Sandwell Safeguarding Children Board

SSCB Quality Assurance Framework

Document Control

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2 September 2015	Lisa Burn DI Mick Spellman Dr Helen Grindulis	1	Initial version drafted
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Executive Summary

This is Sandwell's Safeguarding Children's Board (SSCB) Quality Assurance Framework which has been developed by Quality of Practice and Performance sub group with support from all SSCB sub groups. The purpose of the document is to provide all partners within the SSCB with a framework to assess the performance of multi-agency safeguarding practice within Sandwell and the effectiveness of the SSCB itself.

The framework sets out the SSCB's approach to quality assurance, which is to ensure openness and transparency and create a culture of continuous learning and challenge.

This incorporates 6 stages –

1) Monitor, audit, and gather user feedback and performance data
2) Analyse and evaluate findings.
3) Report on findings and disseminate key improvement messages.
4) Identify training needs and update policies and procedures.
5) Deliver training, policy and guidance.
6) Measure the impact of training and audit/case review recommendations

In order to guide this approach in ensuring that all children and young people are safeguarded in Sandwell, the Quality Assurance Framework will reflect the SSCB's Business Plan priorities and the SSCB Improvement Plan and will provide an underpinning structure to measure and assure these priorities are achieved.

The Quality Assurance Framework will ensure that data and quality assurance outputs are regularly reviewed through governance and challenge structures with the aim to create a learning organisation whereby key learning is disseminated, built into learning and training and embedded in practice, policies and guidance.

The mechanism for implementing the quality assurance framework will be through each sub group having a comprehensive action plans linked to the framework and through the SSCB Improvement Plan. Regular updates will be given at the sub group chairs group who oversee all action plans.

1. Introduction

1.1 The safeguarding of children is complex in nature; this is due to the conflicting complexities of the interacting human and organisational histories, behaviours and relationships. Effective quality assurance in the context of Safeguarding children will recognise and work with this complexity whilst seeking to ensure that safeguarding services are appropriate, represent value for money, are valued by our service users and above all make a positive difference to the lives of children and families locally.

1.2 Safeguarding of children is often referred to as 'everyone's business' in that it is not just the responsibility of qualified social workers but of every professional that comes into contact with a child. This is now a value enshrined in the Children Act (2004), the Munro Review of Child Protection (Final Report, 2011) and the revised 'Working Together to Safeguard Children' Statutory Guidance (HM Government, 2015).

1.3 Sandwell's Quality Assurance Framework is informed by inspections and audits both internal and external.

Role of the SSCB in Quality Assurance

1.4 The Children Act 2004 requires each Local Authority to establish a Local Safeguarding Children Board (LSCB or SSCB in Sandwell). The Sandwell Safeguarding Children Board (SSCB) is a key statutory mechanism for agreeing how relevant organisations in each local area will co-operate to safeguard and promote the welfare of children, and ensure that single agency and multi-agency work in child protection is effective and of a good standard.

1.5 The SSCB is committed to fulfilling the role of being a learning organisation and through its statutory functions and reviews, will scrutinise and challenge local safeguarding arrangements and practice in order to improve services to safeguard and promote the welfare of children in Sandwell. As such, one of the key functions of the SSCB is to review the quality and impact of safeguarding practice across the wider partnership. Traditionally this is done by a series of quality audits on practice, undertaken on a multi-agency basis but the role of the board in quality assurance is much broader.

1.6 The SSCB has a number of core functions, defined below, all of which need some element of quality assurance. These are:

- Develop thresholds, safeguarding policies and procedures and ensure they can be accessed by all
- Monitor and evaluate impact of safeguarding practice – both individually and by agencies and as a collective
- Monitoring partner compliance with the statutory requirement to have effective safeguarding arrangements in place via comprehensive Section 11 and S175 audits
- To collate multi-agency data across the partnership about safeguarding activity and to ensure that the SSCB has a clear understanding of the performance of agencies and to respond to emerging themes/trends and benchmarked to statistical neighbours
- Analyse information about child deaths, completing an annual report on key findings and disseminating learning through appropriate campaigns
- To ensure there is a coordinate response to unexpected deaths and adherence to the process.
- Undertake Serious Case Reviews, Child Death reviews and Individual Management Reviews, ensuring effective dissemination of learning across organisations.
- To fully utilise the learning and improvement framework to ensure that the quality and impact of training is assessed and that training available clearly reflects priorities identified by the LSCB

Defining Quality Assurance

1.7 Quality Assurance is the process by which we evaluate our work to understand if it is working and making an impact in Safeguarding children

- It is not about high level data – or simply how much we do and how quickly we do it.
- It is about checking if we did the right things at the right time and whether the end result was the best it could be for the children and families we work with.
- It therefore involves a review of the work we have done to provide learning for work we will do in the future.

1.8 This quality assurance framework will also consider that effective safeguarding can only happen by putting children and young people at the centre of the system which is underpinned by two key principles:

1. *Safeguarding is everyone's responsibility, each member of the SSCB should play their part and represent the views of the clients that they work with;*
2. *For effective services there needs to be clear understanding of the needs and views of children and young people.*

1.9 Partner agencies and all local organisations who work with children and families in Sandwell 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/challenging agencies who are not providing adequate resources
- Contributing to audits and reviews undertaken by the LSCB.
- Ensuring lessons learnt from SCR's, Audits and Reviews of are disseminated widely within their organisation (e.g. internal training, policies/procedures, implementing actions plans).
- Ensuring that lessons learnt from SCR's, Audits and Reviews are embedded into practice (e.g. evaluation via auditing, staff surveys).

1.10 Quality Assurance is a continual and inclusive process which incorporates analysis of quantitative and qualitative data to make recommendations for areas of improvement. This is not a standalone process and is structured and themed to take place across single agencies represented on the SSCB and through multi-agency processes.

1.11 By ensuring good quality assurance mechanisms are in place we will be able to effectively monitor whether the SSCB is functioning to achieve good quality outcomes for children against the business plan priorities and the SSCB improvement plan.

2. Our Approach to Quality Assurance

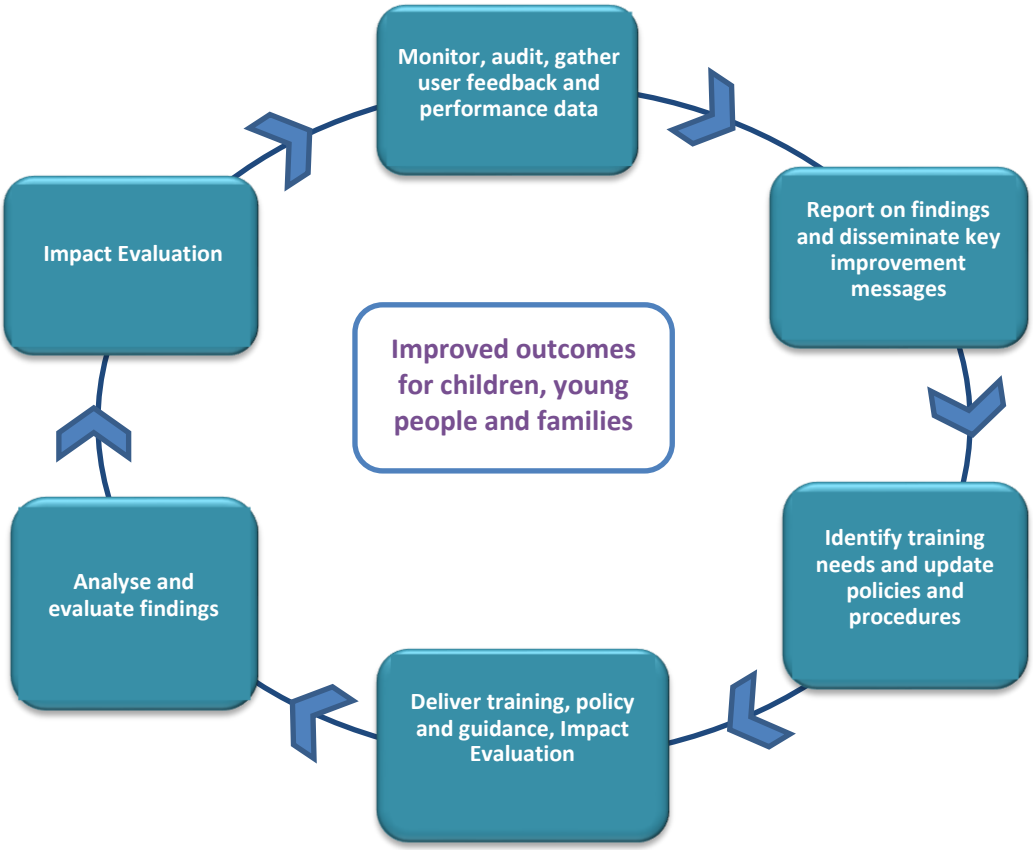
2.1 Our overall approach to Quality Assurance in Sandwell is to ensure openness and transparency and create a culture of continuous learning and challenge. The framework is underpinned by our commitment to establish a culture of cross - organisational learning.

2.2 A central part of the role of members of the SSCB will be to assess the impact of the work of the SSCB on outcomes for children and families and to understand if we could have met these earlier, better or with greater collaboration.

2.3 Our approach to Quality Assurance and a culture of continuous learning is demonstrated by our learning and improvement cycle (Figure 1), which

incorporates six stages. Each stage is essential for continuous improvement, identification of good practice and areas for further improvement.

Figure 1: Learning and improvement cycle



2.4 Each stage is essential for continuous improvement, identification of good practice and areas for further improvement.

- ***Monitoring, audits, performance data and service user feedback*** will provide a mechanism for identifying areas for quality assurance.
- ***Analysing key findings and creating a report on the findings and recommendations*** will provide a framework for dissemination of learning across the SSCB, subgroups, partners and organisations.
- ***By identifying training needs, updating policies and procedures*** we are establishing a process for implementing learning.
- ***Measuring the impact of recommendations from serious case reviews, child death reviews and multi-agency audits***, will give an indication if learning has been embedded and if practice has improved.

3. Key components of the Quality Assurance Framework

This section of the framework sets out the key component parts used by the SSCB to monitor the quality of its endeavours and the impact on outcomes for children. The framework will reflect the business plan in order to ensure that all activity carried out by the SSCB will be subject to quality assurance.

The Business plan has identified priority areas to be met and the framework will provide an underpinning structure to measure and assure these are achieved. These are;

Strategic Priority 1	*SSCB **communicates effectively** to ensure that the work of the Board is well publicised, that learning is disseminated and that the voice of children, young people, practitioners and the wider community (including minority groups and faith groups) are able to influence the Board's work.*
Strategic Priority 2	*SSCB is assured that **effective arrangements are in place** for responding to key safeguarding risks including early help, child sexual exploitation (abuse), neglect, domestic abuse, mental health of children and young people and that there is consistently good practice across safeguarding services.*
Strategic Priority 3	*SSCB has a **clear understanding of the effectiveness of safeguarding systems** in Sandwell (and can evidence how this is used to influence the Boards priorities*

There are key components that will underpin how the Quality Assurance Framework and the Learning and Improvement Cycle process will be achieved. These include;

- **Measuring Outcomes utilising qualitative and quantitative data**
  - A data set that links qualitative and quantitative data to identify areas for quality improvement and assurance and to measure against the business plan priorities
  - Performance reports drawn from the dataset routinely form part of the SSCB agenda and prompt scrutiny and challenge
- **Audits**
  - Undertaking a biennial Section 11 Audit with partner and Subject S11 submissions to rigorous challenge and monitor action plans
  - Undertaking an annual S175 Audit with all Education Providers in Sandwell and subject submissions to rigorous challenge and monitor action plans
  - Having a robust audit cycle with identified themes linked to the business plan priorities.
  - Learning from both multi agency and single agency audits which includes measuring the impact of this learning
  - Implementing a "Walking the Floor" exercise
- **Serious Case, Management and Child Death Reviews**
  - Recommendations and learning from SCRs, Child Death Reviews and Individual Management Reviews to be disseminated and monitored for evaluation of impact.

- **Policies and Procedures**
  - Ensuring SSCB have a full range of Policies that are updated in line with set review dates
  - Reviewing Policies against best practice
- **Service User Feedback**
  - A robust approach for collecting and analysing Service User feedback understanding what children and young people require to feel safe to ensure this is underpinning recommendations for improvement and effectiveness of the SSCB.
- **Workforce Engagement and Development-**
  - Proactive engagement of the workforce will help identify the safeguarding workforce's needs, inform training to aid their development and provide feedback on the effectiveness of the SSCB.
- **Partnership Working**
  - The SSCB recognises that collaborative working keeps children safe and ensures that they play an effective role in improvement, engaging all partners.
  - Engage faith groups in safeguarding children, focussing on specific areas of child abuse including female genital mutilation, honour based violence, CSE and child trafficking.
- **Governance and Scrutiny**
  - The governance structure and scrutiny measures will provide a clear line of accountability for the SSCB.

3.1 Measuring outcomes utilising qualitative and quantitative data

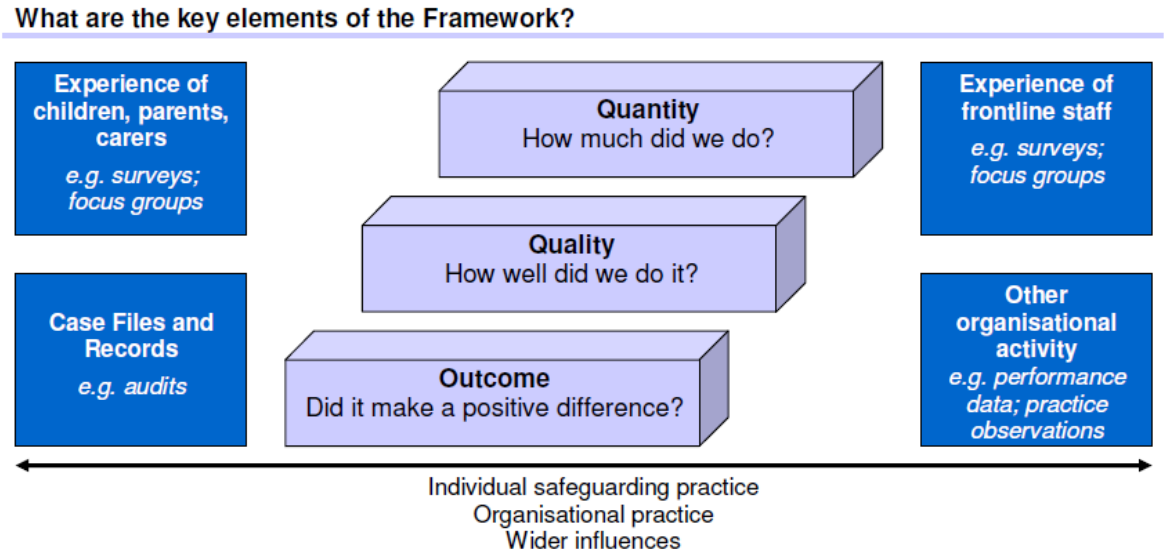
3.1.1 The core data set for the SSCB will provide a set of quantitative indicators linked to the business priority areas. This will also include additional information from each of the single agencies as for each organisation or partnership there are also service areas which are particularly important to 'get right' in terms of quality and outcome because of their known impact on **keeping children and young people safe**.

3.1.2 Quantitative information alone will not fully determine the impact of the SSCB or the quality of its activities. We intend to draw together both quantitative and qualitative information against our priorities to assess the difference made to safeguarding across Sandwell and the outcomes achieved as a result of our collective activity.

3.1.3 These can be defined as:

- **Quantitative** – This type of evidence is concerned with "how much or how many"; examples are data and trends, performance indicators and targets.
- **Qualitative** – This type of evidence is concerned with "how well something is done", examples are quality of assessments, case audits, mapping evidence to criteria and capturing the views of practitioners, children and families,.
- **Outcome –** This type of evidence is concerned with "so what", what difference has an intervention made to children and families and whether anyone is better off. Examples are reduction/cessation in harm, increase in attendance at appointments, improved well-being

Fig 2: Elements of the Framework



3.1.4 During the course of the current business plan (2015/2016) reporting will be implemented by the subgroups to reflect this approach. This will include quarterly quantitative reporting from sub-group agencies in the form of the updated dataset and yearly reporting on qualitative engagement with service users and the multi-agency workforce. Evidence of how outcomes are being met will be communicated via mid-year summary report to the SSCB chairs group, regular features within the Newsletters and the annual report.

3.2 Audits

3.2.1 The SSCB and Quality Assurance Framework has a particular focus on ensuring that those key people and organisations that have a duty under Section 11 of the Children Act 2004 or Section 175 or 157 of the Education Act 2002 are fulfilling their statutory obligations about safeguarding and **promoting the welfare of children and young people**.

3.2.2 Single, multi-agency, S175/157 and Section 11 audits will provide a key mechanism for quality assuring safeguarding practice in Sandwell and form an essential part of the Quality Assurance Framework

3.2.3 To ensure Partnership working is effective and all key partners are well engaged and make an active contribution to improve the delivery of services for children and young people a S11 audit will be conducted on an biennial basis and S175/157 audit on an annual basis.

3.2.4 The S175/157 & S11 submissions will be subject to rigorous challenge and moderated accordingly through a series of Assurance Panels, which are coordinated by the Quality of Practice and Performance sub group. At the end of each panel an action plan is agreed and is monitored by the QPP and reported into the SSCB sub group chairs meeting.

3.2.5 To evaluate single and multi-agency working the SSCB will require a structured programme of case files audits with a focus on:

- Looking at the involvement of the different agencies;
- and Identifying the quality of practice, adherence to protocols and lessons to be learned in terms of single agency, multi-agency and multidisciplinary practice.

3.2.6 On behalf of the SSCB, the Quality of Practice and Performance Sub Group will undertake quality audits of cases where there are two or more agencies involved in working with a family. The core membership of this group is based on social care, education, health and the police, and probation but other agencies are involved where relevant.

3.2.7 The schedule of audit for the Board will be influenced by and aligned to the priorities within the business plan. Audits may also be carried out in response to the findings of other elements of this Framework, such as analysis of the data set, emerging themes or outcomes of case audits/SCRs. Audits may also be instigated by changes to legislation or national agendas.

Fig 3: Audit Cycle

3.2.8 These audits are conducted using a multi-agency audit tool, and the analysis and findings are collated, including recommendations for further improvement, and reported quarterly to the SSCB.

3.2.9 Recommendations from audits are phrased as actions that need to be Specific, Measurable, Achievable, and Realistic and delivered within an agreed Timescale (SMART). These recommended actions must be accepted by the Board or the Chairs Group and monitored effectively by the wider Board. Some of the resulting actions will form part of specific subgroup action plans and be reported regularly to the SSCB individual subgroup meetings.

3.2.10 'Learning and recommendations from case file audit action plans are implemented and robustly monitored by the QPP

3.2.11 Embedding and evaluating the impact of learning from audits will be carried out through audits of previous audit recommendations along with following the process identified in the Learning and Improvement Framework.

3.2.12 Carrying out multi-agency audits will enable the SSCB to identify opportunities where agencies could have worked better together to **keep children and young people safe and identify actions to be shared with the workforce to protect children from serious harm in the future**. These should also be linked to the prevention of Serious Case Reviews.

3.2.13 Partnership working will be further strengthened through the implementation of "Walking the Floor" activities where Board members spend time with frontline practitioners in different settings

3.3 Serious Case, Management and Child Death Reviews

3.3.1 In conducting Serious Case Reviews (SCRs), Sandwell will adopt the criteria in Working Together to Safeguard Children (2015). The Independent Chair of the SSCB is aware of their responsibilities for initiating a SCR when a child or young person dies or suffers a serious injury or impairment, and abuse or neglect is known or suspected to be a factor. An SCR must also carried out when a child or young person dies in Police custody, in a Youth Offending Institution, in a Secure Training Centre, or where the young person was detained under the Mental Health Act (2005).

3.3.2 Under the new framework and evaluation schedule for inspections of services for children in need of help and protection, children looked after and care leavers (2015) Ofsted inspectors will require sight of the findings of any SCRs undertaken, and the outcomes of the evaluation of any such reviews. The SSCB is required to demonstrate that it has learnt from SCRs and that practice has evolved as a result of the review.

3.3.3 The SSCB should demonstrate good quality assurance in relation to SCR's by;

- Being proactive in ensuring that lessons are learned from SCR's and in disseminating information from SCR findings.
- Having an SCR process that not only does focuses on what went wrong, but also why it went wrong.
- Using SCR findings to drive improvement and to influence future plans
- Ensuring that recommendations are implemented, holding agencies to account for progression of their action plans.
- Learning from the process of carrying out SCR's
- Understanding how implementing the findings of SCR's make a difference to children, young people and their families.
- Ensuring the child's voice is included within the review but also any recommendations.

3.3.4 'Learning Lessons from Serious Case Reviews is embedded into the 2015-16 SSCB Learning Catalogue and engages all partners and evaluates well.

3.3.5 Lessons from Serious Case Reviews/ Management Reviews/ Audit activity/Child Death Reviews are effectively pinpointed and incorporated into both the learning and development cycle (and the performance management cycle) to ensure that lessons are learned

3.3.6 In reviewing the death of each child, the Child Death Overview Panel (CDOP) will consider modifiable factors and actions will be recommended to relevant partner agencies, for example, in the family environment, parenting capacity or service provision, and consider what action could be taken locally and what action could be taken at a regional or national level. (Working Together 2015).

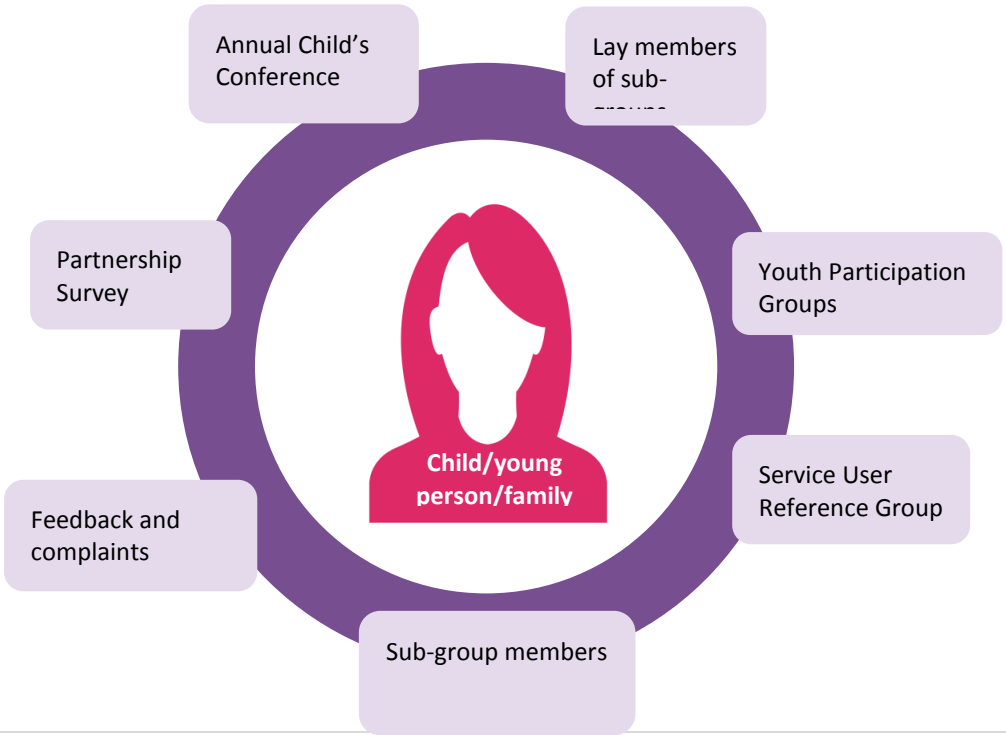
3.4 Policies and Procedures

3.4.1 The policies and procedures sub group will ensure there is a review schedule to ensure SSCB have a full range of Policies that are updated in line with set review dates that are reviewed against best practice.

3.5 Service User Feedback

3.5.1 Service user feedback is integral to our quality assurance framework and how we develop and improve our services. The key ways we gain feedback are outlined in Figure 4

Figure 4: Feedback methods



3.5.2 The SSCB approach to ensuring service user feedback is detailed below and should inform future priorities for the board including future training, policies and any key campaigns.

- **Lay members of sub-groups** – As well has having professional members, sub-group chairs will have the option to invite lay members from Sandwell to be part of the sub-group. This will provide additional scrutiny and ensure that the service user perspective is considered in decision making.
- **Youth participation groups** – Sandwell currently has existing young participation groups. The SSCB will utilise these groups in order to gain the service user perspective. This will include testing new safeguarding policies and procedures.
- **Sub group members** – Sub-group members often have contact with service users or supervise workers that do. They will ensure that they represent the views of those that use their service. Each agency will provide the SSCB with any information from service user consultations.
- **S175 Audit** – the QPP will work directly with schools through the S175 Audit and panels
- **Partnership Survey** – The SSCB will carry out an annual partnership survey during which partner agencies will have an opportunity to feedback information on how effective safeguarding services are for their clients.
- **Faith Communities** - In conjunction with SSAB, host a multi-faith awareness-raising event to illicit the voice of the community in their safeguarding work
- **Annual Child's Conference** – The SSCB will gather feedback from Sandwell Children Services' annual child's conference in order to influence decision making.
- The SSCB will demonstrate, through the quantitative and qualitative data of the '**Quality Assurance Outcomes Framework'** and the Annual Report that the views of service users has been utilised to influence the work of the SSCB

The SSCB's approach to service user feedback recognises that children and families are the experts on their own needs and will avoid being tokenistic, ensuring that any consultation creates actions. This will involve consultation on SCR's, **including children and young people's views on actions that would keep them safe from harm**.

3.6 Workforce Engagement and Development

3.6.1 A focus on quality assurance which not only encompasses process and practice can help build a sustainable culture of improving local practice and performance. A collective approach to quality assurance means that those individuals, groups and organisations conducting inspections, audits and other quality assurance approaches share responsibility for ensuring that all levels of staff are actively engaged in the quality assurance process and it is essential that all levels of staff play a part in driving forward good quality work.

3.6.2 The SSCB will engage the workforce utilising regular communication with partner agencies through the provision of learning approaches, training, the SSCB website, quarterly newsletters, news updates and conducting an annual survey.

3.6.3 The SSCB also has a responsibility to assess the effectiveness of single and multi-agency training. It also needs to be assured that sufficient quality and trained staff are in place across agencies to ensure effective safeguarding.

3.6.4 All agencies will report to the SSCB on single agency training provided. Some identified agencies will also provide information on staff numbers and turnover. This will be considered and monitored at the QPP sub group.

3.6.5 The SSCB will consider analysis of this information, alongside evidence of provision and attendance in relation to the multi-agency training provided under the auspices of the SSCB. This will be included in the Annual Report. The Board will also receive an annual report on allegations against staff and will oversee implementation of any guidance and actions arising.

3.6.6 The SSCB will be able to demonstrate its oversight of multi-agency training and workforce issues, and development of recommendations and actions in response to analysis of the information provided. It will also take a quality assurance role through the Learning and Development subgroup to ensure that training delivered is of high quality. This will be obtained through feedback on training which will be co-ordinated and reported quarterly by the Learning and Development Coordinator

3.6.7 The SSCB will utilise its' regular contact with the multi-agency workforce to gather feedback on current issues for service users, collect qualitative information on the safety of children in Sandwell and due to the multi-agency nature of training take note of any partnership working issues.

3.7 Partnership Working

3.7.1 The SSCB expects each partner agency to meet minimum standards for safeguarding including:

- Key professionals understand how to identify if children are suffering or likely to suffer abuse or neglect;
- Thresholds for access to services are clear, understood and implemented locally by all professionals working with children, young people and families;
- Practice is consistently **child-centred, effective and of a high standard, contributing to significantly improved protection outcomes for children and young people**;
- **Vulnerable children and young people are helped and protected** through a clear, outcome-focused plan that is shared with, and understood by, the family and regularly reviewed;
- Decision making for vulnerable children and young people is undertaken by suitably qualified and experienced staff and/or managers, as appropriate, and those decisions are recorded effectively;.

- Case recording is coherent, timely, reflects the work undertaken and the outcomes achieved, and includes an up-to-date case chronology;
- Information sharing between agencies and professionals is timely, specific and effective; and
- Multi-agency case conferences, strategy meetings and core groups are other multi-agency meetings effective. Information sharing between agencies and professionals is timely, specific and effective.
- Multi-agency case conferences, strategy meetings and core groups are other multi-agency meetings effective.

3.7.2 **The SSCB recognises the learning from SCR's and that a collective approach to safeguarding by agencies keeps children safe from serious harm.** This will be evident throughout its communication with the workforce with a particular emphasis on professionals maintaining relationships with families and continuous risk assessment after the family has become involved with children's services. The impact of this will be evaluated by feedback from professionals.

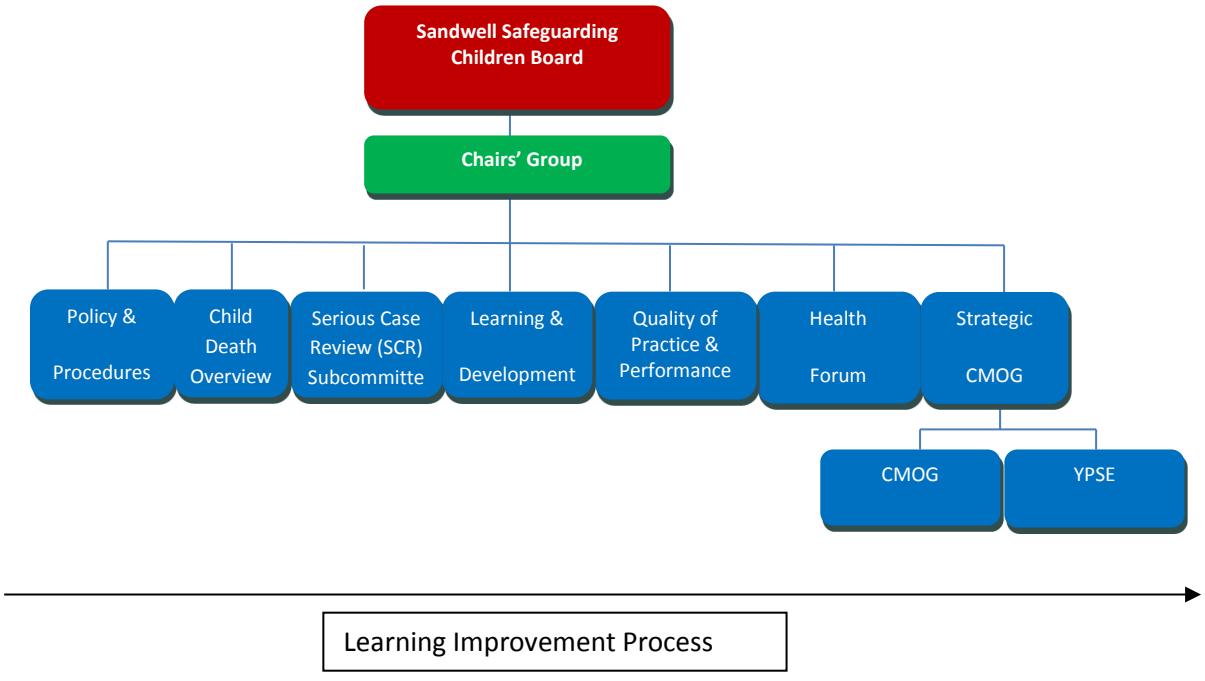
3.7.3 The SSCB will undertake an annual partnership improvement survey. This will be an online survey for all partner agencies and assess the effectiveness of currently multi-agency safeguarding arrangements through worker feedback and collate information on how this could be improved. This will also provide feedback and scrutiny for SSCB effectiveness.

3.7.4 To further ensure that children and young people are able to influence the work of the LSCB and that the wider community is involved through ensuring that the Board has active lay members and engages with faith groups

3.7.5 Work with the Local Family Justice Board to ensure it scrutinises outcomes for children within the court system

3.8 Governance and Scrutiny

Fig 5. The SSCB Governance and Accountability



3.8.1 The Quality Assurance Framework is owned by the SSCB on behalf of all partners in Sandwell. It is through the Board and primarily its Quality of Practice and Performance (QPP) Sub-Group that agencies will drive improvement to safeguarding of children through joint working and accountability to each other.

3.8.2 It is the role of the QPP to routinely monitor and scrutinise multi-agency performance, progress and quality, and support the SSCB Chairs Group in ensuring improvements are not only made but sustained.

3.8.3 The QPP is accountable to the SSCB Chairs Group. All sub-groups of the Board have a responsibility for actively contributing to the framework and implementation of the activities outlined within it.

3.8.4 Issues or exceptions should be flagged to the SSCB Chairs Group and SSCB Board as appropriate.

4. Quality Reporting

4.1.1 The SSCB will ensure that the data and quality assurance outputs are regularly reviewed through SSCB governance and challenge structures (Figure 5). The SSCB aims to create a learning organisation whereby key information and learning is disseminated, built into learning and training and embedded in practice, policies and guidance.

4.1.2 Each agency will collate qualitative and quantitative information and feed this back to the Quality of Practice and Performance Sub Group via the Quality and Governance Officer on a quarterly basis.

4.1.3 The quality and governance officer will collect this information, along with single agency annual reports into the annual report and the SSCB annual data set which will be shared with all sub-group members.

5. Implementing the Quality Assurance Framework

5.1.1 The Quality Assurance Framework will be monitored through comprehensive sub group minutes and action logs which will be discussed on a bi monthly basis at the sub group chairs group. Updates on quality from the SSCB sub groups will be overseen by the Quality of Practice and Performance.

5.1.2 The SSCB Improvement Plan will also be used to ensure quality is driven at the highest level, the progress of the plan is monitored and obverse by the SSCB chairs group on a bi monthly basis.

5.1.3 Quality Assurance will also be driven through the monitoring of S11 actions by QPP

5.1.4 QPP members who sit on other SSCB sub groups will be conduits for quality assurance.

5.1.5 The SSCB coordinators will work closely to ensure quality assurance is reviewed through each of the sub groups via the sub group action plans