



Quality Assurance, Learning and Improvement Framework



Introduction

Working Together to Safeguard Children (Department for Education, 2015) identifies a number of principles that should be applied by all LSCBs in relation to learning and improvement.

General aims of this framework include:

- Enabling professionals and organisations to reflect on the quality of their services and highlight good practice so that multi-agency partners know what works well.
- Identify how we will ensure a rigorous, objective analysis when areas for improvement are identified so that partner agencies are aware of what and why, so that lessons are learnt across local agencies.
- Facilitate or coordinate learning between organisations.
- Identify the range of reviews that will be carried out (including that of cases which do not meet statutory criteria).
- Bring together the data and other information collected by the Board so that there are lasting improvements across organisations.
- Listen to and respond to the voices of children, young people and their families and the children's workforce.

Roles and responsibilities

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

The LSCB 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 LSCB.
- 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).

Underlying Principles

Below are the principles upon which this Framework has been developed. Although slightly adapted for the purpose of this Framework, they relate directly to the principles that Working Together (2015) states LSCBs and partner agencies should apply to all reviews:

- We will promote a culture of **continuous** learning and improvement across the organisations, identifying opportunities to draw on what works and promote good practice.

- The approach taken to Quality Assurance, Learning and Improvement should be **proportionate** according to the scale and level of complexity of the issues being examined.
- Reviews of serious cases will be led by individuals who are **independent** of the case under review and of the organisations whose actions are being reviewed.
- Professionals must be **involved** fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith.
- The involvement of **families**, including surviving children, must always be considered. This is important for ensuring the child is at the centre of the process.
- The final reports of SCR's will be **published** and including a report as to 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.
- Improvements will be monitored and followed up so that agencies ensure **sustained** improvements in services and the outcomes for children.

Interface with Performance Management

One of the objectives of this framework is to help the LSCB understand and assure itself with regard to safeguarding children in Bracknell Forest. This framework alone cannot tell the Board everything it needs to know but should be understood as part of a broad range of information that the Board analyses and reviews. The below seeks to place the Learning and Improvement Framework in the context of the other sources of information the Board draws on:

<p>Quantitative Information on Performance</p> <p>Numerical performance indicators. This would include single agency indicators relevant to safeguarding, multi-agency indicators agreed by the partnership locally. (LSCB Performance Management 'Orange' Book)</p>	<p>Learning and Improvement</p> <p>Qualitative information from auditing, QA exercises, SCRs etc. both single agency and multi-agency. Section 11 audit activity, single and multi-agency file audits, reflective discussions, assurance reports on specific topics and inspection and peer review outcomes.</p> <p>Some information is gathered routinely, some reactively for specific reasons.</p>
<p>Views of children and their families about services</p> <p>Findings of single agency and LSCB audits / review and through surveys and consultations with specific groups / fora for young people.</p> <p>These could be routine or pragmatically organised.</p>	<p>Feedback from Frontline Staff and Managers</p> <p>Findings of single agency and LSCB audits / reviews / surveys.</p> <p>These could be routine or pragmatically organised.</p>

Components of the Framework

The below framework seeks to show the learning and improvement activity in relation to a constant cycle of identification - dissemination - evaluation.

Type of review	Description	Who	Reporting
Child Protection Incident Review (CPIR) Case Notification and Review	Where a serious incident has occurred each service to complete to verify if a case meets the criteria of a SCR.	Partner agencies Relevant organisations	LSCB via LISG
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. ¹	Partner agencies Relevant organisations Independent Reviewer LSCB Business Team	LSCB via LISG
Multi-agency case review	Review of a safeguarding incident which falls below the threshold for an SCR.	Partner agencies Relevant organisations Possible Independent Reviewer. LSCB Business Team	LSCB via LISG
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	LSCB Business Team
Child Death Review	A review of all child deaths up the age of 18. ²	Child Death Overview Panel (CDOP)	LSCB
Multi-agency case audits including thematic audits	Audit of practice relating to a child's journey through the system and / or relating to a specific safeguarding issue (case sample). Annual audit programme undertaken.	Partner agencies Relevant organisations LSCB Business Team	LSCB via LISG
Surveys and consultations	Electronic questionnaires designed to gather feedback to influence decisions, policies or procedures.	Relevant organisations LSCB Business	LSCB via LISG

¹ Criteria for an SCR are set out in Regulation 5 of the Local Safeguarding Children Boards Regulations 2006.

² The LSCB's function in relation to child deaths is set out in Regulation 6 of the Local Safeguarding Children Boards Regulations 2006.

	This may be a standalone piece of work or as part of a case audit or review.	Team	
Roundtable Discussions	To explore the wider context relating to identified issues. Learning gleaned is disseminated and/or informs recommendations for further actions.	Relevant organisations LSCB Business Team	LSCB via LISG
Single agency audits	Audit of practice (case sample)	Partner agency	LSCB via LISG
S11 audits	Self assessment of an organisation's safeguarding arrangements and practice (Section 11 of the Children Act 2004).	Partner agency Pan-Berks S11 Sub-Group BF S11 Panel	LSCB via LISG
S175/157 audits	Self assessment of a school's safeguarding arrangements and practice (s.175/157 of the Education Act 2002).	Schools BF S11 Panel	LSCB via LISG
National and regional research, SCRs, etc	Key messages from research, other LSCBs SCRs and inspections.	LSCB Business Team	LSCB via LISG

Improving services

a) Identification of Learning

Identification of key learning is achieved through the function of the Learning and Improvement Sub Group (LISG), a sub group of the LSCB.

The LISG 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 LISG has a responsibility for scrutiny and quality assurance of safeguarding arrangements and practice across Bracknell Forest and exercises this responsibility by taking an overview of performance data, conducting multi-agency case audits, overseeing the Section 11 self assessment process and receiving single agency audits, outcomes from inspection and specialist reports.

The LISG chair reports key learning identified through its quality assurance activity, including the case audit programme to the LSCB Board on a regular basis and via a six-monthly report.

b) 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. <i>Calendar can viewed at:</i>	Partner agencies Relevant organisations	LSCB via BF T&PD Sub-Group

	www.bflscb.org.uk/training	BF Training and Professional Development (L&PD) Sub Group LSCB Business Team	
	LSCB multi-agency 'learning and improvement' workshops. <i>These occur 3-4 times a year. Information can be viewed at: www.bflscb.org.uk/training</i>	Partner agencies Relevant organisations BF Training and Professional Development (L&PD) Sub Group LSCB Business Team	LSCB via BF T&PD Sub-Group
	LSCB briefings and communication strategy	Partner agencies Relevant organisations LSCB Business Team	LSCB via LISG /Comms & Comm Eng Sub Group
	Publication of serious case review final reports. www.bflscb.org.uk	LSCB	LSCB
	Single agency training	Partner Agencies	LSCB via LISG
	Single agency briefings and other communication strategies	Partner Agencies	LSCB via LISG
	Local, regional and national learning on Social Media	LSCB Business Team	Comms & Comm Eng Sub Group
Actions to improve practice	Single and Multi-agency action plans from case reviews and case audits	Partner agencies Relevant organisations LSCB Business Team	LSCB via LISG
	Single and Multi-agency action plans from S11 audits	Partner agencies Relevant organisations LSCB Business Team	LSCB via Pan Berks S 11 sub group and BF S.11 group into LISG.
	Actions arising from reporting to LSCB / LISG	Partner agencies Relevant organisations LSCB Business Team	LSCB via LISG

c) 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 Bracknell Forest.

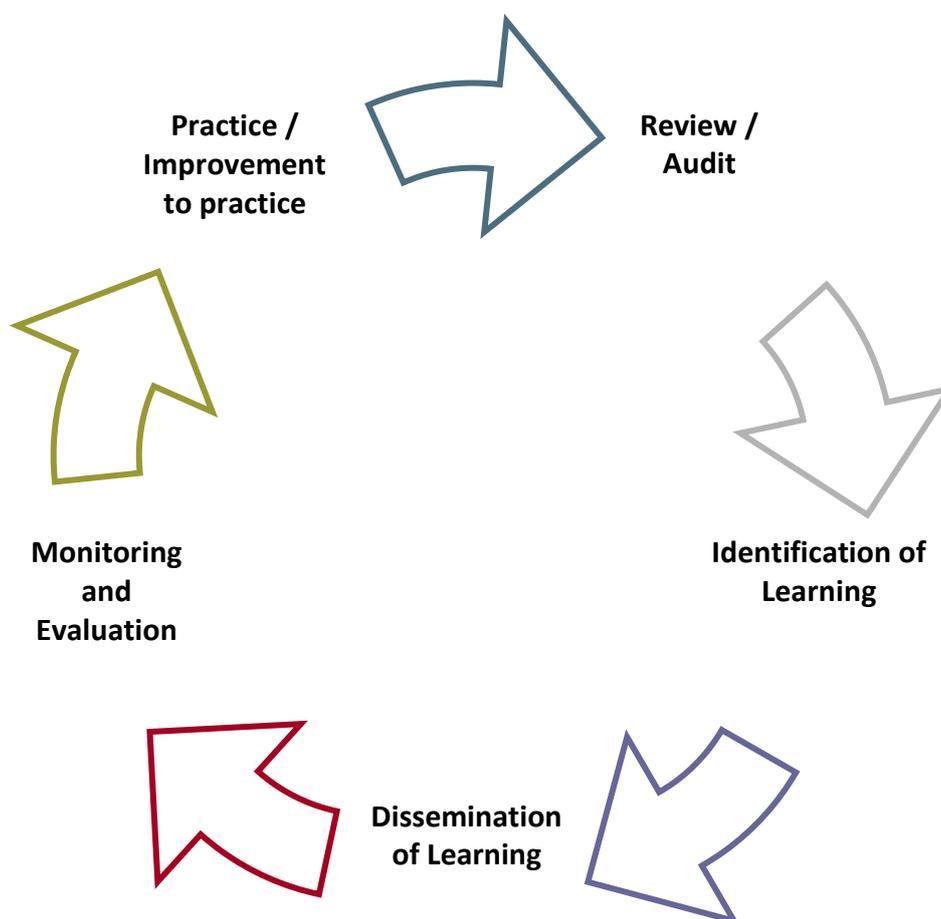
Bracknell Forest LSCB as part of its quality assurance activity evaluates the impact of lessons learnt from reviews of practice. Evaluation includes:

How	Who	Reporting
Single and Multi-agency case file audits <i>(multi-agency audits are planned for 16-17)</i>	Partner agencies Relevant organisations LSCB Business Team	LSCB via LISG

Case reviews	Partner agencies Relevant organisations LSCB Business Team	LSCB via LISG
Reporting on action plans (<i>Follow up on Child C SCR action plans due Aug 2016</i>)	Partner agencies Relevant organisations LSCB Business Team	LSCB via LISG
Evaluation of training (<i>Initial impact of inter-agency training due July 16</i>)	Partner agencies Relevant organisations LSCB Business Team	LSCB via LISG

This evaluation process identifies whether or not lessons have been learnt and can identify new issues. This process completes the learning lesson feedback loop (below).

Learning Lessons Feedback Loop



Child Death Overview Panel

The Child Death Overview Panel (CDOP) operates on a pan-Berkshire basis covering six unitary authority areas and as a sub group of the 6 LSCBs. It has a responsibility to review information on all child deaths in Bracknell Forest and is accountable to the LSCB Chair. The CDOP reviews all child deaths, with the exception of legal and planned terminations,

and babies who are stillborn. With reference to learning, improvement and quality assurance they have a duty around:

- Determining whether the death was deemed preventable, that is, those deaths in which modifiable factors may have contributed to the death and decide what, if any, actions could be taken to prevent future such deaths.
- Making recommendations to the LSCB or other relevant bodies promptly so that action can be taken to prevent future such deaths where possible.
- Identifying patterns or trends in local data and reporting these to the LSCB.
- Where a suspicion arises that neglect or abuse may have been a factor in the child's death, referring a case back to the LSCB Chair for consideration of whether an SCR is required; agreeing local procedures for responding to unexpected deaths of children.

Serious Case Reviews in Bracknell Forest

Working Together 2015 states "LSCBs may use any learning model which is consistent with the principles in this guidance, including the systems methodology recommended by Professor Munro". Bracknell Forest Safeguarding Children Board has not set a single methodology it would use in the event of an SCR but would give consideration to the options available and select the best process for each individual case.

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 included within the CPIR notification form and Pan-Berks Child Protection Procedures.

http://www.proceduresonline.com/berks/bracknell/p_ser_case_rev.html

Implementation and Review of the Learning and Improvement Framework

All LSCB members will:

- Make sure that the Learning and Improvement Framework is widely understood within their own setting.
- Provide strategic leadership within their own services and to the LSCB Sub-Groups for learning and improvement priorities.
- Seek assurance and evidence that learning is effective and embedded and improvements are driven forward where identified.

The LSCB will maintain and develop this framework, responding to local and national policies and priorities. This framework is intended to be an iterative document - added to and amended as defined by the LSCB Learning and Improvement Sub-Group and formally reviewed annually.

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