Keeping children safe is everyone's responsibility

Quality Assurance and Learning and Improvement Framework

December 2013

Introduction

The statutory objectives and functions of the LSCB (Section 14 of the Children Act 2004) are to coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area and to ensure the effectiveness of what is done by each person or body for those purposes.

One of the key mechanisms for ensuring effectiveness is to have a quality assurance framework. Equally important in a quality assurance process is the opportunity to learn from the quality assurance activity, bringing about sustained changes in in practice and improved outcomes for children and families. This document represents both a quality assurance and learning and improvement framework (QAALIF).

The Quality Assurance aspect of the Framework addresses the ways in which Brent LSCB will ensure effectiveness by considering a range of qualitative and quantative data under three dimensions.

- The effectiveness of member organisations to safeguard and promote the welfare of children
- The effectiveness of multi-agency practice to safeguard and promote the welfare of children
- The effectiveness of the LSCB and it's members safeguard and promote the welfare of children

The learning and improvement aspect of the framework is in accordance with the requirements of Working Together to Safeguard Children 2013, which requires Boards to maintain a local learning and improvement framework which is shared across local organisations who work with children and families to enable them to be clear about their responsibilities, learn from experiences and improve services as a result.

This work will be undertaken under the auspices of the Quality Audit and Outcomes sub group but there will be significant links to the work of the:

- Governance, Accountability and Business Processes sub group with regards to the effectiveness of the Board,
- The Serious Case Review sub group, Child Death Overview Panel and Developing a Learning Culture with regards to practice and learning
- The Voice of the Child and the Community Reference Groups with regards to sharing experiences.

Roles and Responsibilities

The LSCB will implement the Quality Assurance and Learning Improvement Framework to encourage best practice in safeguarding in Brent by understanding strengths and weaknesses and taking action to promote good practice and offering challenge and support to member organisations where weaknesses in service may be identified.

This will be achieved through the range of QA and learning activities and it will be the responsibility of the LSCB and it's Executive and sub groups to identify relevant recommendations that will promote improved outcomes for children and young people.

These recommendations may relate to either multi or single agency processes or practices.

Multi –agency

This will be monitored through the Partnership Improvement Plan (PIP) which will be considered by the full LSCB at each meeting. Reports based on themes or specific subject areas will be considered throughout the year.

Single agency

This will be monitored through the Quality, Audit and Outcomes sub group and any areas of concern will be reported into the Executive.

If there are any concerns about any member agency not preforming effectively with regards to its safeguarding and promotion of the welfare of children role, this will be addressed by the Chair of the Board addressing the concerns identified and the remedial actions required. This should be viewed as part of the challenge and support role. If it is not possible for these concerns to be addressed within this context it may be necessary to share concerns with national governing bodies, inspectorates or governing bodies.

Quality Assurance and Learning improvement Cycle

The Quality Assurance and Learning Improvement Cycle is the mechanism whereby quality assurance/case review activities are undertaken; information is collated at both a strategic and operational level reviewing the effectiveness or not of the work taking place. Actions are identified to address development areas to improve practice or safeguarding arrangements, plans are monitored and impact evaluated. This will result in further QA activities to ensure sustainability and improvement.

Quality Assurance and Learning Improvement Activities

Dimension 1 Effectiveness of each member organisation to safeguard and promote the welfare of children and young people	
• Section 11 audits • Outcomes of inspections • Single Agency annual reports • Local Authority Designated Officer (LADO) report	• Multi-Agency Public Protection Arrangements (MAPPA) report • Multi-Agency Risk Assessment Conference (MARAC) report • School Safeguarding Audit?

Dimension 2 Effectiveness of multi agency practice to safeguard and promote the welfare of children and young people	
• LSCB data set • Multi agency audits • Themed case audits • Case Studies • The Voice of the Child	• Serious Case Reviews • Management reviews • Reflective practice reviews • Effectiveness of the MASH

Dimension 3 Effectiveness of Brent LSCB to safeguard and promote the welfare of children and young people.	
• Brent LSCB audit tool	• Chairs 360 evaluation

Feedback on experiences will be through activities of the Voice of the child sub group and the Community reference group.

Principles for Learning and Improvement

1. There should be a culture of continuous leaning and improvement across organisations which work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice.

2. Reviews to be undertaken, not only on cases which meet statutory criteria, but also on cases which can provide useful insights about the way organisations work together.

3. Reports from cases meeting the criteria for a Serious Case Review (SCR) will be published in full unless there are compelling reasons not to do so.

4. LSCB's and partner agencies should make information available about issues identified in all reviews and audits so that partners the Board itself can be held to account by the public for making improvements.

5. The approach taken to reviews should be proportionate to the scale and level of complexity of the issues examined.

6. Reviews of serious cases must be led by individuals who are independent of the case under review and the organisations whose actions are reviewed.

7. Professionals must be fully involved in reviews and invited to contribute without fear of being blamed for actions they took using sound professional judgements

8. Wherever possible, families, including surviving children should be advised about the review process and their role within the review, their input sought where appropriate and feedback given with regards to the outcome of the review.

9. The impact of SCRs and other reviews on improving services must be included in the LSCB annual report with improvements sustained by regular monitoring.