Bedford Borough
Safeguarding Children Board

Learning and Improvement Framework 2017 - 2019

1. Introduction

Working Together to Safeguard Children (2015) reinforces the duty of Local Safeguarding Children Boards (LSCBs) and provides a guide to inter-agency working to safeguard and promote the welfare of children. Chapter 4 outlines the responsibility to have in place a clear framework to monitor the effectiveness of local services, and to maintain a local learning and improvement framework that is shared across organisations who work with children in the area.

"*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*"

This updated framework is the mechanism by which the BBSCB will address these statutory requirements to ensure these responsibilities are met and that we actively contribute to sustainable improvements in practice. It also describes elements of the quality assurance process of practice.

BBSCB Commitment to Learning and Improvement

BBSCB is committed to a culture of continuous learning and improvement and through this framework will ensure that:

- reviews are conducted regularly, and not only on cases which meet statutory criteria, considering what has happened but also why, and taking action to learn from findings;
- we make effective use of the richness of the qualitative and quantitative intelligence that is already within the local area;
- a proportionate approach to performance management and quality assurance is maintained which assures us that early help and safeguarding is effective, but makes the most of opportunities for a whole area approach of analysis of particular themes and issues (such as Neglect);
- challenge is provided to front line practice in all agencies in the local area as well as leadership, governance and guidance, which is evidence based;
- actions will be monitored and ensure they result in lasting improvements to safeguarding and early help services.
- there is transparency and accountability to the public as well as the professional world.

Whilst some aspects of this framework build on existing practice, we want to improve transfer of learning and it's impact. In developing this framework, there is an opportunity to consider further how we learn and find out how we can ensure that learning from evidence and reviews can be most effectively embedded in practice. In essence, we are committed to knowing:

- Are we doing the right things?
- Are we making a difference?

2. Our learning and improvement principles

- The child and their family at the centre of the process.
- There is a culture of continuous learning and improvement
- Partners are effective at challenging each other and holding each other to account
- We are honest and transparent in our appraisal of practice
- We fully involve practitioners/managers in case reviews
- Case reviews should be proportionate
- Improvements must be monitored and reviewed so findings make a real impact
- Local partnerships are clear about where services and practice needs improvement and how resulting action plans will lead to sustainable improvements
- We will learn from experience, both good and problematic
- Learning must contribute to improved services and outcomes for children and young people.

The framework operates as a "feedback loop" and is explicit in describing how learning and areas for practice improvement are:

- **IDENTIFIED**
- **DISSEMINATED**
- **EMBEDDED**; and
- **EVALUATED** for direct **IMPACT** on outcomes for children and young people.

The framework will be reviewed biannually or when new legislation and key drivers come into being. We will consider what changes are emerging in the next 12-18 months to ensure the framework reflects those aspects that BBSCB should be driving and the local area is prepared for changes through the BBSCB. Our processes supporting the framework will be based on robust evidence, lessons learnt and key messages and we will share findings of reviews and our analysis of performance, and assessment of the effectiveness of safeguarding and early help with professionals both in Bedford Borough and across Bedfordshire and other LSCBs where appropriate.

BBSCB will ensure that children and young people's voices are heard by:

- Direct engagement by the BBSCB Independent Chair
- Children in Care and Youth Parliament feedback
- Complaints & Compliments
- Advocacy & Independent Visiting
- IRO feedback
- Targeted engagement and consultation with children, families and communities
- Lay member feedback.

3. Roles and Responsibilities

The responsibility of all agencies that make up the Board and Board members is to:

- Ensure provision of good quality information across the elements of the framework from their organisation in a timely manner;
- Ensure sufficient time is given prior to each meeting and during meetings to consider any reports or information presented;
- Participate in meeting discussions in a manner which provides appropriate challenge and support without blame;
- Ensure they feedback to relevant people and gain support within their own organisation;
- Undertake any actions agreed.

3.1 Other BBSCB sub groups

Sub groups of the Board cannot work in isolation and there will be some areas of shared work or focus. Having agreed methods of communication and understanding will ensure evidence is shared and triangulated, and groups are able to contribute to the annual plan effectively. These are essential elements of a learning and improvement framework. For example, training data from the workforce group may be considered alongside audits and performance analysis to determine whether training has made a difference and vice versa.

3.2 Information and Quality Assurance Officers

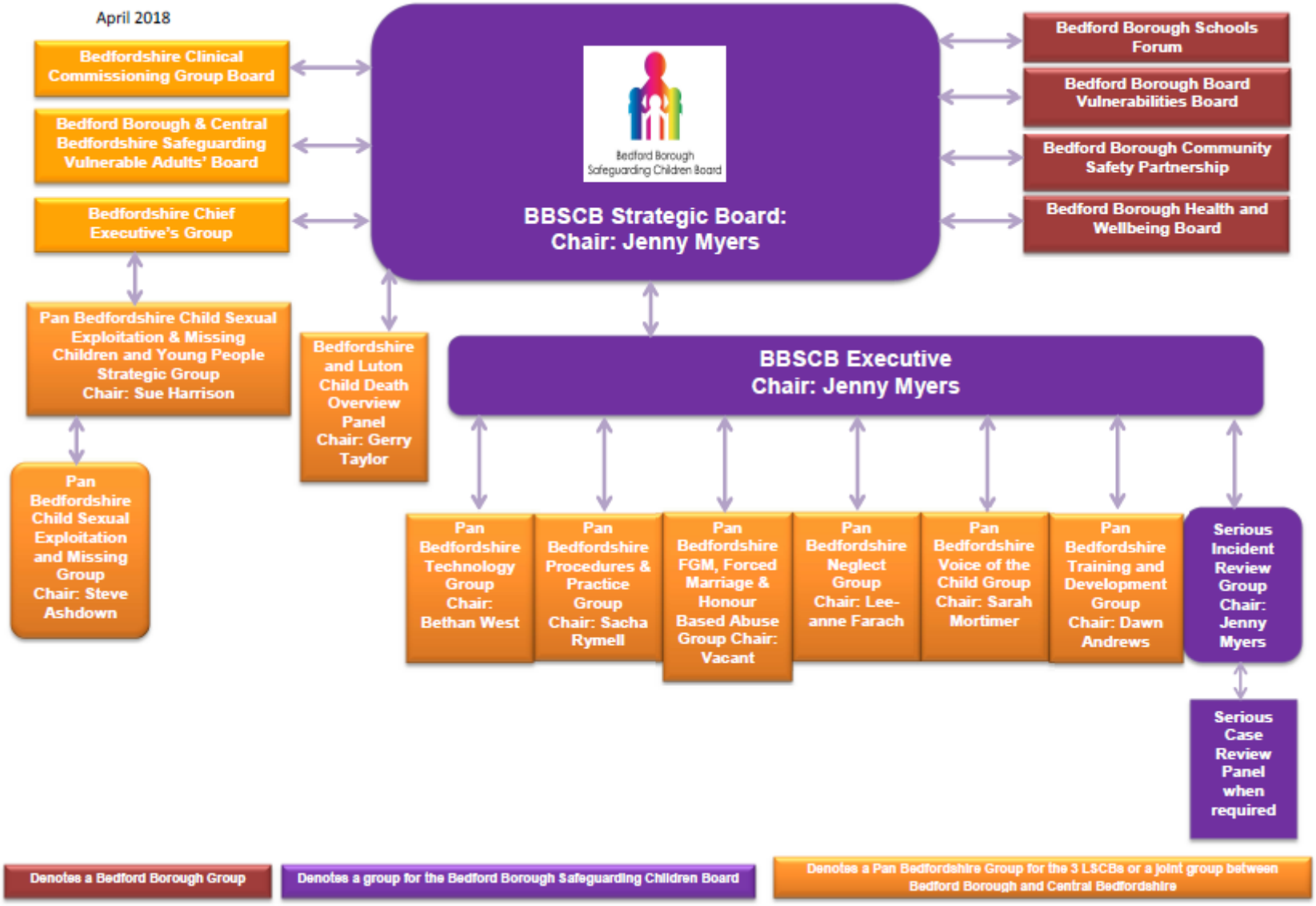
Staff within partner agencies will provide timely robust information (qualitative or quantitative) together with operational supporting commentary as agreed, ensuring the Board is aware of any changes to performance indicators or reporting in their agency which may affect information required by the Board, and to offer suggested alternative intelligence which may better support the needs of the Board in undertaking their role in assessing effectiveness of early help and safeguarding.

3.3 BBSCB Independent Chair

The Independent Chair will ensure that the Learning and Improvement Framework is working effectively, and any non-compliance is investigated so that support or challenge can be provided as needed. BBSCB will ensure that the framework is monitored and quality assured through the Executive Group of the Board. This group will commission a number of task and finish groups or work streams. When necessary the Serious Incident Review Group (SIRG) will establish a Serious Case Review Panel.

Whilst the responsibilities of different parts of the Board and its partners are outlined below, it is expected that everyone will contribute to provision, analysis of a full range of evidence to demonstrate that practice is informed, modified and sustainably improved by data, feedback, research and intelligence about the quality of services and the experiences of children, young people and families who use them.

In addition to BBSCB's responsibility for children and young people in Bedford Borough, we will ensure cost effectiveness and collaborative working with neighbouring areas and Safeguarding Children Boards on common topics with shared task and finish groups or work as appropriate, these can be seen in the BBSCB structure below.


April 2018
Bedfordshire Clinical Commissioning Group Board
Bedford Borough & Central Bedfordshire Safeguarding Vulnerable Adults' Board
Bedfordshire Chief Executive's Group
Bedford Borough Safeguarding Children Board
BBSCB Strategic Board: Chair: Jenny Myers
Bedford Borough Schools Forum
Bedford Borough Board Vulnerabilities Board
Bedford Borough Community Safety Partnership
Bedford Borough Health and Wellbeing Board
Pan Bedfordshire Child Sexual Exploitation & Missing Children and Young People Strategic Group Chair: Sue Harrison
Bedfordshire and Luton Child Death Overview Panel Chair: Gerry Taylor
BBSCB Executive Chair: Jenny Myers
Pan Bedfordshire Child Sexual Exploitation and Missing Group Chair: Steve Ashdown
Pan Bedfordshire Technology Group Chair: Bethan West
Pan Bedfordshire Procedures & Practice Group Chair: Sacha Rymell
Pan Bedfordshire FGM, Forced Marriage & Honour Based Abuse Group Chair: Vacant
Pan Bedfordshire Neglect Group Chair: Lee-anne Farach
Pan Bedfordshire Voice of the Child Group Chair: Sarah Mortimer
Pan Bedfordshire Training and Development Group Chair: Dawn Andrews
Serious Incident Review Group Chair: Jenny Myers
Serious Case Review Panel when required
Denotes a Bedford Borough Group
Denotes a group for the Bedford Borough Safeguarding Children Board
Denotes a Pan Bedfordshire Group for the 3 LSCBs or a joint group between Bedford Borough and Central Bedfordshire

The

Learning and Improvement Framework

Reviews, audits, data and feedback are undertaken to learn from past events and practice and identify any weaknesses in the safeguarding system. The BBSCB will use this learning to improve practice and services for vulnerable children, young people and their families. All reviews consolidate learning about what is working well and what presents challenges to organisations (both child and adult-facing) within Bedford Borough. Central to all review processes will be an unswerving focus on trying to understand events from a child and young person's perspective. The elements of the framework are interconnected, providing the evidence that will help us to fulfill our responsibilities:

Case Reviews	Serious Case Reviews
	Child death reviews
	Multi agency practice/partnership reviews (including reviews of child protection incidents which fall below threshold for SCR)
	Domestic Homicide Reviews
Audits and Data	Section 11 audits
	Section 175/157 Audits
	Single agency audit & performance data
	Multi-agency audits
	Performance information to the Board
	Themed reports
Feedback	Feedback from children, families and communities
	Feedback from the frontline practitioners
	Feedback from workforce development

4.1 Case Reviews

BBSCB will ensure 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 and that this learning is actively shared with relevant agencies. Our review process will look at what happened in a case, and why, and what action will be taken to learn from the review findings; We will ensure that 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.
BBSCB will use a formal panel process for Serious Case Reviews and decide on other types of case reviews, practitioner forums or audits through the Serious Incident Review Group. The Board itself may direct a review based on the outcome of reporting or emerging information. For cases that are considered for Serious Case Reviews, the final decision if a case meets the Serious Case Review criteria will rest with the BBSCB Independent Chair.

For decision making on other forms of review, the decision will sit with the BBSCB Independent Chair using existing reporting mechanisms to inform the Board. It is the responsibility of all chairs and the membership of their groups to ensure that the review does not duplicate other processes and adheres to the principles outlined previously in this document. Whilst the type of review conducted may differ, all will be conducted in a fair, impartial, thorough, and transparent way, and be undertaken in line with guidance provided in Working Together 2015.

4.2 Audits

Activities like auditing should not be seen as once off events but as part of a continuous cycle of planning, acting, doing and reviewing or from the learning perspective, identifying, capturing, sharing and using the new or refined knowledge. All elements of BBSCB activity, including auditing should inform and be informed by all information sources and elements.

Multi-agency audits should be solution-focused and conducted in a spirit of open learning with the intention of further improving outcomes for children. Action points from audit will be rooted in practice, so any changes arising are more likely to be owned and complied with by practitioners. Using audit as a cycle of improvement and not as a way of allocating blame will also have a beneficial effect on everyday interactions between practitioners from different agencies and will encourage challenge on 'live cases' to take place in an open minded way.

The auditing process provides one of the best learning opportunities for both workers and organisations. Auditing will assess and measure the quality of professional practice and test:

- Whether the child/young person's voice has been heard through intervention.
- Whether multi-agency practice is making a difference for children, young people and their families – captured in large part by involving them in the audit process.
- Whether or not what is happening ought to be happening
- Whether current practice meets required standards, procedures and published guidelines
- Whether current evidence about good practice is being applied.

A record of audits undertaken and their effectiveness will be kept centrally by the BBSCB Business Manager to ensure quantity of audits, areas covered, results and learning from audits is monitored and reported to the Board, and they are revisited to establish if improvement made. This will include regular single agency audits and multi-agency audits carried out by the BBSCB and may include information on the theme of the audit, participating agencies, where the information is shared, resulting recommendations and evidence of changes to practice arising out of the audits.

4.3 Data

The BBSCB will oversee an agreed dataset that monitors key points in the "journey of the child" and enables the BBSCB to provide appropriate support and challenge to partners for their performance, on both an individual and multi-agency perspective. The Performance & Audit Group will review the multi-agency dataset alongside qualitative and quantitative information as part of a rolling cycle of quality assurance, performance management learning and improvement.

We will gather and utilise a range of data to assist in measuring quantity and quality:

- Effort: inputs including workforce and resource information (including training, skills), service/support availability; outputs such as how much did we do and how well did we do it.
- Effect/Outcomes: is anyone better off and 'what difference have we made?'

The multi-agency performance dataset will be presented to the Strategic Board and Executive Group at each meeting accompanied by a highlight report. At the Strategic Board 3 specific performance data will be highlighted for discussion.

5. Success Criteria – what does good look like?

'Good' may look different depending on where the organisation or service's current performance is, and whilst there may be minimum acceptable standards, setting targets or success criteria will largely depend on:

- minimum national/legislative standards and requirements
- historic performance and trends
- performance of similar/other organisations or services (benchmarking)
- forecasting or 'horizon scanning' what is likely to happen in the organisation or local area that may affect future performance (e.g. changes in resources, economy, population, legislation).

BBSCB will strive, when assessing performance and setting improvement targets, to take into account national and local factors such as Ofsted inspection judgments, examples of good practice, and learning from high-performing LSCBs and individual agencies. Reviews of individual cases, or an audit on a number of cases, can also be selected on the basis of good practice, to help identify learning, disseminate the learning and embed into practice the characteristics that lead to good outcomes for children and their families.

6. Disseminating and Embedding Learning

Disseminating and embedding good practice, what works well and learning from when things go wrong is an important part of supporting a culture of continuous learning and improvement. Integral to the success of this framework will be the sharing of learning across organisations to ensure transparency, accountability and consistent improvement to practice.

Senior leaders across all organisations will be expected to drive a culture whereby learning is effectively disseminated and embedded into the day-to-day practice of front-line staff. The delivery of key learning messages will be undertaken by the BBSCB via the following processes;

- BBSCB Training Programme
- Single Agency Training
- BBSCB and single agency Briefings and Campaigns
- Communication Strategy, e.g BBSCB Webpages and Twitter

- Publication of SCRs and Case Reviews
- BBSCB Annual Report

7. Evaluating Learning & Evidencing Impact

The aim of the activity outlined in this framework is to make a positive impact on frontline practice and in turn improve outcomes for children and young people in Bedford Borough. Our most frequent question will be "*what difference have we made to children and young people's safety and wellbeing as a result of identifying learning, disseminating lessons and embedding those lessons in day to day practice."*

There will be a variety of mechanisms by which we will achieve this, using new and existing approaches, however the most important evaluation will be the targeted tracking of individual children and young people and being clear about the difference that any learning would have made to the child and young person if applied at the time of intervention.

8. How do we obtain children, young people, families and community experience?

8.1 Direct Engagement by the BBSCB Independent Chair

The Independent Chair of the BBSCB will on a bi-annual basis meet a number of children, young people and their families to directly speak with them about their experiences of the multi-agency safeguarding system across Bedford Borough. These scheduled visits will include children and young people who live in families where identified risk factors are the same as those identified in the BBSCB Business Plan. The Independent Chair will also engage with ad-hoc engagement with children, families and communities during the course of the Independent Chair's tenure.

8.2 IRO Feedback

The Independent Reviewing Officers (IRO) provides independent scrutiny of cases and plays a role in identifying practice themes emerging from the cases that they review. The IRO provides intelligence and learning themes in respect of responses to individual children and families, issues pertinent to single agencies and learning in respect of how the partnership work together to improve outcomes for children subject to child protection planning and child in care processes.

8.3 Children in Care and Youth Parliament Feedback

The members of the Children in Care Council and Youth Parliament are supported and encouraged to provide feedback on existing service delivery and views about future directions directly to the Head of Service for Safeguarding and Quality Assurance. The BBSCB will ensure that the Independent Chair attend at least one council meeting each year and may, through the Bedford Borough Council Head of Service for Safeguarding and Quality Assurance and Engagement and Development Strategic Manager approach the groups for specific pieces of work regarding safeguarding children and young people.

8.4 Complaints / Compliments
Feedback from children and families along with information obtained from complaints investigations provide an insight into how well the safeguarding system is working. Relevant lessons established through the statutory complaints process overseen by Bedford Borough Council will be shared with the BBSCB for analysis and identification of learning for the system. Direct complaints made to the BBSCB and monitoring of the Escalation Procedures will provide further intelligence in respect of related safeguarding issues/themes/lessons.

8.5 Advocacy / Independent Visiting
Bedford Borough Children's Services commissions an independent advocacy service, NYAS, to work with our children and young people to ensure they are able to communicate their wishes as thoroughly as possible to professionals. Bedford Borough Children's Services will provide an Annual report to the BBSCB detailing the key messages coming from children and young people with regards to their safeguarding needs.

8.6 Targeted engagement and consultation with children, families and the community
The BBSCB will remain on the front-foot with regards to seeking the experiences of children, families and the community. Targeted face to face engagement by the Independent Chair and by BBSCB representatives will be facilitated where the BBSCB identifies specific issues / groups of children / families / communities with whom it needs to engage. This might arise based on identified learning that requires further exploration with children, families and communities themselves. Targeted engagement may also take the form of specific surveys. The BBSCB will seek to utilise the expertise of the voluntary and community sector, via Bedfordshire CVS, when initiating work in this regard.

8.7 Lay member feedback
The two Lay members will, through the BBSCB Business Plan, ensure that there is opportunity for them to feedback on the work they do with children, young people and their families and share their views about their experiences of safeguarding responses across Bedford Borough. Lay members will be involved in specific BBSCB projects and will provide a transparent and independent/non-professional account of their opinions about children's experiences.

9. How do we review practice?
9.1 Serious Case Reviews
Serious Case reviews (SCRs) are a statutory requirement and key source of learning in helping to understand what happened and why when things go wrong for a child or young person. It is a multi-agency review of a case and looks at how professionals and organisations worked together with the child or young person at the centre of the review.

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the functions of LSCBs. This includes the requirement for LSCBs to undertake reviews of serious cases in specified circumstances. Regulation 5(1)(e) and (2) set out an LSCB's function in relation to serious case reviews, namely:

5(1)(e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

(2) For the purposes of paragraph (1) (e) a serious case is one where:
(a) abuse or neglect of a child is known or suspected; and
(b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

In addition, even if one of the criteria is not met, 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. The same applies where a child dies who was detained under the Mental Health Act 1983 or where a child aged 16 or 17 was the subject of a deprivation of liberty order under the Mental Capacity Act 2005.

The final decision if a case meets the SCR criteria will rest with the LSCB's Independent Chair.

Preparation - All agencies represented on the BBSCB have a duty to cooperate and participate in a Serious Case Review. Any professional can ask the BBSCB to consider a SCR, although there will be three usual sources of referral:

- Cases identified by the Chief Officer Children's Services, Bedford Borough Council, via the child protection planning processes;
- Cases identified by the rapid response or Child Death Overview Panel process when a child or young person dies unexpectedly;
- Cases identified by partner agencies or via another Local Authority or LSCB.

The BBSCB SIRG will come to a view about whether a case meets the criteria for a SCR, and make a recommendation to the Independent Chair of BBSCB. The BBSCB Independent Chair may seek peer challenge from another LSCB Chair or the National SCR Panel when considering their decision. Once a decision to conduct a SCR has been taken by the Chair, a SCR Panel will be formed, chaired by an independent person, and including relevant senior managers from each agency who will oversee the process. The BBSCB will inform Ofsted and the national panel of their decision relating to an incident considered by the SIRG.

Process - The SCR Panel agrees the scope and key issues of the review, drawing up clear terms of reference, including the time frame. The BBSCB will appoint at least one Independent Reviewer who is independent from the BBSCB and the organisations involved in the case.

Each agency who were involved with the child, young person and family will be required to be engaged in identifying the appropriate actions to make improvements for reviewing the case. This may involve identifying an Individual Management Review (IMR) author, who will produce a chronology of events, a summary and analysis of involvement, decision making, and adherence to policy and procedures. The IMR reports should also identify good practice, lessons to be learned, and recommendations for action.

However, the SCR Panel may also decide that the most informative method of reviewing the case may not be through the use of IMRs, but could involve an approach such as the SCIE methodology or one that includes direct contributions from front line practitioners who were

involved with the child and their family, as well as members of the family if appropriate. The BBSCB has used such approaches that are described in this Framework in the section “Partnership Reviews”.

The Independent Overview Author is commissioned to collate the information from the IMR reports, as well as from meetings with front line practitioners, and family members, into a final report, together with an action plan that addresses the recommendations. This report is published in a suitably anonymised manner in order to protect the identity of the children, and other relevant family members.

Learning - The purpose of under-taking a SCR is to learn lessons for improving both individual agency and inter-agency working, so that it is imperative that lessons are learned and acted upon. The findings are not only important for the professionals involved locally in cases, but the learning from an individual case can also enhance national learning.

The BBSCB makes arrangements to provide feedback of the key findings and debriefing to staff who have been closely involved in the SCR. Information is also communicated about the examples of good practice, as well as where changes need to be made. It is important to integrate the learning from individual reviews alongside other reviews that have been undertaken, both nationally and locally. Learning from the reviews is incorporated into the BBSCB Training Programme. Learning from the SCRs is taken to regular Briefing Sessions that members of the SIRG carry out on an on-going basis for all front line staff and their managers.

9.2 Multi-Agency Case Reviews

Management reviews are reviews of all cases falling below the Serious Case Review threshold. Cases can involve incidents where a child has been harmed and there are concerns about multi-agency practice, or involve incidents where multi-agency practice is considered to be good (after a child has been harmed or where a child has been prevented from being harmed) and agencies seek to identify the characteristics and enablers of that good multi-agency practice. Where the BBSCB considers the criteria for a Multi-Agency Case Review is met the BBSCB will decide the most appropriate methodology for conducting the review – either independent review or multi-agency audit process.

9.3 Single Agency Case Reviews

Individual agencies will on occasions be required to undertake their own internal reviews of practice involving near misses and/or serious incidents that did not involve other agencies. In the interests of joint learning and transparency, the BBSCB will expect any relevant lessons arising from single agency reviews to be considered under the Learning and Improvement Framework.

9.4 Child Death Reviews

The Local Safeguarding Children Board (LSCB) functions in relation to child deaths are set out in Regulation 6 of the Local Safeguarding Children Boards Regulations 2006, made under section 14(2) of the Children Act 2004. The LSCB is responsible for:

a) collecting and analysing information about each death with a view to identifying -
   (i) any case giving rise to the need for a review mentioned in regulation 5(1)(e);

(ii) any matters of concern affecting the safety and welfare of children in the area of the authority;
(iii) any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area; and
(b) putting in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

The Child Death Overview Panel (CDOP) conducts a comprehensive review of the circumstances surrounding a child's death. Qualitative and quantitative data is collected including all single agency reporting, critical incident reports, serious incident reports and the Coroner's inquisition. The CDOP Manager reports to the BBSCB on a six monthly basis on the learning from CDOP which is then disseminated to the respective BBSCB member organisations for onward dissemination to staff. The CDOP also produces an annual report identifying themes, trends and learning for the BBSCB which is presented to the Strategic Board.

9.5 Domestic Homicide Reviews

When there has been a death of an individual of 16 years or over which has, or appears to have, resulted from violence, abuse or neglect by a person to whom s/he was related to, had been in an intimate personal relationship or was a member of the same household then a Domestic Homicide or Serious Incident review will be undertaken (if the deceased person was 16 – 18 years then a Serious Case Review will be undertaken, with the Domestic Violence fully considered). The BBSCB is involved in all reviews where there are children living in the house and the findings and recommendations are considered by the BBSCB.

9.6 Reviews by the Bedford Borough & Central Bedfordshire Safeguarding Adults Board

Relevant opportunities to establish joint learning across both the BBSCB and the BBCBSAB will be established through SCR, Case Review and DHR processes

10. How do we audit?

10.1 Multi-Agency Thematic Case Audits

Multi-agency case audits provide a valuable means to inform the BBSCB of the effectiveness of frontline practice in protecting children and young people and how well the lessons of previous Serious Case Reviews have been learnt, as well as the impact of training. The BBSCB have developed a forward plan of themed audits that will run throughout the year. Themed audit days are scheduled and will involve a multi-agency audit team auditing a number of cases following a set structure. The selection of themes for audit are guided by the knowledge arising from the identified learning as part of this framework; including local professional knowledge and feedback from children, families and communities that identifies possible practice issues. Frontline practitioners and managers will be involved via focus groups. Parents and young people will be involved wherever possible. The days will focus on the child's lived experience, the quality and impact of practice and will involve 'appreciative elements', to highlight what worked well in cases as well as areas for action. Lessons for dissemination will be identified via the Executive Group and reported to the Strategic Board.

10.2 Single-Agency Audits

The multi-agency case audit work is complimentary to single agency case auditing that should occur in most organisations as part of their assurance of their duties under section 11 of the Children Act 2004. Agencies should present the findings from these case audits, with particular emphasis on the lessons for the effectiveness of multi-agency working, to the BBSCB, via the Performance and Audit Group.

10.3 Section 11 of the Children Act 2004

Section 11 of the Children Act 2004 requires a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children[1]. Partner agencies are required to self-evaluate their compliance against the standards and submit a safeguarding improvement plan for the coming 12 months. Agencies will assess their compliance using an audit tool reflecting the Children Act 2004 requirements and then submit the report of findings, or sign a declaration of compliance. Agencies are also expected to report on progress of improvements to safeguarding during the previous 12 months.

10.4 Section 175 and 157 of the Education Act 2002

Section 175 of the Education Act 2002 came into effect on the 1 June 2004. Section 175 requires school governing bodies, local education authorities and further education institutions to make arrangements to safeguard and promote the welfare of children. Similar requirements are in place for proprietors of Independent Schools under Section 157 of the Education Act 2002.

The BBSCB is required to monitor the effectiveness of safeguarding arrangements in schools and undertakes an audit cycle consistent with the Section 11 audit process. The findings are analysed with suggested improvements made to assist schools who have not yet reached the required standard.

11. How do we obtain front-line intelligence?

11.1 BBSCB front-line practitioners group/visits

The Independent Chair and Board members will undertake a range of visits to front-line staff from a range of agencies across the course of the year. The Independent Chair will also attend a Frontline Practitioners meeting, where practitioners will be invited to discuss safeguarding matters in respect of their own agency or as part of inert-agency work. The intention is to provide front-line staff with visible leadership from the Board; together with opportunities to share their perspectives on what is working well and what isn't. The Frontline Practitioners Group will continue to act as a forum of safeguarding expertise for the Board and a source of relevant frontline expertise in respect of identifying learning / trends and priorities for the Board.

[1] Statutory guidance on Section 11 of the Children Act 2004 sets out the standards and can be accessed at http://webarchive.nationalarchives.gov.uk/20130401151715/https://www.education.gov.uk/publications/standard/publicationdetail/page1/dfes-0036-2007

11.2 BBSCB Training and Development Feedback

Feedback from front-line staff will also be captured through formal feedback at BBSCB training events and follow evaluation BBSCB events will be used to capture professionals' views in respect of specific issues alongside the evaluation of the training event itself. In addition quarterly impact reports will be presented to the training and development sub group to review progress against the training and development strategy and demonstrate impact on practice.

11.3 IRO feedback

The Independent Reviewing Officers will provide intelligence in respect of its independent view as to how the safeguarding system operates – specifically in respect of the most vulnerable children across Bedford Borough.

12. How do we learn from external lessons?

12.1 National Research and Serious Case Reviews

The BBSCB will use identified learning from research and published Serious Case Reviews to assist in improving local safeguarding arrangements. Key learning and themes will be disseminated to staff consistent with this framework.

12.2 Strategic Partnership Feedback

The BBSCB works closely with the Health & Wellbeing Board, Community Safety Partnership, Domestic Abuse Partnership and the Safeguarding Adult Board in Bedford Borough through a defined protocol that enables challenge, scrutiny and feedback to be given to the BBSCB on its priorities and performance. This feedback will be used to help identify areas of learning that improve the quality of practice and service delivery.

12.3 Overview and Scrutiny Feedback

The safeguarding system receives scrutiny and challenge from the democratic functions of Overview and Scrutiny within Bedford Borough. This forum also forms an important part of the framework in terms of identifying lessons and areas for improvement.

12.4 Agency Assurance/Annual Reports

During the course of each year, relevant reports will be produced for the BBSCB, providing a narrative account of the work being undertaken in particular areas. These reports will be expected to identify any relevant learning that has been identified in respect of their specific safeguarding themes. The following list is not exhaustive and the BBSCB may request additional reporting on specific areas based on its analysis of what areas require focus;

- LADO – including safer recruitment
- Private Fostering
- IRO
- Looked After Children

- Missing Children
- Children with Disabilities
- Child Sexual Exploitation

13. Quality Assurance

As well as providing effective opportunities for the safeguarding system to learn and improve, the functions required to deliver this Learning and Improvement Framework, will also provide evidence to the BBSCB in its **assurance** role – i.e. forming a view as to the effectiveness of the system and being assured that through the co-ordination of services, agencies and their staff work effectively to minimise risks of harm to children and young people and improve their wellbeing and life chances.

The BBSCB should be able to, on an on-going basis, **assess the health** of the safeguarding children system within their area, ensuring effective leadership connects with font line practice, children and their families, through focus on quality, performance management and an ability to learn.

For quality assurance to be effective there needs to be the following elements:

- Planned and annually reviewed multi-agency case auditing and single agency case auditing.
- Regular performance reporting, on a selected number of critical measures linked to safeguarding priorities, from across the safeguarding system, where analysis has been undertaken prior to reports presented to the BBSCB which enables the BBSCB members to understand how their area is performing comparatively as well as local information that highlights differences in service standards and outcomes.
- The production of the BBSCB Annual Report on safeguarding children which provides a rigorous and transparent assessment of the performance of local services, identifies areas of weaknesses, the causes of those weaknesses and the action being taken to address them as well as other proposals for action. It should contain lessons from all reviews undertaken within the reporting period.
- Reporting of performance and any failure to meet standards, from the Independent Review Unit, and other key service areas as appropriate.
- The view of parents and children subject to safeguarding plans, for example, complaints and compliments, views gathered from the advocacy service, feedback from children in care.
- The views of staff working within the children's workforce, gathered through agency surveys or through the Staff Safeguarding Children Section 11 survey.
- The quality assurance activities to be reported should be reviewed annually.

In addition, quality assurance assumes a number of quality management principles including:

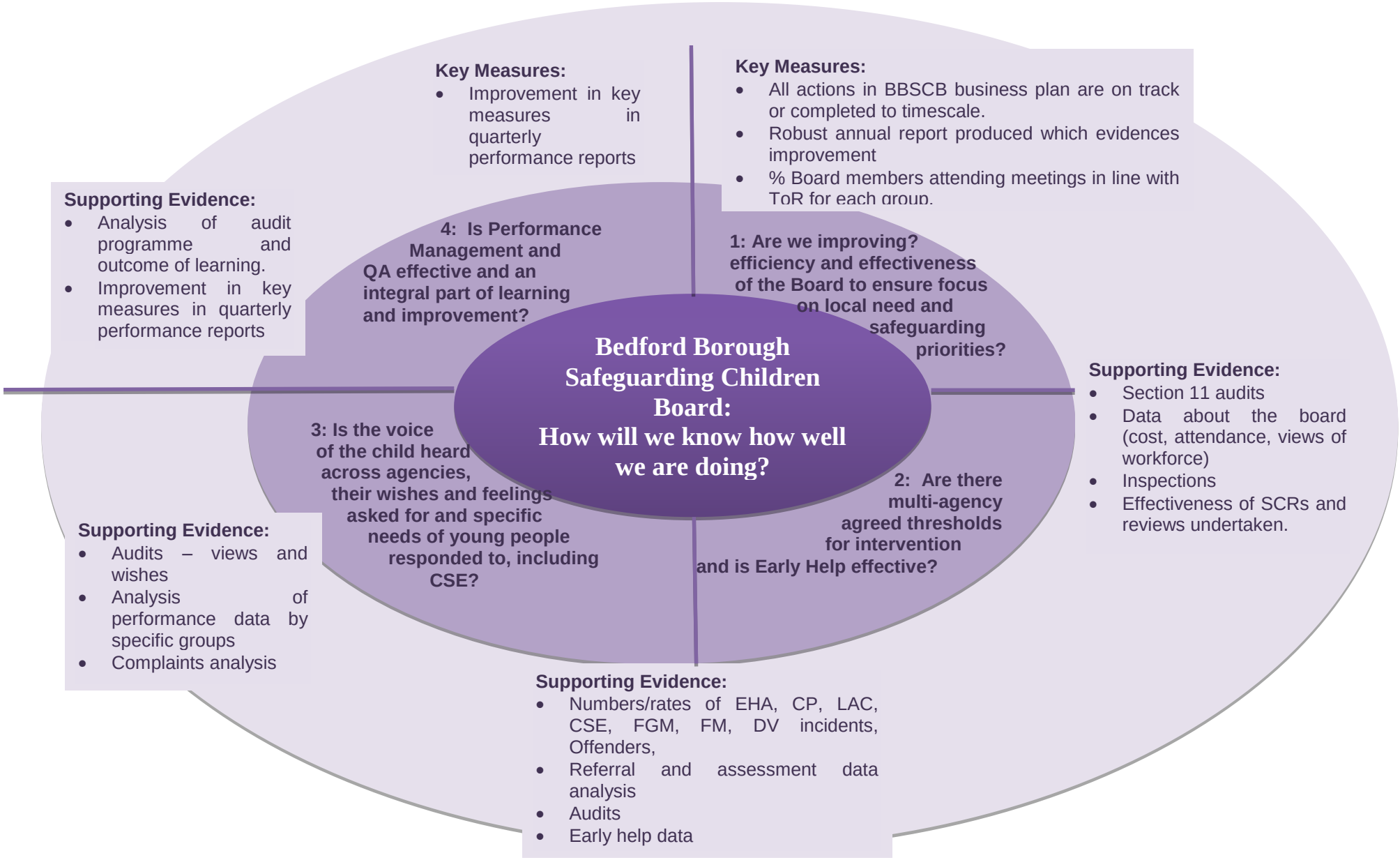
- a strong focus on the experiences of children, young people and their families;
- the motivation of senior leaders, top management and the children's workforce; and
- a process approach to continually improving the safeguarding children system.

Quality assurance will enable the BBSCB to monitor front-line practice, identify gaps in and provide effective challenge to all partners. It will facilitate the BBSCB in bringing robust independent scrutiny and challenge to safeguarding issues, processes and systems and help ensure the quality and effectiveness of single agency and multi-agency work within the safeguarding arena.

The BBSCB must demonstrate good practice by[2]:

- having comprehensive and integrated systems to allow the scrutiny of performance in key areas, at different levels and in geographical localities;
- involving frontline workers in audit processes;
- using independent audits and inspection findings to drive improvement;
- employing a variety of techniques and taking a very thorough approach to auditing;
- adopting a thematic and planned approach to auditing;
- using the outcomes of audits to learn and improve practice;
- assessing the impact of changes resulting from audit findings on children and young people and their families rather than confining attention to changes in processes;
    - agencies challenging each other's practice and hold each other to account;
    - scrutinising not only their own agency activities but also those of other bodies.

The elements that comprise quality assurance will be annually reviewed to ensure that the most appropriate qualitative, quantitative and outcome performance measures are utilised, mapped against the key priorities so that the members ensure that a regular flow of information is reported to the Board.


Key Measures:
Improvement in key measures in quarterly performance reports
Key Measures:
All actions in BBSCB business plan are on track or completed to timescale.
Robust annual report produced which evidences improvement
% Board members attending meetings in line with ToR for each group.
Supporting Evidence:
Analysis of audit programme and outcome of learning.
Improvement in key measures in quarterly performance reports
4: Is Performance Management and QA effective and an integral part of learning and improvement?
1: Are we improving? efficiency and effectiveness of the Board to ensure focus on local need and safeguarding priorities?
Bedford Borough Safeguarding Children Board: How will we know how well we are doing?
Supporting Evidence:
Section 11 audits
Data about the board (cost, attendance, views of workforce)
Inspections
Effectiveness of SCRs and reviews undertaken.
3: Is the voice of the child heard across agencies, their wishes and feelings asked for and specific needs of young people responded to, including CSE?
2: Are there multi-agency agreed thresholds for intervention and is Early Help effective?
Supporting Evidence:
Audits – views and wishes
Analysis of performance data by specific groups
Complaints analysis
Supporting Evidence:
Numbers/rates of EHA, CP, LAC, CSE, FGM, FM, DV incidents, Offenders,
Referral and assessment data analysis
Audits
Early help data

Appendix 7-Single Agency Highlight report to the BBSCB Performance and Audit Group

How much have we done? How well have we done it? Have we made a difference?

Name Of Organisation:	
Name(s) Of Person(s) Reporting:	
Period Covered By Report:	
Summary - including incidents, safeguarding activity, training, auditing work undertaken, what challenges have impacted on your services? For example: new IT systems, workforce issues, reduction in budgets etc.	
Please provide a concise summary of the quarterly data provided using the top tips guide below (Appendix one) to tell the Board the story behind the data? For example - a brief introduction/context - Indicate the time period covered by the report - What are you worried about? What needs to change?	
How will this proposal/action impact on equality/diversity for children? **Please include detailed comment -** For example: Ethnicity: Bedford Hospital monitors the number of children in Bedford Borough who attend A&E to establish if there is any disproportiality in attendance of those from minority ethnic groups.	
During this reporting period, has a Serious Incident Report been submitted to the SCR Group?	
Since your last report have you/your agency identified any safeguarding risks or issues for inclusion in the BBSCB Risk Log? If yes, please provide details	

Since your last report, has your agency had cause to utilise the LSCB Escalation Procedures http://bedfordscb.proceduresonline.com/chapters/p_reolution_disagree.html If yes, please provide details.
SIRG/BBSCB Decision or action required?

(Please attach any relevant report/document to this form)

Signed..... Date ……..……

TOP TIPS FOR ANALYSING AND DESCRIBING PERFORMANCE TO SHOW "HOW ARE WE DOING?"

The story behind the data (also called commentary or narrative) should be written from the services point of view to *describe* in operational terms what the data is telling us, and what is being done to improve. The top tips below aim to help.

Before you start…

- Reflect:
  - Is the information you have robust enough to answer your question?
  - Check is the data of good quality and within expected ranges. If not – query with those responsible for inputting and for calculating the data
- Reconfirm:
  - Legislative and local requirements – what is minimum performance expected
  - What does good look like? (Is there a target, standard or best practice)
- Right conditions to analyse and interpret:
  - Enough time to undertake analysis, reach conclusions or discuss in meetings as appropriate.

Your Analytical Behaviours

- Asking challenging questions (why …?)
- Reflecting on all possible hypotheses – is there more than one explanation.
- Looking outside - what conclusions have others reach in similar cases?
- Being informed (saying we know from research, being evidence based ….)
- Explaining your rationale for conclusions and decisions and refer to the data
- Be aware of potential biases – including your own
- Keeping a focus on outcomes – "Have we made a difference?"
- What are the financial implications?
- What are the current or potential risks?
- Are there sustainability issues?

Telling the story behind the data and drawing conclusions

- Who is the data describing – are they our target group? Is it inclusive?
- Are we clear about definitions, timeframes and have enough data to draw hypotheses and conclusions?
- Do we have the full picture of inputs, outputs, outcomes and costs? Do we need to?
- What is the current and future context in the local area and service that this relates to?
- Are we able to measure if our CYP are better off (what difference have we made?)
- How do we compare: a) to ourselves historically; b) to others; c) to what good looks like?
- Are we consistent in our approach and outcomes (equity – vulnerable groups)? If not, who is not doing so well?

- Who are the partners that have a role to play in delivering this and achieving the outcomes?
- What works to do better?
- Include in your commentary description of any other data/evidence to support the story or reasons for current performance, for example workforce capacity, budgets, training, managing change, practice standards and quality assurance/audits.
- What do we propose to do to improve?

Planning for improvement

Think about the target, or standard you are trying to achieve: actions must have:

- Responsible leads and resources stated/identified – even if none.
- Clear activities that need to be undertaken – short, sharp actions
- Outcome focused and measurable - what difference will that activity make?
- Timescales - realistic end dates
- Robust monitoring processes where non-achievement and 'stagnation' is not an option.
- Review – avoid words such as 'ongoing' or 'in progress' but be specific exactly what you have done already and when planned or current activities will be done.

Keep it short, sharp, simple. Don't agonise too much over it, but ensure your words assure the reader that you understand what the data is telling you and what your plans are. Chances are as the responsible lead of the service, it will all be in your heads and roll out fairly easily and it is a story you are used to telling many times!

More Detailed Analysis

Your story behind the data should reflect the following:

CLEAR AIMS…

- Provide a good picture of individual cohorts of children, localities, the local area and what is happening.
- Provide an understanding of why the analysis is being done and what you're expecting to get out of it
- Be clear about what good looks like, seriousness of any underperformance and likely consequences or risks if they are not addressed
- State clearly what is going to happen as a direct result of the analysis – the "So What?" question

CONTEXT…

- Show an understanding of the context
- Include analysis of what we don't yet know (analysis is an on-going process and it's acceptable to say we need more information about a particular topic)
- Show an understanding of how the data relates to practice, policy and legislation
- Adopt an open-minded and questioning approach – e.g. is this the only way of understanding this?

- Contain information directly relevant to the purpose of the assessment
- Be clear about timescales

STYLE…

- Be logical, both in terms of 'showing your working' (i.e. making sure your thinking process is clear to the reader; showing how you have got from point to point, how you have used the information available to reach certain conclusions etc.) and in terms of structure, so that recommendations can be seen to follow from the information obtained
- Be succinct, concise, relevant, and specific
- Be free of jargon

EVIDENCE…

- Make explicit the underpinning knowledge and evidence (triangulated) that have informed your findings (including references to research and all information sources)
- Include a clear, evidence-informed prediction about the future performance and likely impact if identified recommendations are not met
- Show confidence in your analysis – include clear sharp statements with evidence to back them up rather than flowery language.

WILL BE REVIEWED…

- Where outcomes have not been achieved, more questions have to be asked to review the assessment:
- Did we have the wrong data/evidence?
- Was the meaning given to the story/analysis flawed?
- Has our hypothesis been disproved/an alternative emerge?
- Has new information emerged?
- Were recommendations or services commissioned or delivered the wrong way?
- Were we attempting to achieve too many outcomes at once resulting from the assessment?
- How can we refine, hypotheses amended, outcomes revised and actions made to succeed?