Wolverhampton Safeguarding Children Board

Quality Assurance Framework

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Working Together 2015 states that Local Safeguarding Children Board (LSCB) has a statutory responsibility to:-

- '*monitor and evaluate the effectiveness of what is done by the local authority and Board partners individually and collectively to safeguard and promote the welfare of children and advise them on ways to improve'* (Regulation 5c of the LSCB Regulations 2006).

This should include as a minimum:

1. assessing the effectiveness and impact of the help being provided to children and families, including early help;
2. quality assuring practice, for example through joint audits of case files involving practitioners and identifying lessons to be learned;
3. assessing whether Board partners are fulfilling their statutory obligations under Section 11 of the Children Act 2004, and parallel duties, and asking board partners to self-evaluate.

The approach and framework applied to undertake this function is informed by national, regional and local safeguarding aims and objectives, research and analysis that is underpinned by 'Working Together to Safeguard Children – a guide to inter-agency working to safeguard and promote the welfare of children' (April 2015).

This framework is designed to ensure that Wolverhampton Safeguarding Children Board (WSCB) effectively meets these requirements, which will complement the existing Section 11 audit which is already embedded and used to ensure that point (3) above is being addressed.

2. The commitment of Wolverhampton Safeguarding Children Board (WSCB)

WSCB is committed to a culture of continuous learning and through this Quality assurance framework will:-

- Ensure a **'full range of reviews and audits'** monitored and reported though the Quality & Performance Committee (Q&PC).

Q&PC's main responsibilities are:-

- To review and embed the 'safeguarding outcomes' work stream of the Business plan.
- To develop challenging and rigorous approaches to monitoring and evaluating the impact of services on safeguarding primarily through S11, multi-agency and thematic audits.
- To collect, analyse performance information in relation to all aspects of safeguarding, identifying themes and areas requiring action and report these at each main Board meeting.

The range of reviews and audits conducted through Q&PC include:

- Serious Case Reviews.
- Child Death reviews.
- Partnership reviews.

- Bi-annual Section 11 reviews and action plans.
- Thematic Audits.
- Multi Agency Case File Audits.
- Single Agency reviews.
- Annual risk Register review.
- Review of regular practitioner focus group meeting issues.
- Peer reviews.

- Through the **Serious Case Review** (SCR) Committee and **Child Death Overview Panel** (CDOP) processes, use systems methodology to assess how the actions of professionals are influenced by their organisations and systems in which they are working. To ensure that lessons learned from these reviews are implemented and positively impact on the improvement of safeguarding and promoting the welfare of children.

- Through the **Law, Policy and Procedure Committee** help organisations develop new procedures and practice guidance and take a lead in developing and endorsing policy and procedures in respective of multi-agency activities.

The primary challenge of quality assurance is to improve the quality of practice and safeguarding outcomes for children and young people. It is not simply about providing data about performance.

3. What is the QA Framework?

The framework is based on an 'Outcomes Based Accountability' (OBA) approach which will help organisations to understand a given area of business/concern by considering:

- What, and how much we do
- How well we do it
- What difference have we made/is anyone better off?

3.1 Content Areas

The areas of focus **(also referred to as themes)** will be determined by local need following consultation with Board partners and informed by evidence such as findings from research, audits, management information and learning from serious case reviews.

Using analysis of research and messages from, Local Government, the following are possible types of content areas:

3.2 Practice Content Areas where the focus is on the following;

Priority Service Areas such as:

- The front door and operation of children in need/child protection assessment and care planning in social work.
- *Vulnerable Groups of Children & Young People* such as children at risk of, or have/are being sexually exploited, children out of education, those regularly missing health appointments.

- *Specific Risk Issues* such as domestic abuse, parental mental health, parental substance misuse
- *Partnership Working* such as practical working arrangements, information sharing and communication and not solely between different organisations but also what happens between different services and professionals within a single organisation.

3.3 Organisational Content Areas where the focus is on issues such as

- workforce & capacity,
- learning & development,
- supervision and support,
- organisational culture,
- Use of resources and evidence-based practice.

3.4 Types of Information

Following agreement of the subject theme, a number of statements will be produced which set out what 'good' should look like in terms of quality and outcomes. This will inform the performance information and measures required for each content area.
There are three types of performance information/measures, these are as follows;

Quantitative information

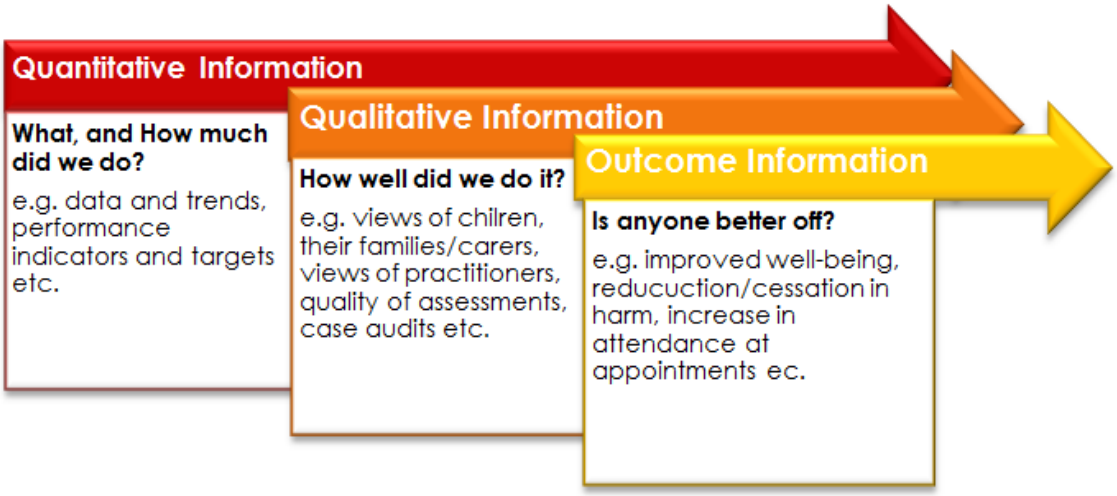
This will help to inform ***what we do***. It answers the questions: 'How much/how many?' For example, 'how many children were made subject to a child protection plan, how many assessments did we complete, how many days training did we provide, how many incidents of domestic violence were referred by the police' etc.

Qualitative information

This will tell us more about ***how well we do it***. It is concerned with the functioning of the organisation, the quality of what was done; for example, 'what percentage of staff trained thought their skills had improved as a result, what percentage of assessments were analytical or kept a child focus, or the percentage of parents who felt that they were treated with respect.'

Outcome information

This tells us ***what difference we have made*** (through our services, strategies and interventions) to the lives of children and their families, namely 'is anyone better off.' For example, the percentage of cases in which domestic violence has ceased the percentage of children who feel safer as a consequence of the intervention they received.



3.5 Sources of Information

Having defined the content areas and the performance information needed, the sources of this information will need to be determined. By and large, two main sources of information have been used in safeguarding quality assurance: data from management information systems and children's/families case records (for example through audits).

Whilst it is recognised that these are important and valuable sources, in order to get a full picture of what is really happening, it is important to capture the experience of children, parents/carers, and the views and experiences of frontline staff and managers.
Therefore the information for quality assurance will come from the following four main sources;

- Consultation with children, parents and carers
- Consultation with front-line staff / managers
- Parents'/children's case records
- Other organisational activity and management information

The most important question that needs 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 experience of children, parents and carers
Obtaining the views of parents and children in safeguarding work requires further development to ensure a full understanding of the quality and impact of services and the source of learning and organisational development.

Understanding parents, carers and children perceptions on how they feel they are treated by the professionals and agencies they interact with is crucial as negative experiences are likely to have an adverse impact on outcomes for children, young people and families. The continuity and quality of relationships, whether people feel listened to, respected, valued and not judged, whether their personal stories are heard, the way in which child protection investigations are explained and handled are all examples of what matters to parents and children.

The experience of front-line staff / managers
Staff and frontline managers will often know about the quality and impact of their own services, and those of partner agencies they work with. Serious Case Reviews have highlighted the false assurance between what is meant to happen in terms of policy and procedure, and what actually happens. It is important to have a constant feedback loop from the frontline to keep senior management and those with governance responsibilities 'reality-based'; not just in terms of what is or is not working, but to assist with ideas for improvement so that changes can be made systematically.

Methods

All partner organisations will need to consider how they collate quantitative, qualitative and outcome-based information from the four sources to inform improvement activity in respect of their safeguarding practice Where possible, partner organisations should use sustainable methods which are part-and-parcel of day-to-day business such as capturing the experience of children/parents at key points of involvement and activity e.g. single assessment, review, closure. For example, practitioners should routinely ask 3 simple questions of service users (children & young people)?

1. Did I listen to you and take account of your views?
2. Did I treat you with respect?
3. Did I make a difference to your life in terms of keeping you safe and well?

In addition, other specific activities can be commissioned or utilised such as the following;

- service user surveys or interviews
- focus groups
- direct contact with senior managers/board members and elected councillors

The messages from children and parents can be reported in two forms:

- aggregated reports of quality and outcomes statements, for example, 'the percentage of parents who reported that they had a good relationship with their health visitor'
- more detailed account of the service users 'story' so that meaning of their experience is communicated

3.6. Measuring impacts and outcomes

It is the duty of WSCB to ensure that processes are in place to measure the impact or outcome for any intervention or training.

This is done primarily through the range of reviews and audits outlined in section two.

These measures are both quantitative and qualitative which should ultimately lead to improved outcomes.

Measure	Evidence	Targets or indicators
Quantitative data (Impacts) e.g. • How much? • How many?	– No. of contacts received by MASH – No. of EHAs completed – No. of looked after children – No of serious case reviews – Attendees at training courses	– Targets set in service plans
Qualitative information e.g. • How well did we do?	– % of attendees has increased – % of complaints – No. of social care referrals decreases – % of LACs who say they feel safe in their placement	– Local measures and performance data – Evaluations
Outcomes e.g. • How are children/families better off? • How have outcomes improved?	– % of families reporting improved well-being increases – Trainees report improved confidence in a specific practice area – % of parents interviewed who say their skills have improved. – % of cases where the investigation did not identify a risk to children	– Customer Surveys – Face to face feedback – Audits

3.7 Working Together 2015 States that LSCBs have a duty to:-

*'Asses the effectiveness and impact of the help being provided to children and families, **including early help.**'*

WSCB will aim to ensure there is **sustainable improvement** in outcomes for children and families.

4. WCSB Quality Assurance Framework

This process is designed to provide a systemic approach to quality assurance. It outlines the role of the Board at each stage.

Systemic Approach	WSCB Roles and Responsibilities
Step One – Identify content areas and agree priorities. • Identify partner and Board areas for measurement? o Are the partner priorities linked to the Boards performance dataset/ indicators?	• Challenge and agree priorities. • Agree measures • These are based on sound local needs analysis?

Step Two – What does 'good' look like.
• What does 'good 'look like for the WSCB Priority area and each content area?
  o Work with each agency and partners to identify what 'good' looks like for their service.
  o What service standards are currently in place that defines these?
	• Provide support for definitions of 'good' in each content area.
	• Capture case study data and share where appropriate.

Step three – Identify source of current performance information.
• What information does the Board or partner currently collect?
  o Is it qualitative, quantitative?
  o What targets are these linked to?
  o What are the timelines?
	• Ensure that data is up to date and accurate
	• Is the data relevant to Board's Performance Dataset?

Step Four – Identify sources of any additional information. • What additional information/data do you need to collect to contribute to the 'good' indicators in step two o How do you capture this information?	• Assist partners with information gathering. • Do any other partners collect similar data?

Step Five – Agree a quality assurance timetable.
• What is the Board or partner 'quality assurance' timetable to ensure this information continues to be captured?
  o How can the Board support
  o Will it be captured as part of Section 11 review?
	• Agree QA timetable with partners and peer review support where appropriate
	• Identify any risks which need to be captured at partners or WSCB strategic level.

4.1 Success criteria - What does 'Good' look like across the WSCB partnership?

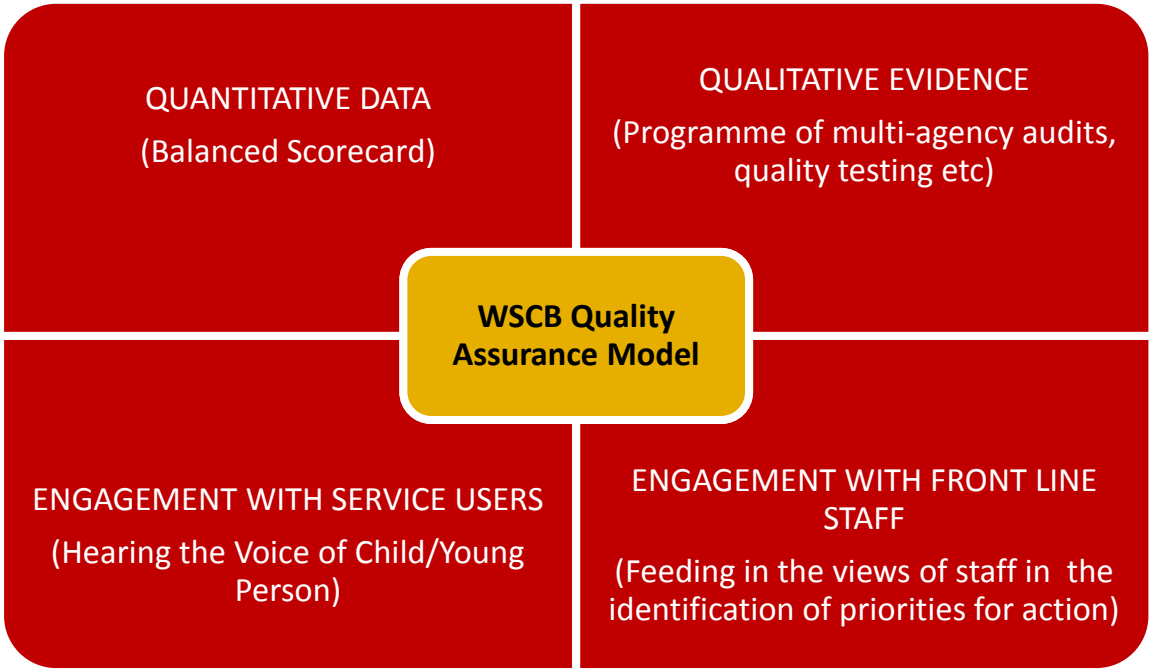
Quality can only be measured if there is a 'desired picture' for each service/content area which can be compared against performance data. Measures of quality should result in **sustained improvement**.

Some examples below of what 'good' may look like in terms of outcomes/Impact across Board partners:-

Examples of outcome statements	Examples of Impact measures
Children's Services • Child protection plans result in objective, tangible improvements in the wellbeing and safety of children and their families • Parents feel empowered and more confident as a result of the involvement of the service • Young people are reporting that they feel safe to walk the streets. • Young people who are not attending school have a route to improve their educational outcomes which in turn is improving their confidence and self esteem • Young people are reporting that a result of the intervention their mental health has improved and consequently their risk taking behaviours have decreased.	• YOS are reporting that crime levels in a particular location are decreasing and targeted individuals are receiving increased levels of 1-1 support. • Mental Health referrals from Schools are decreasing • Incidents of assault on the location have decreased • The number of children reported as 'missing' has decreased over the past 6 months
Police • Families are reporting that Police attending domestic violence incidents treat them with respect, involve the children and provide clear information • Staff feel more confident in dealing with domestic incidents	• The number of DV/DA incidents reported to the police has decreased • Referrals to Social care arising from DV incidents have decreased
Health • Antenatal, midwifery, urgent care and paediatric services are effective in identifying risk indicators and/or potentially vulnerable children and young people thereby reducing any concerns • Staff across the range of Health Services; respond proactively to miss appointments.	• The process for identifying safeguarding cases at A+E are robust • The number of safeguarding cases at NCH A+E has decreased • The number of complaints from Parents have decreased in the past 3 months

Multi-Agency Safeguarding Training (All agencies) • Staff who have received safeguarding training report that they feel more confident in dealing with particular family interventions. • Professionals in the service are operating at a required level of safeguarding children practice competence	• Training evaluations show that and increased no of delegates marked 'excellent' • The numbers of people attending courses has increased

5. The Quality Assurance Model to be applied.



What we do with the information collated is as important as the quality of information we collect. Therefore, the learning from quality assurance will be shared with partners and used meaningfully to change practice and improve outcomes for children, parents and carers.

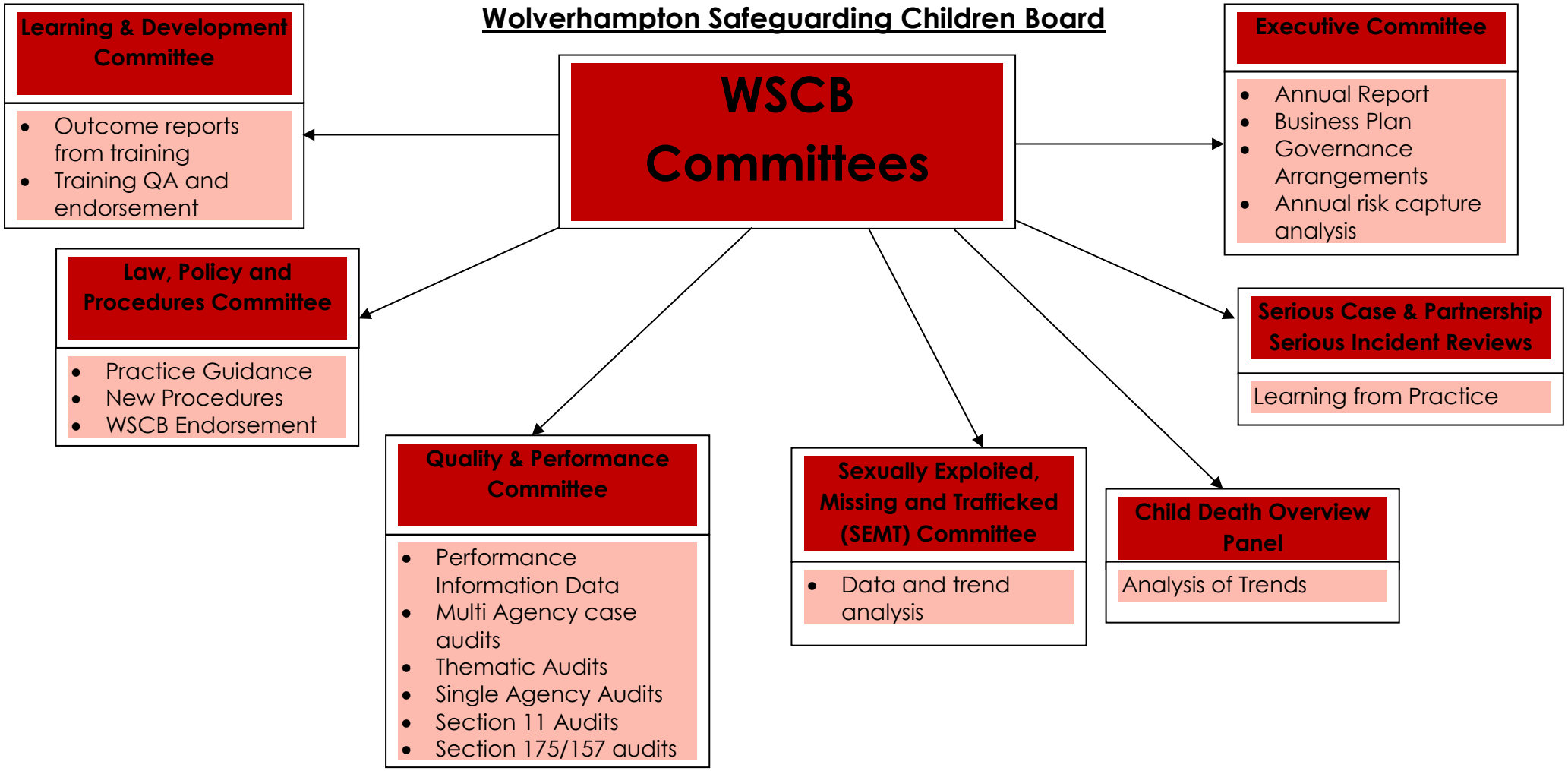
Learning will be linked to the following areas:

- Training
- Team Meetings
- Workforce planning and development
- WSCB Communication Strategy/Plan
- Policy & Procedures
- Commissioning
- Supervision
- Partner Agency Improvement Plans
- WSCB Business Plan
- Workshops and/or discussion Forums

Consequently, it is important that the outcomes of the quality assurance activity inform the input of the work of other Board Committees in line with the WSCB Learning and Improvement Framework.
Progress on quality assurance will be an agenda item at each Q&PC meeting, and this will include reports on key findings, including good practice, any significant risks and/or improvements.
In addition, each year, the Q&PC will review the quality assurance programme for the following year and prioritise the QA content areas.

This area of work for the Board work is critical and based upon the outcomes of this function (and other reporting mechanisms currently operated by the Board and partners within their agencies), in accordance with the provisions of Working Together 2015, the annual report will rely on a detailed analysis of the effectiveness of child safeguarding and the welfare of children within Wolverhampton. The report, through scrutiny of the evidence gained via the quality assurance programme, will highlight good practice and identify where (and how) improvements are to be made.

Quality Assurance Structure



Priority areas for Quality Assurance Compliance 2016

	Description and purpose of Review or Audit	Reporting and Timescale
Serious Case Reviews	To assure the Board that recommendations arising from the lessons learned from Serious Case Reviews are implemented and positively impact on the improvement of safeguarding and promoting the welfare of children	Update to Q&PC as SCRs arise. To WSCB as part of half yearly Performance report
Child Death Review Data	To regularly update the Board on performance in numbers of preventable deaths of children and identify recommendations for action to reduce the number of preventable deaths	Annual full report to Board Quarterly updates via CDOP report to WSCB
Partnership reviews	Criteria for SCR considered but deemed not to reach the threshold. Where referral gives rise to a concern around multi agency working and lessons need to be learned.	Update to Q&PC as cases arise. Recommendations to Board
S.11 Audits and annual reviews	Self-assessment tool designed in partnership with Black Country LSCB's. Designed to assist partners to self-evaluate their own policies, procedures and activities in relation to safeguarding as defined in Section 11 of the Children Act 2004. Helps agencies to reflect upon their practice, identify strengths and weaknesses and to develop an action plan to further enhance effectiveness.	Bi-Annual audits Rolling annual programme of reports on Action Plans to Board by partner agencies over 2 year cycle

Section 175/157 Audits	Section 175 of the Education Act 2002 places a statutory duty on the LEA, Governing Bodies of schools, and FE institutions to safeguard and promote the welfare of children. Section 157 of the same act places the same duty on Independent schools. Audit conducted by School Standards Team (SSVPT) and reported bi-annually to Board Areas for development/improvement collated in an Action Plan to be monitored via Q&PC	Bi-annual programme of audits. Report to Board via SSVPT Action Plan monitored via Q&PC
Single Agency audits and data	To assure the Board that members are monitoring their own Safeguarding practice effectively, this function provides independent scrutiny of targets and performance. Reports to the Q&PC will identify any performance area which might be of concern to the Board, together with action being taken by the Agency	Reports to Q&PC and the Board by single agency when requested
Multi Agency Audits	Quarterly audits on approximately 4 cases designed to assess the quality of work undertaken by all agencies where there are concerns about children throughout all stages i.e. Early Intervention, Referral, Assessment, Planning, Review and Management oversight and recording. Identify any areas which are working well and areas requiring improvement in compliance with practice or procedures.	Quarterly report via Q&PC to Board.
Thematic Audits	To assure the Board on areas of particular concern identified by the Board from performance information Different mechanisms which allow themes or current issues to emerge, which may lead to the need for a thematic audit. These are:- 1. WSCB mullti-agency practitioners focus groups - 2 times a year	Progress reported to Q&PC. Findings reported to Board/Executive Committee as appropriate.

	2. The Local authority Peer Review - Last one in March 2012. 3. Section 11 Audits and S175/157 bi-annual reviews Regulatory Inspections of LA and/or partner agencies safeguarding services	
Annual Risk Register	As part of the process of recording and monitoring risk, the Executive Committee monitors and reports annually on Board risks at .	Annually to main Board and part of performance reporting where appropriate.
Peer reviews	On-going process of peer review through a number of mechanisms i.e. 1. <u>Regional Safeguarding Network/ meetings</u> Quarterly meetings to discuss policy and share good practice 2. <u>Sector Led Improvement programme</u> Led by Strategic Director and LSCB chairs	Various meetings on going throughout the year.