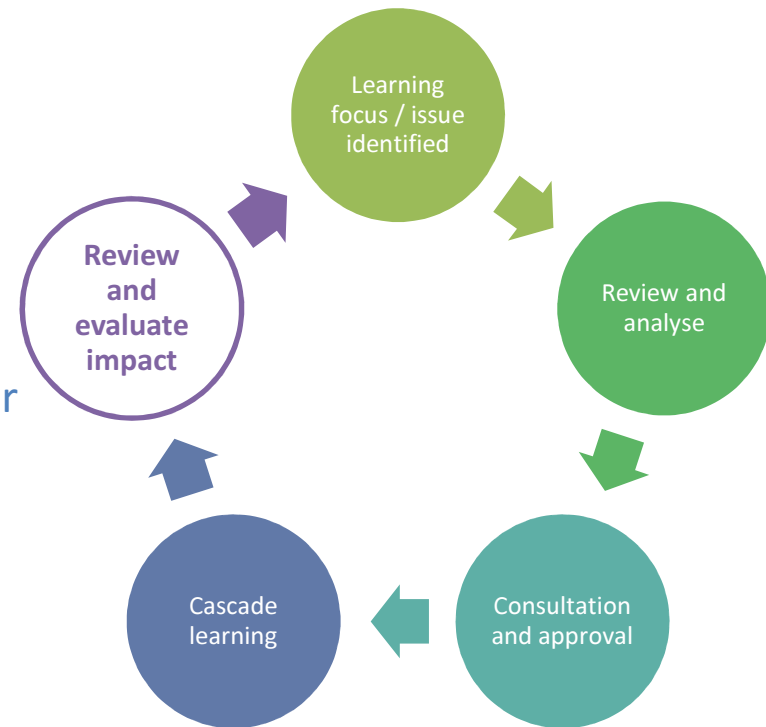


# East Sussex Local Safeguarding Children Board

Learning and Impact Review

# Purpose of review

- Provide an evidence base for the LSCB's impact on frontline practice and outcomes for children and families
- Identifying common learning/issues/areas for development and exploring any reasons behind these, which could then be used to inform future learning and improvement activity and/or future LSCB priorities
- Identifying any organisational improvements that would strengthen the LSCB's learning and development capacity
- Demonstrate the LSCB's focus on review and evaluation of impact; and
- Be used to inform the refresh of the LSCB's Learning and Development Framework



# Overview of recommendations

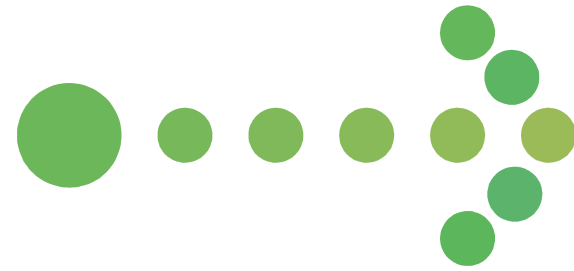
75 recommendations from four  
Serious Case Reviews



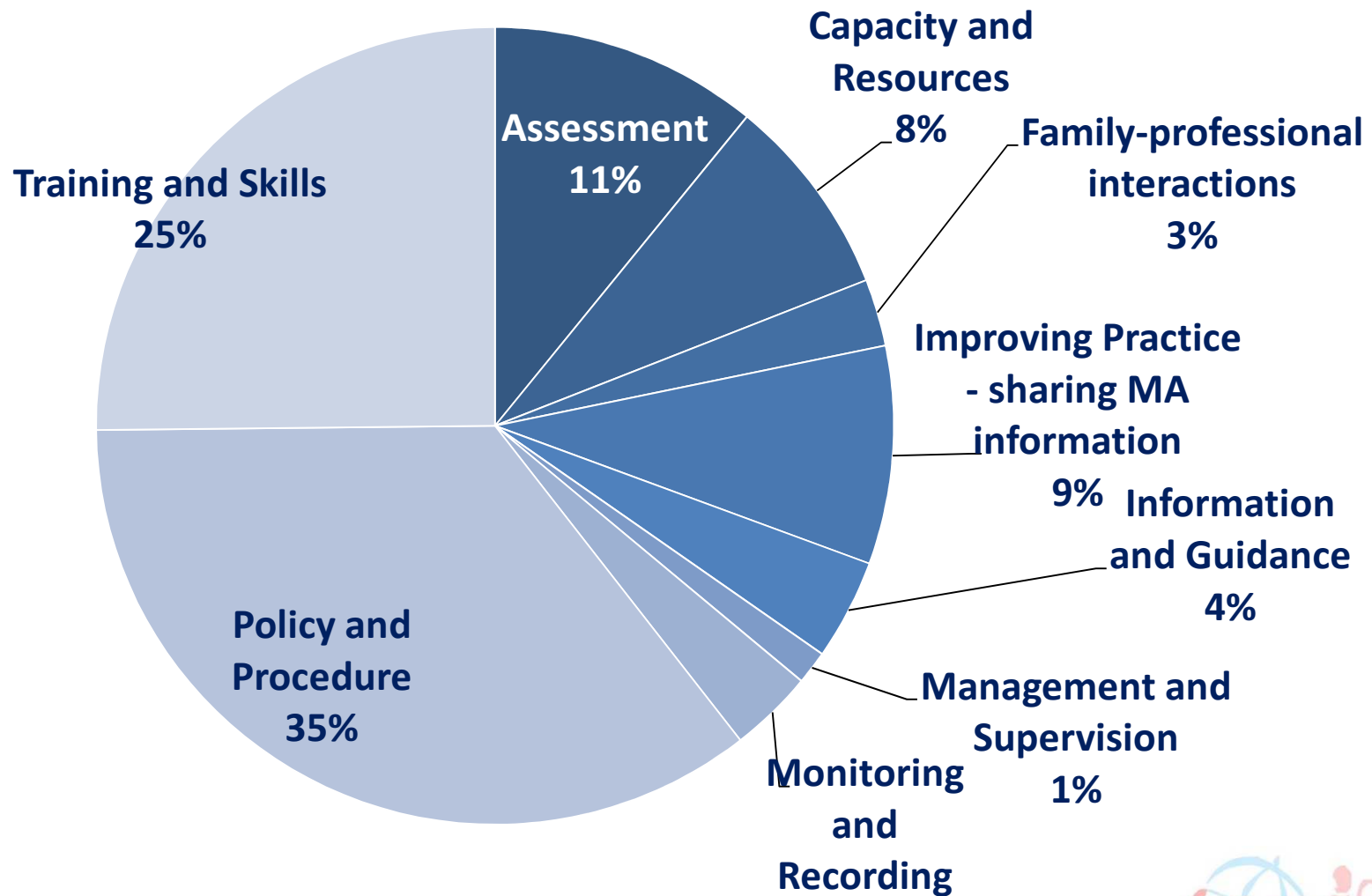
18 recommendations  
from two IMRs



54 recommendations from 15  
QA audits



# Types of recommendations made



# Other themes

- Use of Additional Support Form (maternity services)
- Focus on child's lived experience
- Domestic abuse
- Hidden children
- Identifying vulnerability
- Safeguarding practice improvement in schools
- Working with large families

# What has been achieved?

## Child Q IMR

- Introduction of Safeguarding Reviews in schools – significant impact on practice in individual schools
- DSL Training – significantly improved, leading to improved confidence and knowledge of DSLs and Headteachers
- Introduction of DSL Networks – leads are supported, improved practice

## Sexual Abuse QA Case Audit

- Reminders on timely consideration of paediatric assessments – improved practice as evidenced in subsequent CSA and MACE audits
- Ensuring robust assessment of teenage pregnancy where concerns of exploitative relationship – MACE & CSE practice has strengthened this
- Reminders on professional curiosity – increased awareness by PMs when signing off assessments

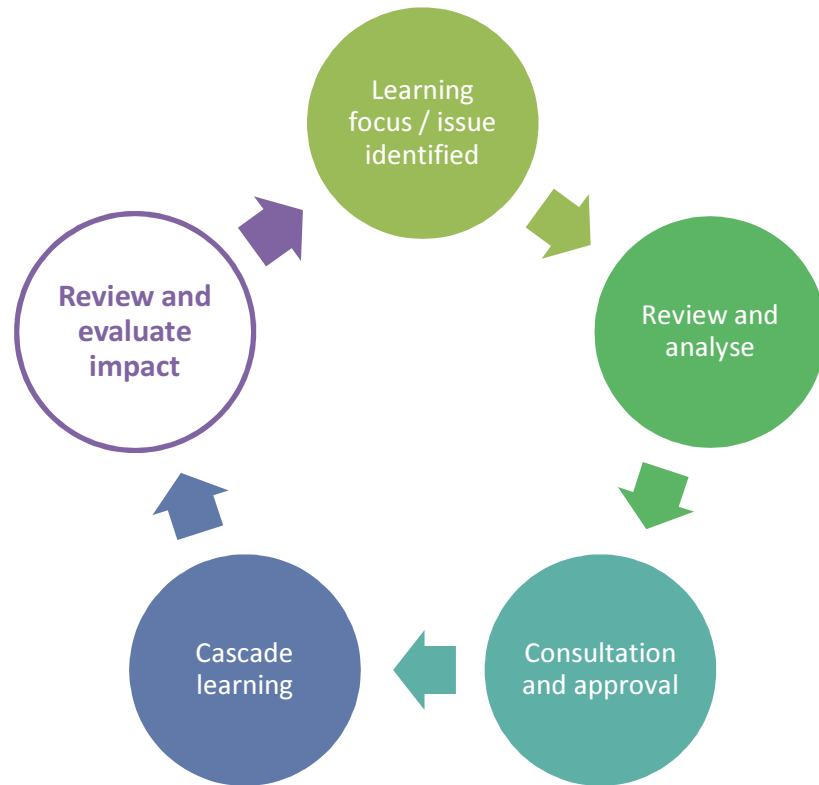
## Child K SCR

- Better information sharing between midwife and Health visitors where risks identified via Additional Support forms – communication via TAF meetings, now L3 via SPOA; sharing of early help plans; ASFs more detailed

# Learning

- Often not clear what the desired impact is
- Some inconsistency in way recommendations are made/written
- Hard to prioritise recommendations for action
- Effective monitoring of impact
- Information not always shared

# Next steps



- a) Guidance for SCR amended to ensure recommendations are consistent between reports and proportionate to desired impact
- b) Be clearer on desired impact want to achieve when making recommendations and agreeing actions
- c) Consider prioritising recommendations for immediate or longer term action

- a) Action planning more robustly tested with agencies/Board
- b) More frequent review of the impact of SCR work

- a) Closer links with Training Subgroup to review and inform training plans.
- b) Strengthen ways to disseminate learning to front line staff



# Breakout activity

Look at the recommendations, think about:

- What is the desired impact on practice we want to achieve?
- What is the desired impact on outcomes?  
How will children be safer?
- What would help to ensure we are better focused on **impact**?