Brighton & Hove LSCB
Quality Assurance Framework

1. Introduction

One of the core functions of the LSCB is to monitor and evaluate the effectiveness of what is done by the authority and their 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:

i. assessing the effectiveness and impact of the help being provided to children and families, including early help;
ii. quality assuring practice, for example through joint audits of case files involving practitioners and identifying lessons to be learned;
iii. 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.

In addition, Working Together 2015 requires a Learning and Improvement Framework to enable professionals and organisations protecting children to reflect on the quality of their service and learn from their practice and that of others.

This framework is designed to ensure that the LSCB effectively meets these requirements. It is guided by the principles for learning and improvement (Brighton & Hove LSCB Learning and Improvement Framework) and compliments the LSCB Section 11 audit tool which is already in use to ensure that point (iii) above is being addressed.

2. What is Quality Assurance?

Quality assurance is about assessing the quality of the work we undertake to safeguard children and understanding the impact of this work in terms of its effectiveness in helping to keep children and young people safe. Effective quality assurance will contribute to a culture of continuous learning and improvement.

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)[1] approach which will help organisations to understand a given area of business/concern by considering:

[1] Mark Friedman, Trying Hard is Not Good Enough, 2005, Trafford Publishing

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

It is also guided by the framework developed by Local Government Improvement and Development & the London Safeguarding Children Board[2].

The framework identifies the **content areas** to focus upon i.e. the LSCB thematic priorities and it uses an appropriate balance of **performance information** to assess the quality of work undertaken to safeguard children and its effectiveness in helping to keep children and young people safe. It explains where and how performance **information can be sourced** using a range of methods.

3.1 Content Areas (also referred to as themes)

There are so many dimensions to safeguarding that if we tried to quality assure everything it would become unmanageable. There is a need therefore to focus on a discreet number of defined areas which the LSCB concludes are the most important. The areas of focus will be determined by local need following consultation with all partner agencies and informed by evidence such as findings from research, audits, management information and learning from serious case reviews.

From their analysis of research and messages from Serious Case Reviews, Local Government Improvement and Development & London SCB have identified the following as possible types of content areas:

1. 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 out of education, those regularly missing health appointments, privately fostered children

   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 just between different organisations but also what happens between different services and professionals within a single organisation.

2. Organisational Content Areas where the focus is on issues such as the workforce & capacity, learning & development, safeguarding wisdom, supervision and support, organisational culture, use of resources and evidence-based practice.

[2] Local Government Improvement and Development & London SCB, Improving Local Safeguarding Outcomes: Developing a strategic quality assurance framework to safeguard children, 2011.

3.2 Types of Information

Once the content areas have been agreed, a number of statements will be produced which set out what 'good' would look like in terms of the quality and outcomes. From this we will then define the kinds of performance information and measures we need about each content area.

There are three types of performance information/measures 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.

Traditionally, quality assurance information in safeguarding has focused largely on quantitative information, with some qualitative information and very little outcome information. The challenge is, over time, to increase the proportion and importance of outcome information as this constitutes what really matters, supported by qualitative information and then quantitative information.

3.3 Sources of Information

Having defined the content areas that matter and the types of performance information needed, the sources for 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, to get a full picture of what is really happening, it is important to capture the experience of children and parents/carers, and the experience of frontline staff and managers. Therefore the information for quality assurance will come from four main sources;

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

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.

The experience of children, parents and carers

Obtaining the views of parents and children in safeguarding work is underdeveloped because it is hard to do, especially in what can be the fraught nature of safeguarding work. Yet it is clearly a rich seam, not just in terms of understanding the quality and impact of services now, but as a source of learning and organisational development.

It's important to know how parents, carers and children feel treated by the professionals and agencies they interact with. If their experience of such interactions is negative, this is likely to have an adverse impact on outcomes. Understanding what matters in terms of engagement and interaction, and whether this is something they experience in reality (and therefore identifying what professionals and agencies need to get right) is something only parents, carers and children can tell us. 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 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?

Methods

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

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

It is important that organisations develop a culture, which demonstrates that the views of staff are valued and taken seriously, and can include saying things that may be uncomfortable for the organisation.

Key activities will include:

- staff surveys and interviews
- focus groups
- staff evaluations of partnership working
- 'walking the floor' and observation of frontline practice by senior managers

The experience of frontline staff can be communicated in an aggregated form or through more interactive and dynamic means.

Parents and children's case records

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

Methods
Case record 'auditing' involves the systematic analysis of records by staff with relevant professional expertise, in order to glean the required information from a sufficient sample of cases to provide a picture of what is going on through aggregating the case findings.

Key activities include:
- Continuous (regular) auditing as part of management oversight arrangements e.g. at key transition points
- Specific or thematic audits as part of an organisation's quality assurance programme
- Management information about safeguarding e.g. quantitative or qualitative measures

Other organisational activity

Organisations have a range of information within their systems which can be used to inform safeguarding quality assurance, for example, human resource information about vetting checks or staff training, vacancy rates or staff turnover.

In addition, there are a number of other organisational activities that will contribute directly to quality assurance of safeguarding, such as:
- Internal Peer 'Deep Dive' Review – a team of reviewers comprising of LSCB partner representatives focusing on a particular service area
- External Peer Review – a team of reviewers comprising of external reviewers focusing on pre or post-inspection or specific areas of safeguarding
- Sector Support – an organisation commissioned to provide safeguarding sector specialist support to undertake a specifically tailored assignment
- Serious Case Reviews or other forms of case review – identification of learning in respect of organisational or partnership working

4. Local Context

4.1 Applying the Framework: Five Stages

Stage One: Agreeing the Content Areas

The Board has already agreed a number of priorities (content areas) for 2013-16.

The LSCB Strategy and Business Plan for 2013-16 sets out the following areas as priority areas for review and development

1. Children and young people in Brighton & Hove are protected effectively from **neglect.**
2. Children and young people in Brighton & Hove are protected effectively from **sexual abuse.**
3. Children and young people in Brighton & Hove are protected effectively from **sexual exploitation**

4. There is a prompt and assured response when referrals are made or new information is received about child care concerns (**referrals)**
5. The process for the early help assessment and the type and level of early help services to be provided is effective in meeting the needs of children and families **(thresholds)**

The LSCB Monitoring & Evaluation Sub Group will agree a number of thematic priorities as per the LSCB Business Plan which are based on local evidence of needs and priorities. In doing so, they will take into account relevant research including issues from serious case reviews, statutory guidance and inspection outcomes.

In addition to the themes above, content areas will also need to include core business such as Referrals, Strategy working and Core Group work and any other areas that have been identified as a priority by the Brighton & Hove LSCB Leadership Group.

As an Example:

Year	Content Areas Theme
2014-15	Specific Risk Issues: Parental Substance Misuse /Domestic Violence Priority Service Areas: Strategy Discussions & Section 47 Enquiries Referrals/Core Groups/Network Meetings
2015-16	Specific Risk Issues: CSE (re-audit), Substance Misuse (Neglect) Priority Service Areas: Young Parents who are care leavers, Combined Referrals & Thresholds & Early Help - Child's Journey, Cases on Duty Systems, Adolescents: Accessibility of Services.

Stage Two: Defining 'what good looks like'

The Monitoring & Evaluation Sub Group will agree a series of overarching outcome and quality statements or standards in respect of the above Content Areas

Stage Three: Sources of information and methods for gathering it

The Monitoring & Evaluation Sub Group will agree a range of sources of information to inform learning and improvement activity. The main sources might include (to be agreed)

- Serious Case Reviews (including national high profile SCRs), Child Death Reviews, Multi agency case reviews, IMRs
- Multi agency case file mapping and auditing
- Management information
- Complaints and Compliments
- Focus groups and surveys
- Practice observations
- Peer Review and Challenge
- Inspection findings

Stage Four: Agreeing a planned quality assurance programme

Some of the activity outlined above is unscheduled by its very nature, such as making a decision to initiate a Serious Case Review, undertaking child death reviews or responding to complaints. With regard to other elements of the Framework, the activity is planned.

Each year the Monitoring & Evaluation Sub Group will review and update a Quality Assurance Programme for approval by the Brighton & Hove LSCB. The programme will be made up of the following activity;

- Peer review and challenge activity
- A planned programme of audit activity
- Specific activity aimed at ascertaining the views of children, young people and their parents/carers or practitioners e.g. CSE survey currently being developed
- Specific areas of focus in respect of organisational activity such as practice observations

Stage Five: Learning & Improvement

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
- LSCB Communication Strategy/Plan
- Policy & procedure
- Commissioning
- Supervision
- Partner Agency Improvement Plans
- LSCB Strategy and Business Plan
- Workshops and/or Interagency Forums

Consequently, it is important that the outcomes of the quality assurance activity inform the input of other LSCB sub groups in line with the principles for learning and improvement (ref. Brighton & Hove LSCB Learning and Improvement Framework).

Progress on quality assurance will be an agenda item at each Monitoring & Evaluation Sub Group meeting, and this will include reports on key findings, including good practice, any significant risks and/or improvements.

In addition, the Monitoring & Evaluation Sub Group will host an annual quality assurance event where the main messages from quality assurance are shared and considered. The event will allow members of the group to reflect on the information, determine the story,

and agree what immediate action is required to improve practice or safeguarding arrangements. It will also be an opportunity to review the quality assurance programme for the following year and prioritise the QA content areas.

4. 2 Governance and Accountability

On the Board's behalf, the Monitoring & Evaluation Sub Group will be responsible for the co-ordination and management of the quality assurance framework. A summary of the Terms of Reference are as follows;

- Initiate, undertake or commission both multi-agency and single agency audits and reviews of safeguarding activities on a regular basis to ensure compliance to the child protection and safeguarding procedures.

- Ensure that the quality assurance methodology is sound and relevant to the Board's safeguarding activities.

- Where appropriate, to include the views of children, young people and their parents who are receiving a service, in quality assurance work.

- Where possible, include the views of practitioners / their managers who are providing a service, in quality assurance work

- Ensure that needs arising from equality and diversity issues for children and their families are taken into account in all the work of the sub group.

- Report findings from audit activity, by this sub group and other member agencies to the Board on a regular basis and make recommendations for change to support improved practice and promote a learning culture. This may include recommendations for additional training; seminars or other media to disseminate good practice.

- Monitor and review action plans arising from multi-agency audits and quality assurance work.

- Initiate and co-ordinate the delivery of an annual thematic audit or review as determined by the annual work programme of the LSCB.

- Assist the LSCB in coordinating a response of individual member agencies to national safeguarding audits and enquiries in order to identify any issues for multi-agency learning.

- **In all relevant audits include the following in the terms of reference/instructions for managers:**

  The Monitoring & Evaluation Sub Committee should be informed of any cases where there are issues related to accessing historical information e.g where assessments or

chronologies are incomplete due to historical information being missed ref: Child G Action Plan & Themed Review: Young Parents & DV Action Plan.

The Monitoring & Evaluation Sub group will publish an annual report of themes (Quarter 3 each year) and improvements made as a result of quality assurance activity conducted by partner agencies and through multi agency processes.

As reported earlier, the group will also hold an annual quality assurance meeting to reflect on the findings from quality assurance and to review & plan the Quality Assurance Programme for the following year. The QA Programme will be approved by the Board each year.

Based upon the outcomes of this (and other reporting mechanisms currently operated by the LSCB), in accordance with the provisions of Working Together 2015, the LSCB Chair's annual report will provide a detailed analysis of the effectiveness of child safeguarding and the welfare of children within Brighton & Hove. The report, through scrutiny of the evidence gained through the quality assurance programme, will highlight good practice and identify where (and how) improvements are to be made.

Appendix 1: LSCB Multi Agency Quality Assurance Programme 2014-2015

LSCB MULTI AGENCY QUALITY ASSURANCE PROGRAMME 2015-16

QA Content Areas	Q1 15-16 (Apr – Jul)	Q2 15-16 (Jul – Sep)	Q3 15-16 (Oct – Dec)	Q4 15-16 (Jan – Mar)	Proposed Type of Quality Assurance Activity
Core Group & Network Meetings [with a focus on the effectiveness of multi-agency working]	X	-	-	-	Multi Agency Audit This was delayed to allow for CSE audit to be prioritised. M&E Lead: Tom Stibbs
* Substance Misuse (Neglect)	-	X	-	-	Multi Agency Audit M&E Lead: Yvette Queffurus (Board Neglect Lead)
**Young parents who are care leavers Multi Agency Audit	-	X	-	-	Multi Agency Audit Single Agency Deep Dive during March 2015 to inform multi-agency audit M&E Lead: TBC
NEW Combined Referrals & Thresholds Multi Agency Audit & *Early Help - Child's Journey - Multi Agency Audit	-	-	X	-	Multi Agency Audit M&E Leads: Clare Poyner & Mat Thomas
**Cases on Duty	-	-	X	-	Multi Agency Audit tbc after Paper shared from SCR subcom.

Systems Multi Agency Audit					M&E Lead: TBC
** Adolescents: Accessibility of Services Multi Agency Audit	-	-	X	-	Focus Groups with young people M&E Lead: TBC
*CSE (Re-Audit) Multi Agency Audit	-	-	-	X	Multi-agency case discussions & Action planning M&E Lead: Lee Horner

***Priority areas of concern from LSCB Business Plan 2013-16**
**** Based on actions from Serious Case or Learning Reviews**

Appendix 2
QUALITY ASSURANCE CONTENT AREAS 'WORKING OUT' TOOL: Note: This is an example using DV&A as the content area.

Q1: Specific Risk Issues: Children and young people in Brighton & Hove are protected effectively from Domestic Violence.			
Quantity: What Are We Doing?	**Quality:** How Well Do We Do It?	**Outcome:** Is Anyone Better Off?	**Sources of Information**
No of Early Help Assessments in the period where DV in the home is identified. No of referrals in the period where the category of primary need is a) DV&A b) DV&A resulting in significant harm c) as a % of all referrals No of CP/CIN Plan cases where DV&A is identified as a significant risk factor in the assessment % of cases where there are no repeat referrals for DV&A within subsequent six, 12, 18 months.	**Good looks like….** Where Early help Assessment has been completed, the impact of DV&A on the child was taken into account Victims of DV&A feel that their situation was taken seriously & understood by professionals The impact of, and risks posed by DV&A are assessed and planned for to a good standard.	**Good looks like…** Victim/parent reports at (Early Help Assessment/CIN /CP Plan) closure that they feel and are safe from DV&A. Children and young people report that they are safe from DV&A and feel safe. In cases where families are receiving help in respect of DV&A, children are doing well in terms of main areas of development e.g. education at the point of closure. Children/YP feel well supported by services & have the information they need. Children/YP have someone to talk to /get help from in an emergency / do not feel isolated.	Performance Data Child & Family Surveys Case audit Consultation with Police SCRs/Learning Reviews
No of DV&A reports to police in	**Good looks like….**		Performance Data

12 month period. No of different families involved in reports to police in this period. No of children involved in reports to Police. % of cases where MARAC held that DV &A ceased. % of cases involving IDVAs where DV &A ceased. % of families where there have been repeat reports to police of DV&A.	Following referral/notification, families receive the following forms of help: - MARAC - Independent Domestic Violence Advisors (IDVAs) - Single assessment and Early Help Assessment EVIDENCE BASED HELP… Cases quality assured by the Police demonstrate that the Police consider the impact of the DV on the child(ren) & young people, and responded appropriately. DV&A incidents attended by police, where the victim or child/yp report that they were treated with respect and were provided with clear information.		Case audit User Surveys Experience of professionals (Police/SW/Health/Probation) in respect of specialist DV services. Consultation with the Violence Against Women & Girls Strategy Manager & Commissioner

Appendix 3
Why undertake multi-agency audits?

The role of the LSCB is crucial in determining the attitude of agencies towards improving practice on a multi-agency basis. Effective partnership working through the LSCB, a robust and systematic approach to quality assurance and the modelling of a cycle of continuous learning through constructive challenge will establish a culture which will permeate through to front-line practice. Multi-agency audits should be solution-focused and conducted in a spirit of open learning with the intention of further improving outcomes for children.

Why conduct audit?

An audit is undertaken to ensure that policy/procedure is being followed. It provides evidence of best practice and can demonstrate the quality of our work to external bodies and inspectors. It also allows areas of weakness to be identified and acted upon.

The actual process of carrying out an audit can sometimes be as beneficial as the outcomes. It provides staff with the time and space to reflect critically on practice. Where different agencies are involved in an audit, there is an opportunity to learn about different roles and responsibilities.

Who should be involved?

It is helpful to have people with a variety of different perspectives within the audit group. The group should therefore include staff from different levels/roles or, where appropriate, different agencies. It is best practice for an audit to be led by someone other than the manager for the area under consideration.

Who decides the multi-agency audit programme?

The function of the Evaluation and Monitoring sub-group of the LSCB is to:

- develop a multi-agency audit tool to monitor the effectiveness of work undertaken by partners and the impact of services on outcomes for children and young people;
- plan and undertake themed audits in relation to relevant areas of interest or areas requiring further analysis as a result of performance information, inspection findings, the child death overview panel and serious case reviews;
- undertake a rolling programme of multi-agency audits and lead on the development of improved systems within and across partner agencies to implement recommendations following audit findings;
- make periodic presentations to social work teams and other relevant teams within key partner agencies on audit findings to raise awareness and understanding of core requirements and gather feedback to inform service improvement.

Appendix 4

Brighton & Hove LSCB Memorandum of Understanding
Multi Agency Safeguarding Audits

This Memorandum of Understanding provides the framework for roles and responsibilities of agencies in the multi agency audit programme.

The LSCB Monitoring & Evaluation Subcommittee will ensure that audits have a clear focus and clearly defined terms of reference and focus on current practice, considering interventions that have occurred within the last 12 months (maximum). Precise timeframes will be established by terms of reference.

Each agency will be required to sign up to the multi agency audit programme and support it at a senior level, over seeing the allocation of resources and ensuring that lessons are implemented within their agency.

The following resource commitments will be required:

- Staff participating in the multi agency audit will need allocated time to attend meetings and undertake work on behalf of the group to ensure that audits are completed within agreed timescales.

- Each agency will need to allocate a manager or senior practitioner who can be the lead for each audit to be undertaken. A joint lead may be agreed as a learning process for those new to undertaking audit work.

- Children's Safeguarding will provide a quality assurance manager. The QA Manager will need time to coordinate and lead the audit process, analysis and write up of learning and recommendations.

- Access to client level data and records from each agency. **Note:** The Monitoring & Evaluation Sub Committee will ensure that all audit activity takes into account confidentiality and data protection.

STATEMENT OF INVOLVEMENT IN MULTI AGENCY AUDITS

Our named representative is: Should they be unable to attend the named substitute has been identified as:	

I CONFIRM ACCEPTANCE OF THIS MEMORANDUM OF UNDERSTANDING

Signed:

On behalf of (agency/organisation name):
Date: