2017-2018

SSCB Quality Assurance Framework

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).

Role of the SSCB in Quality Assurance

1.3 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.

1.4 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.

1.5 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 S175/157 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
- 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.
- Analyse information about child deaths, completing an annual report on key findings and disseminating learning through appropriate campaigns
- 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

1.6 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.

1.7 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.*

1.8 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).

1.9 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.

1.10 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.

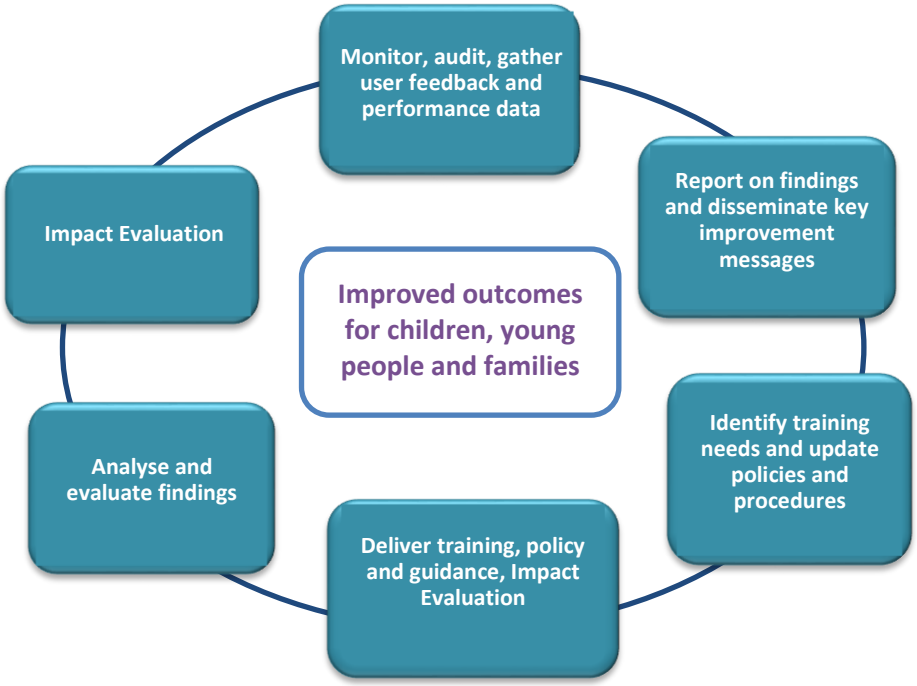
2. Our Approach to Quality Assurance

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



- ***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

- The SSCB data set 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 Audit for Section 11 of the Children Act 2004 with partner and subject audit submissions to rigorous challenge through a series of Assurance Panels and monitoring of action plans
- Undertaking an annual Audit on 175 or 157 of the Education Act 2002 with all Education Providers in Sandwell and subject submissions to rigorous challenge through a series of assurance panels and monitoring of action plans
- Having a robust audit cycle with identified themes linked to the business plan priorities. and in response to the findings of other elements of this framework such as analysis of the data or emerging themes from serious case reviews or child deaths. Audits will
  - Use a multi-agency audit tool
  - Look at the involvement of the different agencies;
  - and Identify the quality of practice, adherence to protocols and lessons to be learned in terms of single agency, multi-agency and multidisciplinary practice.
- Embedding and evaluating the impact of learning from both multi agency and single agency audits through audits of previous audit recommendations along with following the process identified in the learning improvement framework

Serious Case, Management and Child Death Reviews

- SSCB will 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
- Lessons from Serious Case Reviews/ Management Reviews/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
- 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).

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

- Service user feedback is integral to our quality assurance framework and how we develop and improve our services. Feedback methods include;
  - **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, feedback through learning communities and assurance 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, the LADO promotes better awareness and understanding of safeguarding issues to Sandwell's faith groups
  - **Annual Child's Conference** – The SSCB will gather feedback from Sandwell Children Services' annual child's conference in order to influence decision making.

Workforce Engagement and Development

- Proactive engagement of the workforce will help identify the safeguarding needs of the workforce, inform training to aid their development and provide feedback on the effectiveness of the SSCB.
- 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.
- 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.

Partnership Working

- The SSCB recognises that collaborative working keeps children safe and ensures that they play an effective role in improvement, engaging all partners. 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.
- 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

Governance and Scrutiny

- The governance structure and scrutiny measures will provide a clear line of accountability for the SSCB.
- It is through the Board and primarily its QPP Sub-Group that agencies will drive improvement to safeguarding of children through joint working and accountability to each other

4. SSCB Quality Assurance Activity

Type of Assurance Activity undertaken	Description	Who	Reporting	Quality Assurance work completed April 2016 – March 2017
Measuring outcomes utilising qualitative and quantitative data	Key analysis of data themes affecting safeguarding arrangements and practice	• All subgroups	• SSCB via QPP subgroup; quarterly performance reports	• Quarter 1 performance report & dataset presented to SSCB on 20 October 2016 • Quarter 2 & 3 performance report & dataset presented to SSCB on 14 February 2017
Serious Case Review (SCR)	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.	• Partner agencies • Relevant organisations • Independent Reviewer • SSCB Business Unit	• SSCB via the Learning Lessons from SCR and/or a serious case review panel. • Publishing of SCR reports	• Two serious case reviews were commissioned in Quarter 4 and work has commenced
Multi-agency case review	Review of a safeguarding incident which falls below the threshold for a SCR.	• Partner agencies • Relevant organisations • Possible Independent Reviewer • SSCB Business Unit	• SSCB via SCR subcommittee	• A lessons learned review took place during Quarter 2 for 3 children, the report has been drafted • 3 table top reviews took place each focusing on 1 child
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	• SSCB via SCR subcommittee	-
Child Death Review	A review of all child deaths up the age of 18	• Child death Overview Panel (CDOP)	• SSCB via CDOP subgroup	• 38 child deaths were reviewed in Quarter 1, 5 had modifiable factors • 9 child deaths were reviewed in Quarter 2, 6 had modifiable

Type of Assurance Activity undertaken	Description	Who	Reporting	Quality Assurance work completed April 2016 – March 2017
				factors • 13 child deaths were reviewed in Quarter 3, 3 had modifiable factors
Multi-agency thematic case audits	Audit of practice relating to a specific safeguarding issue (case sample)	• Partner agencies • Relevant organisations • SSCB Business Unit	• SSCB via QPP subgroup	-
Multi-agency case audits	Audit of practice relating to a child's journey through the system (case sample)	• Partner agencies • Relevant organisations • SSCB Business Unit	• SSCB via QPP subgroup	• Multi-agency audit on Neglect on 13 June, report & learning notes written and circulated. • Multi-agency audit on CSE & Missing on 23 September report & learning notes written and circulated • Multi-agency audit on Domestic Abuse on 14 November, report & learning notes written and circulated • Multi-agency audit on Early Help & Lead Professional on 13 February, report & learning notes written and circulated
Single agency audits	Audit of practice (case sample) on a single agency basis	• Partner agency	• SSCB via QPP subgroup	• Process for scrutinising single agency audits established • Q1, Q2 & Q3 Audits have been received by partners • Report was written and presented at February QPP Meeting • Q4 has been requested
Section 11 audits	Self-assessment of an organisation's safeguarding arrangements and practice	• Partner agency	• SSCB via QPP subgroup	• Full Section 11 Audit undertaken across the partnership supplemented with a series of

Type of Assurance Activity undertaken	Description	Who	Reporting	Quality Assurance work completed April 2016 – March 2017
	(Section 11 of the Children Act 2004).			'scrutiny panels' • Report presented at May 2016 SSCB meeting • Further S11 Audit will be launched April 2017
Section 175/157 audits	Self-assessment of a schools safeguarding arrangements and practice (section 175/157 of the Education Act 2002)	• Schools	• SSCB via QPP subgroup/ Education Advisory Group	• A new section 175/157 was rolled out on 17 October for completion on 16 December 2016, the audit is 90% compliant across Schools
Service user feedback	Identifying key themes affecting safeguarding arrangements and practice	• All subgroups • Partner agencies • Relevant organisations • Lay members of sub groups • Youth participation groups	• SSCB via QPP subgroup	• Lay members attended SSCB on 26 May, 20 July and 20 October 2016 • Lay members QPP Sub Group on 16 September and 4 November 2016 • A young person is a regular representative on the SSCB and attended 26 May, 20 July and 20 October 2016
Workforce Engagement and Development	Embedding of learning into practice	• Partnership Surveys • Training Impact Assessments	• SSCB via the Learning and Development sub group	• A Workforce survey was drafted in March 2017 and launched in April 2017