Learning and Improvement Framework 2014

Version 1	Ratified	April 2014

Introduction

West Sussex Safeguarding Children Board (WSSCB) is a learning organisation and through its statutory functions reviews, scrutinises and challenges local safeguarding arrangements and practice in order to improve services to safeguard and promote the welfare of children in West Sussex. To support this work WSSCB has developed a quality assurance framework.

Statutory safeguarding guidance, Working Together to Safeguard Children (DfE, 2013) states that professionals and organisations protecting children need to reflect on the quality of their services and that they learn from their practice and that of others in order to improve local safeguarding practice. In order to support this there is a requirement placed on Local Safeguarding Children Boards (LSCBs) to develop and maintain a local learning and improvement framework.

"Local Safeguarding Children Boards (LSCB) 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"[1]

Roles and Responsibilities

This framework is for the WSSCB, partner agencies and all local organisations who work with children and families.

The WSSCB will maintain and develop this framework responding to local and national policies and agendas.

Partner agencies and all local organisations who work with children and families are expected to endorse this framework and embed this framework into their organisational and workforce learning and development policies. In addition partner agencies and local organisations are responsible for:

- Providing staff and other resources to deliver the framework
- Contributing to reviews of practice undertaken by the WSSCB
- Ensuring lessons learnt from these reviews of practice are disseminated widely within their organisation (e.g. internal training, policies/procedures, implementing actions plans)
- Ensuring that lessons learnt from these reviews of practice are embedded into practice (e.g. evaluation via auditing, staff surveys)

[1] DfE (2013) *Working Together to Safeguard Children,* page 65.

Overview

This framework seeks to promote continuous improvement via a feedback loop as described in Appendix 1.

The building blocks to the framework are:

Learning from experience:

a) Reviews of safeguarding practice

b) Identification of learning improvement services

Improving Services:

c) Embedding learning in practice

d) Evaluation of learning

Learning from Experience

a) Reviews of safeguarding practice

"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."[2]

Learning opportunities from safeguarding practice arise from a variety of sources.

This framework sets out the key practice reviews that the WSSCB, partner agencies and other local organisation undertake.

Type of Review	Description	Who	Reporting
Serious Case Review	Where abuse or neglect is known or suspected and either: 1) a child dies; or 2) a child is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child[3]	Partner agencies Relevant organisations Independent Reviewer WSSCB Team	WSSCB via the Case Review Group / and or Learning and Development Group and/or a serious case review panel
Multi-agency Case Review	Review of a safeguarding incident which falls below the threshold for a Serious Case Review	Partner agencies Relevant organisations Possible Independent Reviewer WSSCB Team	WSSCB via Case Review Group (CRG)

[2] Dfe (2013) *Working Together to Safeguard Children*, page 65.

[3] Criteria for an SCR are set out in Regulation 5 of the Local Safeguarding Children Boards Regulations 2006.

Individual Management Review	Review of a safeguarding incident which falls below the threshold for a Serious Case Review and where there are limited concerns about how organisations or professionals	Partner agency	WSSCB Via CRG
Child Death Review	A review of all child deaths up the age of 18.[4]	Child Death Overview Panel	WSSCB
Multi-agency thematic case audits	Audit of practice relating to a specific safeguarding issue (case sample)	Partner agencies Relevant organisations WSSCB Team	WSSCB via MAFAG/ QA & Performance group
Multi-agency case audits	Audit of practice relating to a child's journey through the system (case sample)	Partner agencies Relevant organisations	WSSCB via MAFAG/ QA & Performance group
Single agency audits	Audit of practice (case sample)	Partner agency	WSSCB via QA & Performance group
s.11 audits	Self-assessment of an organisation's safeguarding arrangements and practice (Section 11 of the Children's Act 2004)	Partner agency	WSSCB via QA & Performance group
s.175/157 audits	Self-assessment of a schools safeguarding arrangements and practice (s.175/157 of the Education Act 2002)	Schools	WSSCB via LADO
National research, SCRs, etc	Key messages from research, other LSCB's SCRs.	Learning and Development Group and or Case Review Group	WSSCB

[4] The LSCB's function in relation to child deaths is set out in Regulation 6 of the Local Safeguarding Children Boards Regulations 2006.

Principles for conducting reviews

The following principles, outlined in *Working Together to Safeguard Children,* should be applied by the WSSCB and their partner organisations to all reviews:

- 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 should 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.

Protocols for conducting reviews:

Working Together to Safeguard Children outlines the requirements for conducting case reviews, specifically serious case reviews and child death reviews. Local protocols for conducting case reviews are under development and will be placed on the WSSCB website when available.

b) Identification of Learning

Identification of key learning is achieved through the function of the Case Review Group (CRG), a sub group of the WSSCB.

Reviews of practice are commissioned by two of the WSSCB subgroups: the CRG and the Quality Assurance and Performance Group.

The CRG may commission a Serious Case Review (SCR) or a multi-agency case review in order to provide an analysis, lessons from the case and recommendations for any changes in policy or practice.

The Quality Assurance and Performance Group has a responsibility for scrutiny and quality assurance of safeguarding arrangements and practice across West Sussex and exercises this responsibility by taking an overview of performance, conducting case audits, overseeing the Section 11 self-assessment process and receiving specialist reports.

The Quality Assurance and Performance Group chair attends the CRG on a quarterly basis to report key learning identified through its quality assurance activity, including the case audit programme.

Improving services

c) Embedding learning

In order to improve safeguarding practice learning identified from reviews of practice must be embedded into current practice. This is achieved by:

How	What	Who	Reporting
Dissemination of Learning	Multi-agency training programme	Partner agencies Relevant organisations WSSCB Training Team WSSCB Team	WSSCB via Learning and Development Group
	WSSCB multi-agency 'learning lessons'. Workshops	Partner agencies Relevant organisations WSSCB Learning and Development Team WSSCB Team	WSSCB via Learning and Development Team
	WSSCB briefings	Partner agencies Relevant organisations WSSCB Team	WSSCB via Learning and Development Team / Website
	Publication of Serious Case Review final reports	WSSCB	Website

	Single agency training	Partner agencies	WSSCB via Learning and Development Team
	Single agency briefings and other communication strategies	Partner agencies	WSSCB via Learning and Development Team / Website
Actions to improve practice	Single and Multi-agency actions plans from case reviews	Partner agencies Relevant organisations WSSCB Team	WSSCB via CRG
	Single and Multi-agency actions plans from case audits	Partner agencies Relevant organisations WSSCB Team	WSSCB via QA & Performance Group/ MAFAG
	Single and Multi-agency actions plans from s.11 audits	Partner agencies Relevant organisations WSSCB Team	WSSCB via QA & Performance Group
	Actions arising from reporting to WSSCB/ Q&E Group	Partner agencies Relevant organisations WSSCB Team	WSSCB/ QA & Performance Group

d) Evaluation of learning.

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 West Sussex.

WSSCB as part of its quality assurance activity evaluates the impact of lessons learnt from reviews of practice. Evaluation includes:

How	Who	Reporting
Single and Multi-agency case audits	Partner agencies Relevant organisations WSSCB Team	WSSCB via QA & Performance Group
Case Reviews	Partner agencies Relevant organisations WSSCB Team	WSSCB via CRG
Reporting on action plans	Partner agencies Relevant organisations WSSCB Team	WSSCB via CRG
Evaluation of training	Partner agencies Relevant organisations WSSCB Team	WSSCB via Learning and Development Team

This evaluation process identifies whether or not lessons have been learnt and can identify new issues. This process completes the learning lesson feedback loop outlined in Appendix 1.

Monitoring and review of this framework

This framework will be monitored via the Quality Assurance & Performance Group and be reviewed on an annual basis (or sooner in response to delivery of this framework, governmental guidance, national agendas etc.).

Appendix 1: WSSCB Learning Lessons Feedback Loop