ISLE OF WIGHT SAFEGUARDING CHILDREN BOARD

LEARNING AND IMPROVEMENT FRAMEWORK

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Introduction

The Isle of Wight Safeguarding Children Board (IOWSCB) is a learning partnership 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 on the Isle of Wight. To support this work the IOWSCB 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 LSCBs to develop and maintain a local learning and improvement framework.

"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"[1]

Roles and responsibilities

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

The IOWSCB 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 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 IOWSCB.
- 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 this framework are:

Learning from experience:
a) Reviews of safeguarding practice
b) Identification of learning

Improving services
c) Embedding learning in practice
d) Evaluation of learning

Learning from experience

a) Reviews of 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 IOWSCB, 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. IOWSCB business unit.	IOWSCB via the Serious Case Review Sub Group and/or a serious case review panel.
Multi-agency case review	Review of a safeguarding incident which falls below the threshold for an SCR.	Partner agencies Relevant	IOWSCB via Serious Case Review Sub Group

[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.

Type of review	Description	Who	Reporting
		organisations. Possible Independent Reviewer. IOWSCB business unit.	
Individual management review	Review of a safeguarding incident which falls below the threshold for an SCR and where there are limited concerns about how organisations or professionals worked together to safeguard the child	Partner Agency	IOWSCB via Serious Case Review Sub Group
Child Death Review	A review of all child deaths up the age of 18.[4]	Child Death Overview Panel (CDOP)	IOWSCB
Multi-agency thematic case audits	Audit of practice relating to a specific safeguarding issue (case sample)	Partner agencies Relevant organisations. IOWSCB business unit.	IOWSCB via Performance and Quality Assurance Sub Group
Multi-agency case audits	Audit of practice relating to a child's journey though the system (case sample)	Partner agencies Relevant organisations. IOWSCB business unit.	IOWSCB via Performance and Quality Assurance Sub Group
Single agency audits	Audit of practice (case sample)	Partner agency	IOWSCB via Performance and Quality Assurance Sub Group
Section 11 audits	Self-assessment of an organisation's safeguarding arrangements and practice (Section 11 of the Children Act 2004).	Partner agency	IOWSCB via Performance and Quality Assurance Sub Group

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

Type of review	Description	Who	Reporting
Section 175/157 audits	Self assessment of a schools safeguarding arrangements and practice (s.175/157 of the Education Act 2002)	Schools	IOWSCB via Performance and Quality Assurance Sub Group
National research, SCRs, etc.	Key messages from research, other LSCB's SCRs, Children's Commissioner, government reviews, etc	Serious Case Review Sub Group	IOWSCB

Principles for conducting reviews;
The following principles, outlined in *Working Together to Safeguard Children 2013*, should be applied by the IOWSCB 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 the LSCB annual report and will inform inspections; and
- 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 2013 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 IOWSCB website when available.

b) <u>Identification of Learning</u>
Identification of key learning is achieved through the function of the Serious Case Review Sub Group of the IOWSCB.

Reviews of practice are commissioned by two of the IOWSCB subgroups: the Serious Case Review Sub Group and the Performance and Quality Assurance Sub Group.

The Serious Case Review Sub Group 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 Performance and Quality Assurance Sub Group has a responsibility for scrutiny and quality assurance of safeguarding arrangements and practice across the Isle of Wight. It exercises this responsibility by taking an overview of performance, conducting case audits, overseeing the Section 11 self-assessment process and receiving regular agency/organisation/service and specialist reports.

The Performance and Quality Assurance Sub Group chair attends the Serious Case Review Sub Group 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. Isle of Wight Council Workforce Development Team IOWSCB business unit.	IOWSCB via Hampshire and Isle of Wight Workforce Development Group
	IOWSCB multi-agency 'learning lessons'. workshops	Partner agencies Relevant organisations. Isle of Wight Council Workforce Development Team IOWSCB business unit.	IOWSCB via Hampshire and Isle of Wight Workforce Development Group

How	What	Who	Reporting
	IOWSCB briefings and communication strategy.	Partner agencies Relevant organisations. IOWSCB business unit.	IOWSCB
	Publication of serious case review final reports	IOWSCB	
	Single agency training	Partner Agencies	IOWSCB via Hampshire and Isle of Wight Workforce Development Group
	Single agency briefings and other communication strategies.	Partner Agencies	IOWSCB
Actions to improve practice	Single and Multi-agency actions plans from case reviews.	Partner agencies Relevant organisations. IOWSCB business unit.	IOWSCB via Serious Case Review Sub Group
	Single and Multi-agency actions plans from case audits.	Partner agencies Relevant organisations. IOWSCB business unit.	IOWSCB via Performance and Quality Assurance Sub Group
	Single and Multi-agency actions plans from Section 11 and Section 175 audits.	Partner agencies Relevant organisations. IOWSCB business unit.	IOWSCB via Performance and Quality Assurance Sub Group and the Education Sub Group
	Actions arising from reporting to IOWSCB/Performance and Quality Assurance Sub Group.	Partner agencies Relevant organisations. IOWSCB business unit.	IOWSCB/Performance and Quality Assurance Sub 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 on the Isle of Wight.

As part of its quality assurance framework the IOWSCB 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. IOWSCB business unit.	IOWSCB via Performance and Quality Assurance Sub Group
Case reviews	Partner agencies Relevant organisations. IOWSCB business unit.	IOWSCB via Serious Case Review Sub Group
Reporting on case review action plans.	Partner agencies Relevant organisations. IOWSCB business unit.	IOWSCB via Serious Case Review Sub Group
Evaluation of training.	Partner agencies Relevant organisations. IOWSCB business unit.	IOWSCB via Hampshire and Isle of Wight Workforce Development Group

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 Serious Case Review Sub Group and reviewed on an annual basis (or sooner in response to delivery of this framework, government guidance, national agendas, etc).

Appendix 1: IOWSCB Learning Lessons Feedback Loop