HARROW SAFEGUARDING CHILDREN BOARD

QUALITY ASSURANCE FRAMEWORK 2015

Section 1. Introduction

In order to achieve its statutory functions, Harrow Safeguarding Children Board (HSCB) is required to have a good understanding of the effectiveness of safeguarding arrangements and services in its area. This Framework is set out to provide the HSCB with a clear structure for planning and overseeing its evaluative responsibiliteis and draws from the London Safeguarding Children's Board Guidance for strategic partnerships and individual organisations with safeguarding responsibilities *'Improving Local Safeguarding Outcomes' (2011).*

The Framework also incorporates the lines of enquiry applied by the LGA LSCB *Diagnostic Tool (2015)* to establish whether the HSCB is effective in its scrutiny arrangements and in its response to the findings from the quality assurance processes (Appendix A).

The London LSCB Framework contains three elements:

1. The identification of the HSCB's areas for examination – including current priorities
2. The identification and application of three types of performance information for each area under examination
3. The need to obtain information from an appropriately balanced range of sources, using a range of sources methods

The idea of this framework is that a wide range of people within organisation can and should be involved in the collation of quality assurance information. Quality assurance needs to be owned and sustainable, an important part of the core business for both the HSCB and its member agencies.

Element One: The identification of the HSCB's areas for examination – including current priorities

There are many dimensions to safeguarding that trying to quality assure everything would be overwhelming. The HSCB therefore needs to focus on a discreet number of defined areas which the partnership concludes are the most important in meeting the current and future needs of children in the area.

Practice Content Areas: These defined areas incorporate both nationally and locally identified risks and vulnerabilities

Organisational/Practitioner Content Areas: Evaluating the quality of the workforce and how it is supported through supervision, training, working environments and practice tools is a critical component of understanding its effectiveness.

The working environment extends beyond physical environments and therefore, evaluations must also include scrutiny of organisational cultures. Evaluations must establish whether organisations promote a positive culture of learning and improvement, in order to achieve better outcomes for children.

The HSCB will also seek evidence for the application of evidence-based practice, particularly when funding within services is challenged and risks may impact on jointly agreed priority areas.

Wider Picture Content Areas: Environmental factors such as poverty, poor health outcomes, low educational achievement, and poor housing and crime rates are significant sources or pressure and stress for families. This Framework therefore includes relevant environmental factors.

Element Two: The three type of performance information

Quantitative Information: simply answers the question 'How much/how many?'; for example, the number of children subject to a child protection plan, the number of assessments completed, the number of training days provided, the number of incidents of domestic abuse referred by the police.

Qualitative information: will tell us something about the quality of what was done 'How well did we do it?' This relates to the functioning of organisations, for example, the percentage of people who completed parenting programmes, the percentage of staff who thought their skills had improved as a result of training, the percentage of adult mental health assessments and care plans base on the 'Think Family' principles.

Outcome information: tells us what difference the services, strategies and interventions made to the lives of children and their families 'Is anyone better off?', for example, the percentage of children reporting their family life is happier/safer, the percentage of those completing drug programmes who stop using drugs.

The best way to measure impact/outcomes is for professionals, children and parents to compare the child's / family's position at the point of assessment and then at later points. The key is to frame objectives for the child and family in terms of measurable outcomes which describe what life would look like if services provided and actions by the family have been successful.

Element Three: the different sources of information and methods for obtaining it

Experience of Children, Parents and Carers

One of the most important questions that need to be asked of children, parents and carers is what difference the interventions and services have made to their lives: are things better as a result and in what way? The voices of children, parents and carers will have greatest impact if they are heard directly by both senior and frontline members of organisations.

Methods

There is a range of methods that can be used to capture the experience of children, parents and carers. Where possible, these should be sustainable methods which are part-and-parcel of how organisations conduct their day to day business (e.g. capturing their experiences at key points of involvement: beginning, review, and ending). Specific exercises can be commissioned:

- User survey/interviews conducted by phone or in person – ideally by people who are, and are seen to be, independent of services
- Focus groups
- Senior managers/councillors/LSCB members talking directly to service users or observing visits, interviews etc.

Key messages from customer experience exercises can be aggregated so that quality and outcome statements can be made e.g. 'The percentage of parents who reported that actions by the social worker/health visitor resulted in positive improvements for themselves/their children…'

In addition, there can be more detailed customer stories of their experiences so that the meaning of their experience is also communicated.

Involving Frontline Staff and Managers

The perspective and experiences of frontline staff and managers is crucial in understanding the effectiveness of their individual agency and partnership working.

When dealing with complex human organisations, what is meant to happen in the policy and procedure, and what actually happens can be different things. There needs to be a constant feedback loop from the frontline to keep senior managers and those with governance responsibilities 'reality-based'; not just in terms of what

is/is not working, but also with ideas for improvement so that adjustments can be made systematically.

Methods

The starting point needs to be the development of a culture which demonstrates that the views of staff are valued and taken seriously – and that is appropriate to raise constructive challenges to the organisation.

Methods can include:

- Staff survey exercises and focus groups targeting one or more of the content areas
- An annual partnership survey in which frontline staff in all organisations are asked to evaluate the strengths and weaknesses of partnership working
- Exist interviews
- For those with senior leadership, management or scrutiny responsibilities 'walking the floor' – and observing frontline practice and talking with staff.

As with the experience of children and parents, the experiences of staff need to be communicated in an aggregated form, but also in terms of their stories.

Parents' and children's case records

The case records held by organisations, in whatever format, will be a rich source of information.

Methods

Case record 'auditing': the systematic analysis of records by staff with relevant professional expertise, taken from a sufficient sample of cases to provide a picture of what is going on through aggregating the findings.

Some auditing needs to be continuous as part of regular management oversight arrangements; some will be specific exercises, programmed into the organisation's quality assurance timetable.

Case auditing will include both single agency audits reported to the HSCB for scrutiny as well as the multi-agency case audits led by the HSCB itself.

Governance: HSCB collated Information and Single Agency Management Information

Management information about safeguarding: Most organisations will have some form of electronic or paper client information system that can produce management

information reports – usually quantitative information, with some degree of qualitative information. The HSCB scrutinises this information via presentation of multi-agency quarterly reporting aligned with its agreed data set and through annual or exceptional reporting.

Other organisational activity and management information systems: Organisations will have a range of information in their systems which is relevant to safeguarding quality assurance including Human resources, Finance and learning /development systems e.g. vacancy rates, training completed and expenditure on services)

Peer deep dive reviews: this involves looking at one of the content areas in depth – in particular a priority area for the HSCB. This can be done internally, with a multi-agency review group, or externally to gain further independence and or expertise into the area of scrutiny. .

Academic institutions: Universities with relevant research teams are a possible resource for undertaking quality assurance work.

Inspections: provide insights into a number of the areas in this framework, measured against national inspection criteria.

Serious case review and other reviews: Overview reports undertaken by independent consultants help to answer the question 'how safe and effective are the local safeguarding services and arrangements?'

Other models of capturing learning can include cases that were near misses or where good outcomes were achieved.

Messages from research: help LSCBs know what to focus on, providing a context and benchmark for making sense of what is found about the local position and, in terms of the improvement cycle, can offer ways forward.

Section 2: The identification of the HSCB's areas for examination – including current priorities

1. General LSCB functions – 'Working Together to Safeguarding Children 2015'

To fulfil its statutory functions under regulation 5 of the Local Safeguarding children Boards Regulations 2006, an LSCB should use data and, as a minimum, should:

- Assess the effectiveness of the help being provided to children and families, including early help;

- Assess whether LSCB partners are fulfilling their story obligations set out in chapter 2 of Working Together to Safeguard Children 2015;
- Quality assure practice, including through joint audits of case files involving practitioners and identifying lessons to be learned; and
- Monitor and evaluate the effectiveness of training, including multi-agency training to safeguard and promote the welfare of children.

2. HSCB priorities

In identifying 'content' or priority areas for examination, the HSCB needs to focus on a discreet number of defined areas which the partnership concludes are the most important in meeting the current and future needs of children in the area. Few organisations will have the capacity to immediately capture all the information they need to determine how good their position is in all the areas. The framework needs to be manageable and can be built up over time.

At the beginning of every year the HSCB holds a Business Development meeting to evaluate its performance against its previous business plan and to establish what its new or extended priorities should be. The Development meetings are facilitated by an external consultant to help add further challenge to the achievements and ambitions of the HSCB.

To establish its priorities, the HSCB draws upon developing national agendas and local information, including the Joint Strategic Needs Assessment, learning from reviews, audits and management information from across the partnership.

The agreed priorities are then built in to the overarching quality assurance programme. All work plans for the HSCB sub-committees are required to align their work with the HSCB's statutory annual functions and/or its current areas of priority.

It is anticipated that there will be considerable crossover between the content areas identified by the LSCB and individual agencies. This will enable the LSCB to draw together the information from its partner organisations into a collective overview of safeguarding quality and effectiveness across it whole area.

Section 3. The identification and application of different types of performance information for each area under examination

The HSCB will identify different types of performance information for identified 'content' or priority areas. This will help to provide a more reliable overall picture of performance and test the methods applied where any inconsistencies are found. The performance information will be measured against national descriptors and local expectations of what 'good' should look like.

Wherever possible, reports to the Board should include a summary what good looks like, performance information with comparative information; analysis and action for improvements

in quality and outcomes. Reports should also capture the experiences of parents, children and frontline staff.

As part of day to day business for the Board and its member agencies, some of the information will already be collected on a regular basis. By establishing what it needs to know regarding new priority areas, the HSCB will also identify any additional information that needs to be sought.

The information will be classified under the three headings: **quantity, quality** and **outcomes.**

How to achieve a longer-term overview of progress

To develop a sustainable and manageable timetable, it will be necessary to think longer than one year. The HSCB should aim to gather some quality and outcome information continuously by adapting or introducing sustainable methods to existing business processes. Some information will require specific exercises that need to be planned for e.g. annual auditing or peer reviews. Other information can be sought bi-annually or every three years e.g. external peer reviews.

The timetable will need to be responsive to any exceptional reporting required or to any inspection findings.

Developing a clear organisational learning and improvement cycle.

The HSCBs can use this framework to structure its quality assurance activity by:

- Developing its own quality assurance timetable in which it will undertake or commission additional quality and outcome exercises which have a cross agency or thematic focus.
- Taking at least one major deep dive review of a content area as part of a three year programme; each year undertake at least one repeat audit and review exercise.
- By considering themed reports from agencies alongside each other, the HSCB would be able to identify relationships, dependencies, gaps and cross-cutting issues. By doing so, it will build up an overview picture of safeguarding in the area.

Learning and improvement cycle

The fundamental purpose of this framework is to improve outcomes for children. It therefore needs to be part of a clear improvement process;

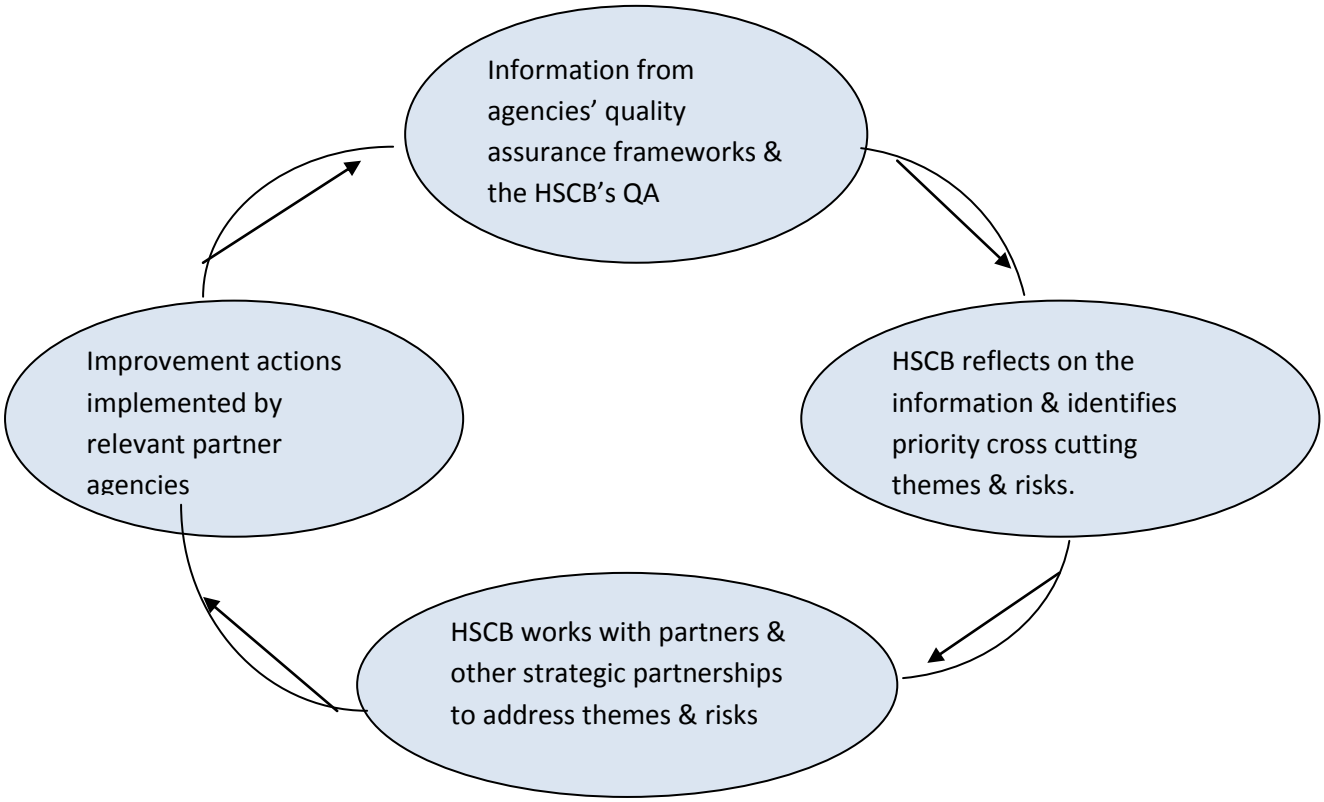
The single agency annual reports and the annual report of the LSCB should contain the key actions to be taken to improve quality and outcomes over the

next 12 months. These reports should include summaries of the messages from children, parents and frontline staff.

The HSCB member agencies should ensure that information also reaches frontline teams. They need to know how parents, children and other professionals experience what they do in a collective sense. This helps to make quality assurance a dynamic process which can have an immediate impact. It can generate ideas from front line staff and their teams on what can be done to improve effectiveness in keeping children safe.

The findings contained in the HSCB's annual report should be shared with other strategic partnerships – giving a focus on outcomes and impact.

Improvement Cycle:



Key questions for the HSCB

- How well have patterns and themes been identified from review and auditing activity?
- Is there a good balance of quantitative, qualitative and outcome measures?

- To what extent do evaluative methods focus on the impact for children and their families?
- Are good practice and effective interventions identified?
- Have audits been directed at priority areas for the HSCB?
- Are recommendations from review and audits SMART?
- Is there evidence that recommendations have been acted upon in a timely manner
- How do lessons from audits and reviews reach front-line practitioners
- What are the mechanisms for receiving feedback from children and their families?

Structure of the HSCB's Quality Assurance Framework

Part A: comprises statutory responsibilities which are expected of all LSCBs and will are carried out from one year to the next. This section outlines how these responsibilities will be evaluated.

Part B: comprises the priority areas agreed by the HSCB and how they will be evaluated. These may be changeable from one year to the next.