Local Government Group

London safeguarding children board

Children and young people

Improving local safeguarding outcomes

Executive summary

Introduction

Who the framework is for

The framework is aimed at strategic partnerships and individual organisations with safeguarding children responsibilities. It has been designed to help those with leadership, senior management or scrutiny responsibility for the safeguarding of children (for example directors of children's services, lead members, NHS trust boards, chief executives, local safeguarding children boards (LSBCs), children's trust boards, senior management teams).

The elements and principles of the framework can also be applied throughout all levels of all organisations that make a contribution to the safeguarding of children (including frontline practice) so that each level of the organisation can self-assess whether it is being effective in keeping children safe.

The primary focus of the framework is on the **child protection** end of the safeguarding continuum.

The purpose of the framework

The framework is intended to help leaders in single organisations and strategic partnerships to answer the question: 'How effective are we at keeping children safe?' in a more systematic, holistic and comprehensive way. And thereby:

- keep children safe
- manage the risk inherent in this area of work
- drive improvement in outcomes for children and their families
- achieve best value.

Why the framework is needed

The framework is needed because existing approaches to the quality assurance of safeguarding children have often been inadequate as they do not address the following principles:

The safeguarding of children is **complex**; this is because of the complexities of interacting human and organisational histories, behaviours and relationships. Effective quality assurance will recognise and work with this complexity.

What matters most in the quality assurance of safeguarding is knowing about the **'wellbeing' outcomes** achieved by children and their families; the **impact** on real lives - whether and in what way their lives are better and safer as a result of the various services, interventions and arrangements.

The **experiences of children, parents and frontline staff** are an essential source of information for determining what outcomes have been achieved.

Effective quality assurance is dynamic, creative and evolving; owned and **developed locally** by reflective and learning organisations taking a few **small but effective steps** that deliver real improvement.

This Framework is available for all organisations and partnerships with safeguarding responsibilities to use. During 2011 several authorities will be piloting the use of the Framework in a range of different ways. Their experiences and ideas are being shared in an electronic 'Community of Practice' which organisations implementing the Framework can join. For further information:

1. Go to http://www.communities.idea.gov.uk and under 'Register and become a member today' select 'Register'.
2. Enter your details as requested and select 'Confirm and complete'. You will then receive an email to confirm your registration.
3. Click on the link in that email to activate your account, and search for the 'Safeguarding Children' CoP from the main list of communities.
4. Click 'Apply to join' – you'll then receive a welcome email. Click on the link in that email.
5. Take part!

What the framework does – and does not – do

The framework is exactly that – it is a framework comprising a number of key elements, within which agencies and partnerships develop their own content, priorities and pace. It contains suggestions and examples of what the content might look like, but is not prescriptive and does not contain 'targets'. It is for individual agencies and partnerships to determine what is right for them, based on their own analysis of evidence. Above all, the philosophy is: try to do quality assurance differently – don't try to do everything; do a few things, but do them well so that you make a measurable difference to children's lives.

The framework is designed to encourage and stimulate **organisational reflection** in the same way that safeguarding supervision should stimulate professional reflection on an individual level.

Developing a strategic quality assurance framework to safeguard children.

Making children safer remains a priority for councils and their partners. This document is a contribution to the achievement of that objective while recognising the scale and complexity of the challenge.

The structure of the framework

There are five modules in the framework.

Module 1 describes the core elements of the framework. It is supported by the remaining four modules which provide a range of **examples** for different sections of the framework. These examples are all illustrative – they are included to paint a clearer picture of the ideas being conveyed, and to trigger reflection by organisations and LSCBs. Individual organisations and LSCBs might decide to adopt some of these examples for their own framework – or none of them, as they might come up with alternatives better suited to their needs. Learning from experience will also result in modification and improvement of what was started with initially.

Module 2 contains examples of what 'good' would look like: these are statements setting out the vision and ambition – in terms of quality and outcomes – that organisations and LSCBs are aspiring to and against which their current performance can be understood and contextualised.

Module 3 contains examples of questions that leadership and scrutiny bodies might ask in respect of quality assurance information. Such questions, together with a clear picture of what 'good' should look like, will enable more empowered and effective safeguarding leadership and scrutiny.

Module 4 gives practical examples of the sources for the different types of information in the different content areas, and ideas for methods for obtaining it.

Module 5 gives examples of quantitative, qualitative and outcome performance measures that can be used to determine how close an organisation is to the 'good' statements in module 2. It is not suggested that organisations or LSCBs should have this number of measures – these are here for illustration; the knack is to have a smaller number of ones which are right for that organisation/LSCB.

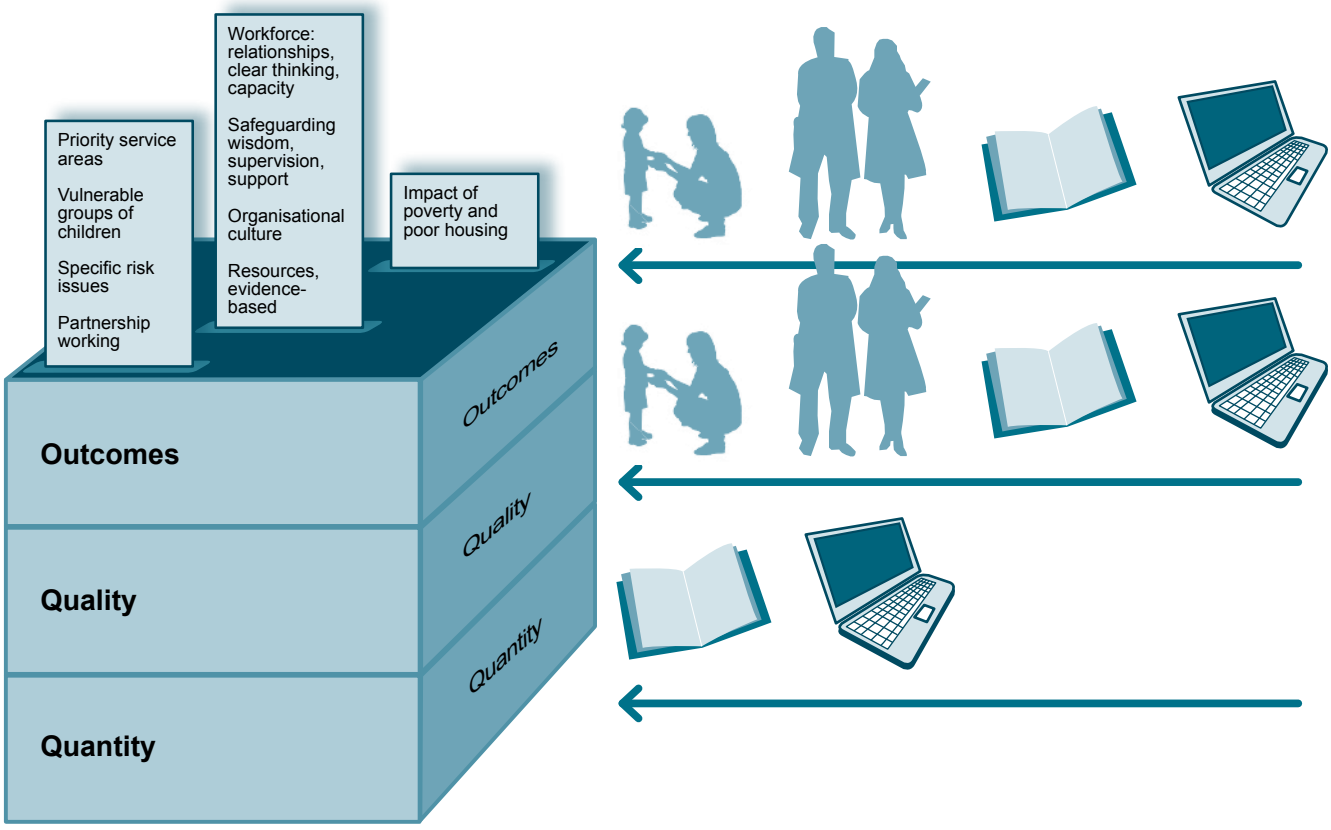
The framework explained

Three essential activities

The framework asks those responsible for leading its application in their area to do three things:

- to identify the **content areas** to focus on
- to have an appropriate balance of **three types of performance information** about each 'content area'
- to obtain this information from an appropriately balanced range of **sources**, using a range of **methods**.

The framework



Content areas

The starting point for building a local framework is for each organisation and partnership to spend time reflecting on what key areas of their business impact on the safeguarding of children – as these are the areas they need to have a grip on in terms of quality and outcomes. These should be evidence-based.

From our analysis of research and messages from Serious Case Reviews, these are likely to include areas with a **practice** focus: priority service areas (for example antenatal and post-natal assessment and support in acute trusts and community health services, the front-door and operation of children in need/child protection assessment and care planning in children's social care), responsibilities for particularly vulnerable groups of children (for example children out of education, those regularly missing health appointments, families that move a lot), the organisation's interface with specific risk factors such as domestic violence, and partnership working.

Other content areas will be of an **organisational** focus for example workforce and capacity-related issues, learning and development, supervision and support, organisational culture, use of resources and evidence-based practice.

The three types of performance information/ measures

Having identified the content areas, the organisations and partnerships then need to reflect on what 'good' would look like in these areas in terms of quality and outcomes.

From this they would then define the kinds of performance information and measures they need about each area. There are three types of performance information/measures:

Quantitative information simply answers the questions 'How much/how many?', for example, for services 'How much did we do?' 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 violence referred by the police.

Qualitative information will tell us something about the quality of what was done: 'How well did we do it?' For example the percentage of people who completed parenting programmes; the percentage of staff trained who thought their skills had improved as a result; the percentage of assessments that were analytical, kept a focus on the child and included the male figures; the percentage of parents who felt they were treated with respect and that their personal history was understood by professionals; the percentage of adult mental health assessments and care plans based on 'Think Family' principles. Quality relates to the **functioning** of the organisation as distinct from the outcome achieved by the organisation.

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 cases in which domestic violence has ceased; the percentage of those completing drug programmes who stop using drugs, the percentage of those completing parenting programmes who are more effective parents, the percentage of children reporting their family life is happier; the percentage of family

situations where ‘low warmth, high criticism’ has been replaced by ‘high warmth, low criticism’. (Compare this outcome information with the National Indicator requirement that initial assessments are completed within 10 days – this tells us about the speed of completing the task but nothing about the quality of that assessment or whether it made the child safe).

These three types of performance information are all important, but the most important information is about outcomes as improving children’s and families’ conditions of wellbeing is what the whole safeguarding system is designed to do. There is little point in everyone being busy if that ‘busy-ness’ does not result in changes to children’s lives.

Traditionally, single agencies and partnerships will have a reasonable amount of information about quantity, some about quality and little about outcomes. The framework encourages a stronger focus on quality and outcomes. See Module 5 of the full framework for examples.

Triangulation

To get the best understanding of quality and impact in respect of the content areas it’s necessary to bring together the information from different sources, as each source is likely to give a partial, but not complete picture. This is triangulation. Improvement plans based on this combination of perspectives are more likely to be on the right track.

The different sources of information

Having defined the content areas that matter and the types of performance information needed, organisations and partnerships then need to work out the sources for this information. Traditionally in safeguarding quality assurance, two main sources have been used: data from management information systems (for example in respect of staffing, training) and children’s/families’ case records (for example through audits). These are important and valuable sources – but only provide a partial picture. To get a full picture of what’s really happening, organisations need to capture the experience of children and parents/carers, and the experience of frontline staff and managers.

As the importance of relationship-based practice is recognised, so the experience of children and parents in terms of how they are treated and whether what is done makes any difference gains more importance.

Similarly, as our understanding of the complexity of safeguarding increases, so the experience of what’s really happening at the frontline needs to be brought into the view of those with leadership and scrutiny responsibilities through systematic feedback loops. And those organisations need to hear not just from their own staff, but the frontline staff in other organisations they interface with.

Implementing a local framework – single organisations

If an organisation (such as a children's social care service, acute hospital trust, mental health trust, probation service) decides to use this framework, they could set the key elements in place by bringing together a range of people with different leadership and delivery roles (including frontline staff) and going through the following steps:

Step 1
Agree the content areas for the organisation.

Step 2
For each content area agree what 'good' looks like in terms of quality and outcomes.

Step 3
Identify the type and source of current performance information about each content area.

Step 4
Identify what additional or different performance information – in terms of type and source – needs to be collected to determine how well the organisation is actually doing in this area relative to its picture of 'good'.

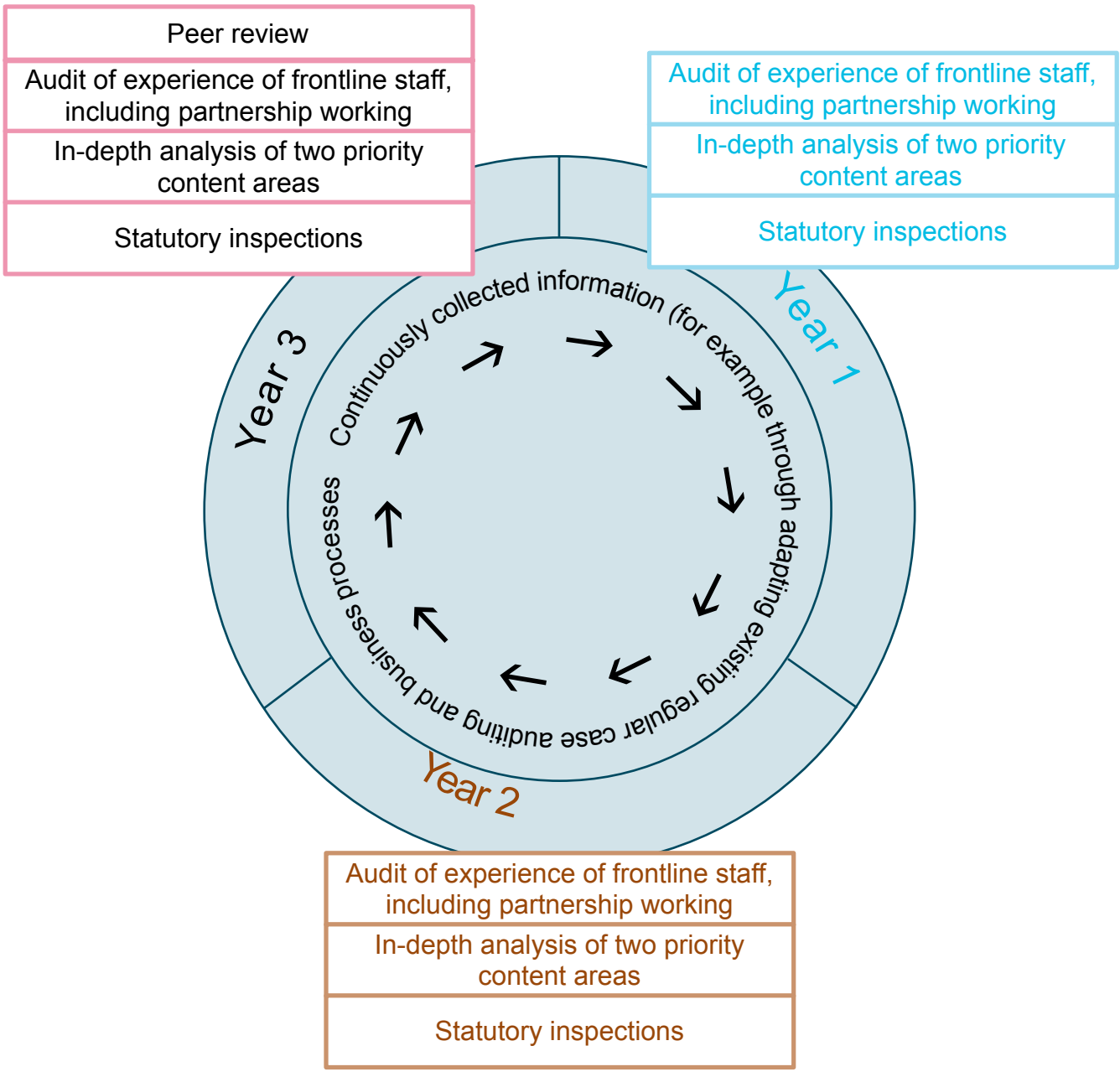
Step 5
Identify how to capture this information. Are there ways of building the capturing of quality and outcome information and the experience of children, parents and staff into the **routine business processes** for example as part of service closure/transfer, or through existing routine case record auditing processes? What **specific exercises** will be needed as part of an annual audit programme, or as part of an annual child/parent or staff feedback programme? Could some of the methods used capture information relevant for several content areas?

Step 6
Agree the priorities. While it's important in Step 1 to work out the content areas relevant to the organisation, 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 organisation's framework needs to be manageable, and can be built up over time. Therefore organisations need to determine which are the priority content areas to get right first – and within the priority areas, what are the **priority** quality and outcome measures? **You might do the prioritisation as Step 2, so that the subsequent steps are initially only followed through for the priority content areas**.

Step 7
Agree your three-year 'quality assurance time-table' for the gathering of information. It's important to plan further than one year. In thinking across three years the organisation can decide which will be the priority content areas to focus on each year so that they can all be worked through systematically. What will be the regular annual exercises for example staff feed-back, and what might be three-yearly exercises (for example peer reviews). Formal external inspections should also be built into this.

Step 8
Agreeing a clear organisational learning and improvement cycle. See 'Governance Frameworks/Learning and Improvement Cycle' below.

Quality assurance timetable for single agencies



Implementing a local framework: the LSCB

LSCBs have a 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." (Working Together to Safeguarding Children, 2010, HM Government).)

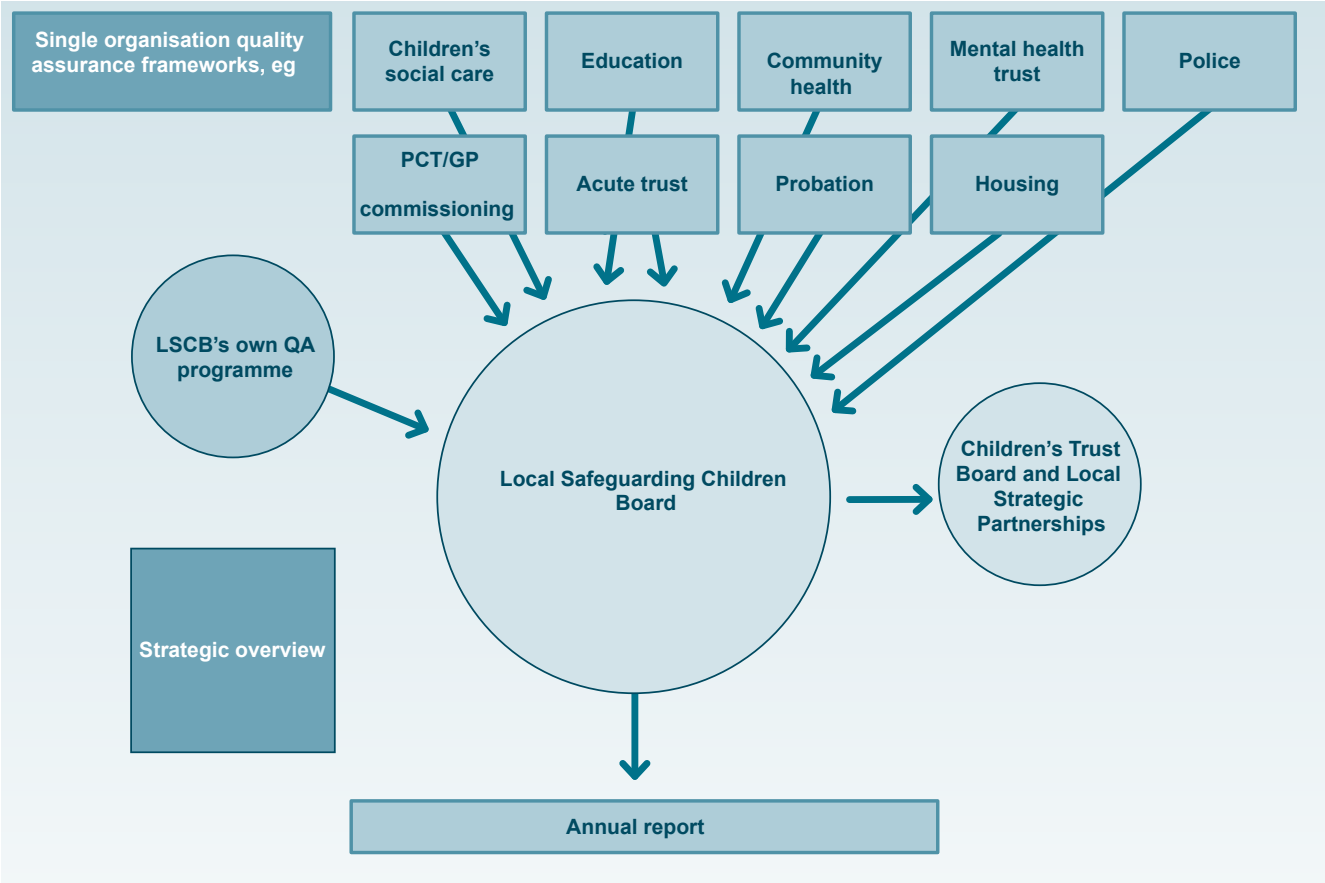
But how do they do this in practice? There are several ways that they can use the framework to fulfil their statutory responsibilities and contribute to improving outcomes for children:

6. If the single agencies in an area are using the framework, the LSCB can draw together the performance information that they are collecting to start to build up an overall picture of safeguarding.
7. The LSCB should have a dialogue with each organisation to agree on appropriate content areas, ensuring that there is a good balance of sources and types of information.
8. The LSCB can identify content areas that it should focus on from a cross-cutting, thematic perspective. This would form the basis for the LSCB's own three-year quality assurance time-table. For example, the LSCB may take domestic violence and safeguarding supervision as priority content areas in Year 1, and parental mental health and learning/ development in Year 2.

It is recommended that LSCBs at a minimum:

- Each year undertake at least one major **'Deep-Dive' review** of a content area as part of a three year programme.
- Each year undertake at least one **'Turning the Curve'** exercise of a content area that has previously been identified as a priority/ concern and work with the Children's Trust Board to make a difference.
- Every three years commission an **external peer review** of a content area or collection of content areas.
- Every two years use the elements of this framework to reflect on their **own impact**.

Developing a strategic overview of safeguarding in an area



Governance frameworks/ learning and improvement cycle

Organisational reflection and action

The end product of the above steps should be that individual organisations and LSCBs will have, over time, an improving picture of the quality and impact of safeguarding services and arrangements. What organisations do with the information collated is as important as the quality of information they collect. What matters is the reflection and interrogation that happens, the understanding of the story behind the information. And then **using** it to improve outcomes for children through evidence-based action planning.

Single organisations

Single agencies need to decide and state clearly which of their senior management, leadership and scrutiny bodies the information derived from their framework should go to. It is likely that it will need to go to more than one. For example, in a health organisation the information might go to both a clinical governance committee and the main trust board. In a local authority the information could go to the senior management team, a scrutiny committee and the cabinet/full council. It is recommended that **once a year** there should be a full safeguarding report based on the framework going to these senior leadership and management groups.

Tip

Many reports to boards and committees, though technically accurate, fail to communicate meaning or generate interest/reflection. **How** the information is presented needs to be considered. One form for such a report could be a 'Safeguarding children report book'. The book would have a section for each of the 'content areas' in the Quality Assurance Framework. Each section would comprise an A3 sheet containing:

1. A summary of why the area is important and what 'good' would look like.
2. Graphs setting out the **priority** quantitative, qualitative and outcome measures – with any relevant comparative information, and year-on-year figures to show the trends. What's the direction of travel; are our improvement plans delivering improved quality and outcomes?
3. The story explaining the information – the analysis.
4. Actions to achieve improvements in quality and outcomes.

In addition, for each section there could be a **story sheet**, capturing some of the experiences and stories of parents, children and frontline staff that lie behind the figures and bringing the issues alive. This helps to remind people that we are talking about the lives of real children and families.

The performance measures that agencies decide to include in their framework should, where possible, be reported **monthly or quarterly** to the senior operational management teams and frontline teams. These monthly or quarterly reports are likely to contain a greater level of detail than in the annual report. For example, there would be value in some of the performance measures being broken down to team or locality level to identify and explore variations. Again, this is not 'reporting for reporting's sake': the reporting should stimulate dynamic reflection on the issues, ideas for improvement and the plans to drive that improvement.

LSCBs

Quality reports based on the Quality Assurance Frameworks of single organisations and its own quality assurance programme would be presented to the LSCB. By considering the reports from single agencies alongside each other, the LSCB would be able to identify relationships, dependencies, cross-cutting issues and themes, and the areas of greatest strength and vulnerability. It would thus build up an overview picture of safeguarding in the area as well as in individual organisations.

This will enable the LSCB to offer a far more constructive challenge to individual partner organisations and the children's strategic partnership as a whole. The LSCB does not provide, manage or commission services.

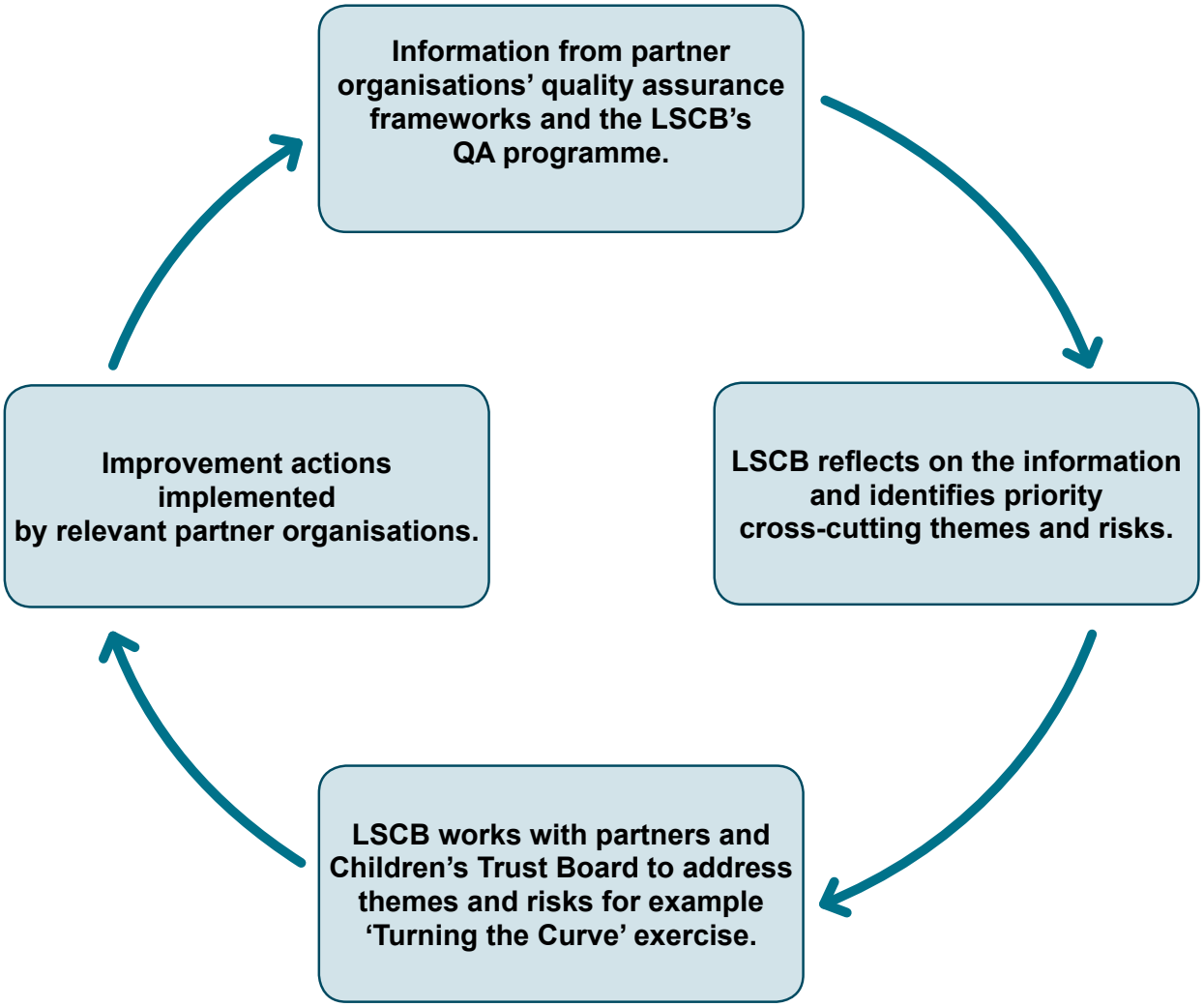
But it can:

- challenge its board partners to evidence the quality and impact of their safeguarding work
- expect them to develop and implement improvement plans which deliver improved quality and outcomes where needed
- hold them to account for delivering the improved quality and outcomes as a result of the improvement plans, ie keeping a spotlight on areas of vulnerability until confident of improvement.

The LSCB's **annual report** can now become far more analytical with a greater focus on outcomes and impact, rather than a more traditional focus on reporting activity - thus fulfilling the expectation of 'Working Together' (Chapter 3) that "The report should provide robust challenge to the work of the Children's Trust Board in driving improvements in the safeguarding of children and young people and in promoting their welfare."

The LSCB might also initiate a **'Turning the Curve Exercise'** to focus on, and lead improvement in, an area of particular concern for example domestic violence or neglect (see 'Trying Hard is Not Good Enough', Mark Friedman, 2005). The idea here is for the LSCB to focus its energies on achieving real progress in one or two areas at a time, rather than minimal impact in several areas.

LSCBs and improvement



The framework in full

An electronic copy of the full document **'Improving local safeguarding outcomes: developing a strategic quality assurance framework to safeguard children'** can be obtained at http:/tinyurl.com/LGID-QAF

Acknowledgements

The framework has been informed by ideas and principles from 'Outcome-Based Accountability' (OBA) and has used some of the associated terminology. (See 'Trying Hard is Not Good Enough', Mark Friedman, 2005, Trafford Publishing.)

The framework has also drawn on, and been informed by, the contents of the reports and documents listed in the bibliography. The report 'Understanding Serious Case Reviews and their Impact: A Biennial Analysis of Serious Case Reviews 2005-07' (Marion Brandon, Sue Bailey, Pippa Belderson, Ruth Gardner, Peter Sidebotham, Jane Dodsworth, Catherine Warren and Jane Black; DCSF June 2009) has been a particularly important source.

Local Government Group
Local Government House
Smith Square
London SW1P 3HZ

Telephone 020 7664 3000
Fax 020 7664 3030
Email info@local.gov.uk

www.local.gov.uk

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