggested that we consider ways to promote the thematic learning, both as a coherent framework as well as focusing on specific areas of concern. The NSCB Business Unit organises SCR roadshows across the county whenever an SCR is published to take the learning directly to the frontline and middle management. Local SCR are also shared with all training providers through its workforce development subgroup.

Single agencies are also responsible for disseminating the learning to their staff and this is tested through the Section 11 self assessment process.

Appendix 1:

Practice Standards: Outcomes & Evidence Expected

1. PROFESSIONAL CURIOSITY AND PRACTICE

- 1.1 Practice is child centred and recognises the children and young people we work with as unique individuals
- 1.2 Multi-agency assessments are analytical, of a high quality, and make full use of all the child/family's history
- 1.3 Parents and carers, including less visible parents, are fully involved with safeguarding and child protection processes, and issues of PR and consent are routinely explored
- 1.4 The workforce is highly skilled and trained to recognise, address and challenge disguised compliance
- 1.5 Practice takes account of the impact of different types of abuse, both emotional and physical, and addresses the needs of the child

2. INFORMATION-SHARING AND FORA FOR DISCUSSION

- 2.1 Engagement with children and young people is effective and professionals build positive relationships with children and young people, helping them to feel safe
- 2.2 Norfolk has effective systems in place to track concerns within agencies, records include all relevant information and all relevant information is shared between agencies, with a particular focus on Domestic Abuse
- 2.3 Appropriate professionals are engaged in decision-making within the Multi-Agency Safeguarding Hub and other multi-agency discussions, in particular health partners
- 2.4 Information recorded in assessments and agency records is high quality and shared with children, family and the multi-agency partnership in a timely manner
- 2.5 Practitioners from all agencies understand the difference between consultations and referrals, and feel confident in making referrals to the MASH. Feedback on referrals is provided in a timely way

3. COLLABORATIVE WORKING AND DECISION-MAKING

- 3.1 Professionals are confident to challenge one another and be challenged within the multi-agency arena in order to achieve the best outcomes for the child
- 3.2 Norfolk applies consistent thresholds and there is a clear rationale in each case for why decisions have been made, leading to appropriate and timely referrals for intervention

- 3.3 Significant case decisions in respect of safeguarding are made jointly across agencies and supported by multi-agency planning to best meet the needs of the child
- 3.4 Norfolk's Early Help offer is well established and includes robust mechanisms for proactive review and challenge to ensure cases do not drift

4. OWNERSHIP AND ACCOUNTABILITY: POLICY, PROCEDURE AND GUIDANCE

- 4.1 All agencies understand and follow national guidance in relation to information sharing when working with children and families
- 4.2 Practice standards for Early Help are in place and QA systems are used routinely to ensure the quality of the FSP process
- 4.3 Staff supervision is of a high quality and provided to all frontline staff working with children and families
- 4.4 Practitioners and managers are able to confidently exercise sound professional judgement in order to safeguard vulnerable children and young people
- 4.5 Policies and procedures are in place to support all staff in achieving positive outcomes for children, specifically in relation to Domestic Abuse and Neglect

Ownership and accountability: commissioning and gaps

- 5.1 Practitioners and managers have access to specialist advice and services when working with complex cases (including CSA)

Ownership and accountability: NSCB monitoring and scrutiny

- 6.1 All agencies are aware of, promote and follow NSCB policies, with a specific focus on Professional Disagreements, Disclosure Protocol and Working with Reluctant and Hostile families
- 6.2 Practitioners are confident when working with cases where neglect, sexual abuse and/or domestic abuse are present, including at the Early Help stage
- 6.3 Robust processes and arrangements are in place to ensure that the actions from SCRs are completed and that learning is shared and embedded across the children's workforce