Local Government
Improvement and Development

London safeguarding children board

Improving local safeguarding outcomes

Developing a strategic quality assurance framework to safeguard children

Contents

Framework developer
David Worlock,
Independent Consultant and Chair of the London Local Safeguarding Children Board (LSCB) Chairs' Network

Project advisory team
Rob Hutchinson CBE,
Independent Consultant, providing technical advice on Outcomes-Based Accountability

Paul Curran,
Head of Safeguarding Programme, Local Government Improvement and Development

Vivien Lines,
London Regional Safeguarding Adviser

Acknowledgements
This framework has been informed by ideas and principles from 'Outcomes-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.

Introduction to the framework

Who the framework is for

This 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 to gain a better understanding of how safe children are in their services and communities eg Directors of Children's Services, Lead Members, NHS trust boards, Chief Executives, Local Safeguarding Children Boards (LSCBs), 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.

Principles underpinning the framework

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 small steps.

We're all **learning** about how to develop an outcomes approach to safeguarding; we won't get it right immediately; what matters is to make a start in the right direction.

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.

The primary focus of this framework is on the 'child protection' end of the safeguarding continuum, although relevant reference is made to the broader picture issues affecting child safety.

The modules in 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 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 leadership and scrutiny bodies might ask in respect of quality assurance information; currently, organisational reflection and challenge might be limited if such bodies are not confident about what the critical questions are to get beneath the surface of the information provided. 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.

Module 1
The framework explained

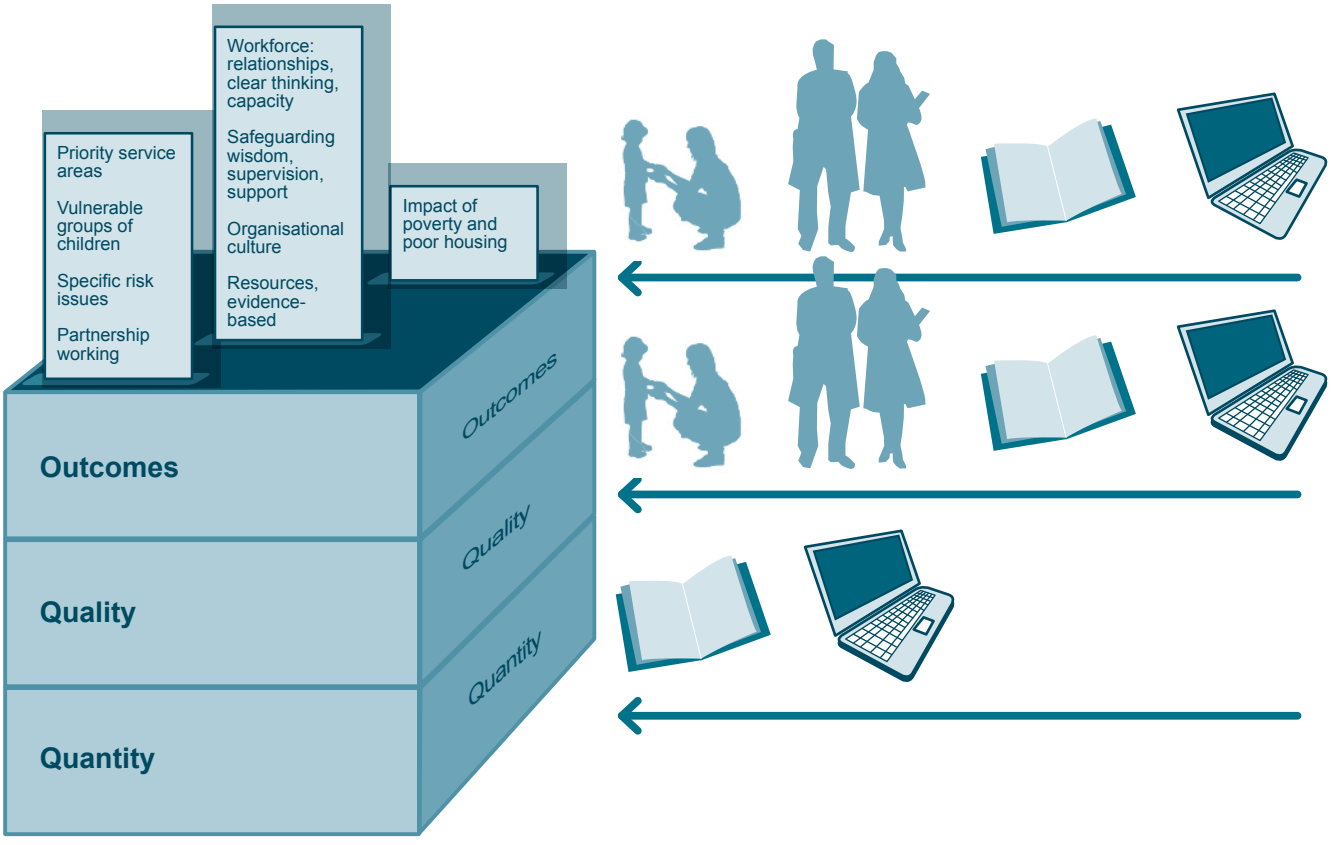
Section one
The three elements of the framework

The essence of this framework can be summarised as follows:

In order for those with safeguarding leadership, management and scrutiny responsibilities in individual organisations and partnerships to achieve a good understanding of the effectiveness of safeguarding arrangements and services in their service/area, they need:

- 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.

Figure 1: The framework



Element one
The content areas

There are so many dimensions to safeguarding that trying to quality assure everything would be overwhelming. There is therefore a need to focus on a discreet number of defined areas which the organisation/partnership concludes are the most important. What matters is that there is a logical, evidence-based reason for choosing the particular areas – based on reflection on relevant research, and the particular needs and priorities of your organisation or area.

Our analysis of recent research evidence – including issues from serious case reviews (SCRs) – statutory guidance and inspection frameworks and experience has identified the following as possible content areas (Figure 2) to be considered for inclusion in your own Quality Assurance Framework (QAF). Content areas do not exist in isolation; they interact with and modify each other and need to be understood as part of a total system. They fall into three groups:

Practice content areas

Priority service areas

For each organisation or partnership, there will be service areas which it will be particularly important to 'get right' in terms of quality and outcome because of their known impact on safeguarding eg the front door services (eg Referral and Assessment in Children's Social Care, A&E, police public protection desk); the operation of the formal child protection and children in need planning processes; antenatal and post-natal assessment, support and planning; vulnerable adolescents' mental health services; and health visitor services to vulnerable families.

Vulnerable groups of children

There are particular groups of children whose circumstances make them more vulnerable to safeguarding risks. Some of these groups will be common to all LSCB areas (disabled children, looked after children, children in highly mobile families, children missing education, children without GPs, children frequently missing health appointments, privately fostered children). Some will be specific to an area because, for example, they are near to points of entry into the country, local socio-economic characteristics that lead to problems such as gang activity or neglect, or presence in their area of facilities such as Young Offender Institutions (YOIs).

Specific risk issues

There is evidence from serious case reviews, research and experience that there are specific risk issues that can affect the wellbeing and safeguarding of children and are relevant to all organisations. Knowing what impact individual organisations and partnerships are having on these issues is therefore important. Key risk issues include:

- domestic violence
- parental mental health
- parental substance misuse.

Partnership working: how well professionals and organisations work together

Children and families need professionals and organisations that work well together to promote their wellbeing and safety. Failure to work together continues to be a key message from SCRs. It can take various forms; these include practical working arrangements, but also the mindset in which organisations and professionals approach what they do. Silo thinking and practice, poor information sharing and communication of 'meaning', lack of professional confidence

and leadership, and unclear or unresolved safeguarding thresholds are all regularly reported. Partnership working is not just about what goes on **between** different organisations, but is relevant for what happens between the different services and professionals **within** a single organisation.

Organisational/practitioner content areas

Workforce: relationships, clear thinking and capacity

Safeguarding involves the management of risk within a complex system of human relationships. The main actors are human beings: the families themselves, their networks and the professionals who work with them. The quality and capacity of the practitioners affects their impact. Children and their families need safe practitioners. Practitioners who have the time and human and emotional skills to engage families, to establish and maintain consistent relationships; the time and ability to think clearly and reflectively; and who practice within an evidence-based framework that enables them to intervene effectively.

Safeguarding wisdom, 'supervision' and support

'Learning and development' need to be more than acquiring information about new facts and processes. They need to be about the development and application of emotional, social and intellectual intelligence – of safeguarding wisdom. And we need to know whether learning and development 'inputs' actually do impact on practice, and whether changed practice (when it happens) leads to better outcomes for children and parents.

'Safeguarding wisdom' is nurtured through supervision. The interacting complexity and impact of the personal stories, current situations and human dynamics involved in safeguarding; the ease with which the focus on the child can be lost and unhelpful mindsets unknowingly developed (eg rule of optimism, desensitisation to poor standards); the need to stand back and think clearly and critically: these are realities that affect **all** practitioners. Each organisation – even if they do not use the term 'supervision' – will need some systematic means of providing opportunities for their staff to:

- reflect on the quality and impact of their practice
- develop their curiosity and enhance clarity of thinking
- provide the **support** to deal constructively with the emotional and psychological impact of the work.

Support includes, on a practical level, ensuring staff have decent working environments, equipment and practice tools that enhance effective practice.

Organisational culture

We know that safeguarding of children is complex and challenging work, which has an emotional and psychological impact on those who practise it, who in turn need to be clear thinking, confident, challenging (and open to challenge) and continually developing their skills and knowledge. The culture of the organisation they work for can be one which positively supports staff and managers and thereby contributes to the achievement of good outcomes for children; or it can be one which at best makes little positive contribution to the achieving of good outcomes or, at worst, makes the achievement of good outcomes less likely. Leaders in the organisation have a key role to play in setting the cultural tone and modelling the values and behaviours they wish to characterise their organisation.

Use of resources and evidence-based practice

Children and their families should have a right to expect that the interventions and services that are provided under the 'safeguarding' banner are supported by evidence that they can make a difference. There has been a growing body of research evidence relevant to safeguarding children work, including evidence about what services and interventions are effective (eg Research in Practice, C4EO, SCIE). The central question is the extent to which this growing knowledge base informs the strategic planning, commissioning and development of safeguarding related services and arrangements, as well as the day-to-day practice of individual professionals. This is a particularly critical question when funding for services is reducing, and decisions are being made about what services to invest in.

There are other issues that need to be considered when quality assuring the resource dimension of safeguarding as they can impact on outcomes: the balance between early intervention and specialist services; the balance between frontline and support services; the impact of service decommissioning; the use of untapped resources; and finding no or low cost solutions.

Wider picture content areas

The impact of poverty and poor housing

Wider environmental factors do not inevitably lead to the neglect and abuse of children, in the same way that adult mental health does not lead inevitably to abuse and neglect. Nonetheless poverty and poor housing are significant sources of pressure and stress for families, which can impact on parenting and the wellbeing of children and for some contribute to safeguarding risk.

(Other wider picture content areas that LSCBs might want to consider – depending on the needs of their area and confidence in respect of child protection arrangements – could include, for example, bullying, knife crime, road safety, fire safety, low educational achievement, poor health outcomes).

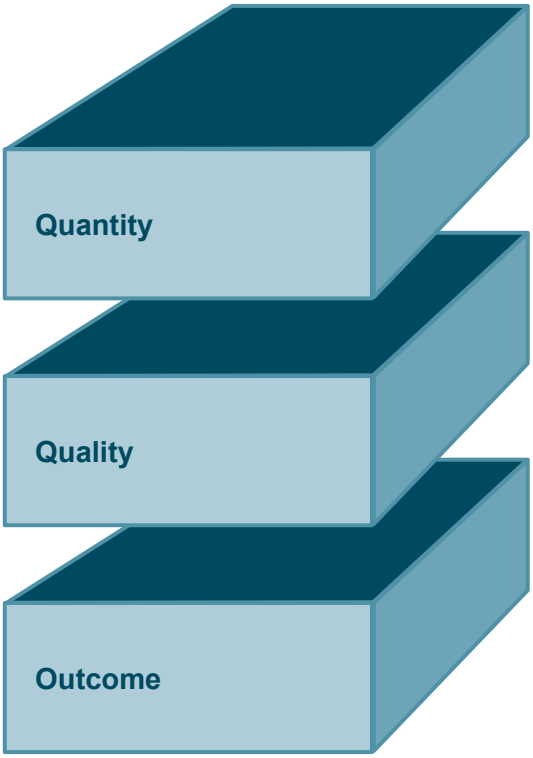
Figure 2: Examples of possible content areas

Priority service areas	**Vulnerable groups**	**Specific risk issues**
Partnership working	**Workforce: relationships, clear thinking, capacity**	**Safeguarding wisdom, supervision, support**
Organisational culture	**Use of resources/ evidence-based practice**	**Poverty/poor housing**

Element two
The three types of performance information

For quality assurance purposes, all performance information will be one of three types:

Figure 3: Three types of performance information



Quantitative information simply answers the questions 'How much/how many?'; for example, for services "How much did we do?" eg 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?" eg 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?" eg 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 NI 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 types of information can act as **performance measures** in respect of the organisation's quality and outcome standards (ie the 'good' in Section two below, and Module 2)**.** They are all valuable but they are not of equal value. The information that really matters is the outcome information, followed in importance by the qualitative information and then quantitative.

Traditionally, quality assurance information in safeguarding has focused largely on quantitative information, to some extent on qualitative information and hardly at all on outcome information. The challenge is, over time, to increase the proportion of outcome information.

Tips

Articulating outcome measures can be tricky as we easily revert to thinking in terms of quantity and quality. But it can be done, and outcomes can be very concrete: things that you observe, hear, smell and touch; and things that children and parents experience and feel. It just takes some thinking through and reflection to work out what might be meaningful outcome measures for particular services or areas of activity. They can be revisited and revised over time as wisdom grows.
Module 5 contains examples of quantitative, qualitative and outcome performance measures.

Outcomes: before and after
The best way to measure impact/outcomes is for professionals, children and parents to compare the child's/family's position at the point of assessment and then at **later** points. The key is to frame objectives for the child and family in terms of measurable outcomes which describe what the child's/family's life would look like if services provided and actions by the family have been successful eg:

- domestic violence has stopped
- parental drug use is no longer impacting on parenting
- parental mental health is no longer adversely impacting on the child
- family relationships are marked by high warmth and low criticism
- child is meeting developmental mile-stones
- parents are confident in parenting
- father plays an active and constructive role
- physical care is of a good standard eg children are warmly dressed
- children are saying they are happier/safer as a result of the help they have received
- parents report that intervention has helped their parenting.

The 'later points' may be at closure, transfer or six, 12 months after the end of involvement.

There are tools available to measure the 'before' and 'after' which are relevant for some situations.

The outcomes achieved in individual cases can then be **aggregated** to give an overall strategic picture of the impact of the service.

Element three
The different sources of information and methods for obtaining it

The information required for quality assurance will come from four main sources:

Figure 4: Sources of information

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.

If organisations spend time collating and reflecting on this experience, they will identify concrete changes to improve that experience and, ultimately, outcomes. It's about developing **organisational emotional intelligence.**

The most important question that needs to be asked of children, parents and carers is what **difference** (**outcome/impact**) the interventions and services have made to their lives: are things better as a result and in what way? As noted above, whereas organisations and professionals can struggle to frame what they are doing in terms of outcome statements, parents and children often appear to have less trouble in using 'everyday' language (much as professionals might do if talking about what they wanted for themselves or their families) to describe what they want to be different in their lives and how things have improved.

Tip

Perhaps one of the keys to becoming outcome focused is to start using the language of parents and children – for both individual case work and strategic evaluation – to articulate outcome objectives and measures?

Anyone who has met with looked after young people or parents on parenting programmes will know how they are able to describe in clear and concrete ways how their lives are better (or not, or worse). The knack is to collect individual stories into an overall picture.

Methods

There is a range of methods that can be used to capture the experience of parents, carers and children. Where possible, you should have **sustainable methods** which are part-and-parcel of how the organisation conducts its **day-to-day business** (eg capturing the experience of parents/children at key points of involvement: beginning, review, ending transition). In addition, specific exercises can be commissioned:

- **User surveys/interviews** conducted by phone or in person – ideally by people who are, and are seen to be, independent of services.
- **Focus groups**
- **Senior managers/councillors/ board members etc**. talking directly to parents, carers and children by involving themselves in the above or talking directly to them by going out on home visits, sitting in on interviews, meetings etc.

The messages from children and parents can be reported in two forms, both of which have value: key messages from customer experience exercises can be **aggregated** so that, for example, quality and outcome statements can be made about "the percentage of parents who reported that they had a positive relationship with their social worker/health visitor" or "who reported that the actions by the social worker/health visitors resulted in positive improvements for themselves/their children."

Alongside this form of reporting there also needs to be the reporting of the more detailed customer **stories** of their experience so that the **meaning** of their experience is also communicated.

Frontline staff and managers

After parents, carers and children, the people with the best knowledge of the actual quality and impact of services are the frontline staff and managers delivering them. Such staff will know not just the quality and impact of their own services, but also that of the partner agencies they work with. This perspective is especially crucial given the importance of partnership working in safeguarding.

An interesting phenomenon with serious case reviews is that the action plans arising from them invariably involve the production or revision of more procedures, guidelines and protocols. Yet it's rare that the problem in these cases is a lack of procedures etc.; the issue is more to do with the failure to implement the polices and procedures that already exist. Despite this, organisations can seek reassurance in the production of policies and procedures, and reports to governance bodies will often refer to the policies and procedures that have been put in place.

This can be false reassurance. We are dealing with complex human organisations which have a range of factors impacting on them both from internal and external sources; what's **meant** to happen in the policy and procedure, and what **actually** happens can be different things. There needs to be a **constant feedback loop** from the frontline to keep the senior management team and those with governance responsibilities 'reality-based': not just in terms of what is/is not working, but also with ideas for improvement so that adjustments can be made systematically.

Methods
The view of staff can be obtained in a range of ways; the starting point, though, needs to be the development of a **culture** which demonstrates that the views of staff are valued and taken seriously – and that it is OK, and in fact positive, to say things that are uncomfortable for the organisation.

These can include:

- staff survey exercises and focus groups targeting one or more of the content areas
- an annual partnership survey in which frontline staff in all organisations are asked to evaluate the strengths and weaknesses of partnership working in respect of key partners
- focus groups
- exit interviews
- for those with senior leadership, management or scrutiny responsibilities 'walking the floor' – observing frontline practice and talking with staff.

As with the experience of children and parents, the experiences of staff need to be communicated in an aggregated form, but also in terms of their **stories**. It's important to know, for example, that 70 per cent of social workers think that their service is safe for children – but we also need to know what this is based on, and what the concerns are of the other 30 per cent.

Tips

Walking the floor
Senior managers walking the floor regularly, talking to staff, listening and observing, sitting in on interviews, going out on visits are things that can easily stop happening in busy organisations, yet are invaluable – managers should book them into their diaries for the next 12 months; and then have unexpected walks!

Observing frontline practice
At least once a year, supervisors should make sure that they go out with their supervisees to observe their practice in situ with families. It's a good way to gauge engagement skills, awareness of the signs of abuse, neglect and other key skills.

Parents' and children's case records

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

Methods
Case record 'auditing': this is the systematic analysis of records by staff with relevant professional expertise, 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.

Some auditing needs to be **continuous** as part of regular management oversight arrangements (eg a set number of records audited each month by managers against a range of criteria); some will be **specific exercises**, programmed into the organisation's quality assurance timetable.

Management information about safeguarding. Most organisations will have some form of electronic or paper client information system that can produce management information reports. Such reports will usually produce quantitative information, some degree of qualitative information, but usually little outcome information.

Tips

Who audits?
Case record auditing can be undertaken not just by operational managers and designated 'quality assurance' staff, but by those with senior management/ leadership responsibilities.

Lead Members, Directors of Children's Services, Executive Directors on NHS Trust Boards etc. could audit four cases each year.

Data protection/confidentiality
Single-agency and multi-agency audits are essential quality assurance methods. When planning auditing, organisations should consider and take account of what the data protection, confidentiality and information sharing issues might be.

Is your auditing tired and process focused?
If your organisation has been using the same audit tool for years, it might be very process focused rather than outcome focused; auditing might have become 'administrative' rather 'impactful'. Audits only have value if they contribute to change and improved outcomes. Time for a refresh?

Other organisational activity and management information systems

Organisations will have a range of information in their systems which is relevant to safeguarding quality assurance eg Human Resource, financial information and learning/ development systems (eg number of people with up-to-date CRBs/GSCC registration; training completed; vacancy rates, experience of staff, turnover; and spend on different services).

Tips

Making sense of it all
Gathering the information is one thing; what really matters is the quality of organisational analysis of the information and whether the organisation translates it into service and outcome improvement. Time is needed to reflect properly. As in individual supervision different stories which might explain the information need to be considered – not just the ones which are most comfortable for the organisation.

Triangulation (Combining sources and methods)
To get the best understanding of quality and impact in respect of the content areas it's necessary to bring together information from different sources, as each source is likely to give a partial, but not complete, picture. Partial pictures can be seriously misleading.

Small steps
Individual organisations and partnerships will vary in their current level of sophistication and development in accessing the different sources. The challenge is for each to make some **small steps** in achieving a balanced portfolio of sources, and in particular giving appropriate priority to the views and experiences of children, parents and frontline staff.

Who does 'quality assurance': inside and out?

The idea of this framework is that a wide range of people **within the organisation** can and should be involved in the collation of quality assurance information from the above sources. Quality assurance needs to be owned and sustainable, an important part of core business. There will need to be some dedicated staff resources with the requisite skills and knowledge (eg in how to construct and conduct user surveys and service evaluations and data analysis) and for the co-ordination of quality assurance activity. However, staff and managers at all levels and those with scrutiny or governance responsibilities do need to be involved in the quality assurance process, and the nature of that involvement needs to be clearly specified. The voices of children, parents and carers, for example, will have greatest impact if they are heard **directly** by both senior and frontline members of the organisation. This wider engagement of people in direct quality assurance will help to ensure that quality assurance is not an activity done by a special unit on the periphery, but is owned and valued by all, creating a quality assurance and learning culture.

However, there are roles for those **outside the organisation** which need to be incorporated into the overall governance framework:

Peer deep dive review
One approach that could be used to look at one of the content areas **in depth** – in particular Priority Service Areas, Specific Risk Issues and Vulnerable Groups – is a 'peer review model'. Co-ordinated by the LSCB, a review team comprising representatives from a number of LSCB partners would be invited to look in depth at a service area which is the primary responsibility of another LSCB partner.

External peer review
Periodically there would be value in commissioning an external peer review, in which the review team comprises people who have no association with the LSCB area. Because those involved in such reviews are not involved in the day-to-day pressures of running the services, they are often able to identify strengths and development areas succinctly, crystallising and articulating key issues. Because this is a review rather than inspection process, it provides an opportunity for calm organisational reflection.

Local Government Improvement and Development (previously known as the IDeA) has developed a peer review model for safeguarding and can be commissioned to provide a trained peer review team. For smaller scale reviews, LSCBs or single agencies could consider linking with LSCBs/ agencies in other areas to undertake exchange peer reviews.

Academic institutions
Universities with relevant research teams are a possible resource for undertaking quality assurance work, though there can be a cost.

Inspections
Inspections (eg the safeguarding inspections undertaken by Ofsted) can provide valuable insights into a number of the areas in this framework.

Serious case reviews and other stories
SCRs now involve independent people to chair the panel and complete the overview report; some Individual Management Reviews (IMRs) are also undertaken by independent people. SCRs can contribute to quality assurance because they help to answer the question "how safe and effective are our safeguarding services and arrangements?" Importantly, they tell a story of what actually happened to people and stories can be powerful means of communication. What the SCR process has proven less effective at achieving is improved outcomes; moreover, SCRs are reactions to what has already gone wrong.

There is an opportunity to consider alternative models for capturing learning from real life stories: not just those where things went wrong, but 'near-misses' and stories where good outcomes were achieved – to build up a picture of what good looks like.

Messages from research
Whilst the messages from national research will not tell individual agencies or LSCBs what the actual position is in their area, it will help them to know what to focus on, a context and benchmark for making sense of what is found about the local position and, in terms of the improvement cycle, offer ways forward.

> Tip
>
> **Module 4** gives examples of different sources of information and methods for different content areas.

Section two
Implementing a local framework

This framework is intended to be used by both **single organisations** and **strategic partnerships.**

The steps for single organisations to take in building their own quality assurance framework (QAF) are described in figure 5.

Once this framework is adopted by an organisation that has safeguarding responsibilities, it is then the responsibility of the organisation to determine the precise content according to their specific circumstances and priorities. The steps can take the form of questions which can be asked and answered by a range of people from across the organisation.

Step 1
What are the 'content areas' that should be in our framework?

Identify all your relevant content areas so there is a total picture – prioritisation comes later.

Step 2
For each 'content area' what does 'good' look like for you?

The idea is to describe through a set of statements the quality and outcome standards the organisation is aspiring to in the content area. This is necessary to enable those with leadership and governance responsibility to have a clear understanding of how well the organisation is actually doing in respect of the content area. Examples of possible statements are contained in Module 2.

Step 3
What performance information about each 'content area' do you **currently** collect in terms of type and source?

How much of this information is about quantity, quality and outcomes? How much comes from the experience of children, parents and staff? It's possible, for example, that some organisations will find they collect a reasonable amount of quantitative information about numbers and activity, but relatively little about quality and outcomes, and that the experience of children, parents and frontline staff is not captured at all.

Step 4
What **additional/different** performance information – in terms of type and source – do you need to collect, to determine how well you are actually doing in this area relative to your picture of 'good'?

See Module 5 for examples. There are no absolutes; the idea is to work out what is most meaningful. This presents an excellent opportunity to develop 'bottom up' quality and outcome performance measures, informed by children, parents and frontline staff that can be developed and refined with the benefit of experience.

Step 5
How do you 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** eg 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 you use capture information relevant for several content areas?

Step 6
What are your priorities?

Whilst 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. Thus 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? **The important thing is to take some small steps and to do them well.**

Step 7
What is your three-year 'quality assurance timetable' for the gathering of information? (Figure 6)

Having decided the priority content areas to focus on, the information required, the sources of the information and the methods for capturing it, the next step is to develop a sustainable and manageable timetable. To do this, it will be necessary to think longer than one year.

- As noted above, it should be possible to gather some quality and outcome information **continuously** by adapting or introducing sustainable methods to existing business processes eg evidence of quality and impact captured when an intervention or service has ended; evidence derived from senior managers 'walking the floor' and hearing the experiences of frontline staff.
- Some information will require specific exercises that need to be planned for. Some can be programmed in to take place **annually** eg an annual audit of the experience of frontline staff of safeguarding within their organisation and of partnership working, of supervision etc; parent/child experience exercises; an in-depth analysis of one or two of the priority content areas (using a range of methods including, for example, a peer review model with partners from other organisations).
- Some activity can be programmed to take place **every three years** eg a peer review involving professionals from outside of the area.
- Build in expected formal **external inspections** into the timetable.

Step 8
Agreeing a clear organisational learning and improvement cycle

This step is described in Section three below.

Tip

Outcome measures and single organisations
Because of the systemic nature of human life, there will not be a simple causal relationship between the input of one service or profession and a particular outcome. This does not need to be a barrier to organisations trying to build a picture of what happens to children and families with whom they have had a lead or significant involvement. Midwifery services working with vulnerable parents need to know in what ways those parents' lives are different; social workers undertaking core assessments need to know what the end result was for those children and families; organisations providing domestic violence services need to know if domestic violence is ceasing/ reducing etc. – even though other professionals might have some involvement. The aim is to build a degree of association between what professionals/services do and outcomes for children, even though it will not be a pure cause-effect relationship.

The learning derived might well have implications for partner organisations and if so should be shared. For example, children's social care might well take the lead in measuring the impact of child protection and children in need plans, but there will be learning from this to be shared with others.

Single organisations might partner up with each other to evaluate quality and impact in some content areas eg children's social care and the adult mental health trust in respect of work with parents with significant mental health needs; the acute trust and the mental health trust in respect of pregnant women with mental health needs.

Figure 5: The steps in building a framework in single organisations

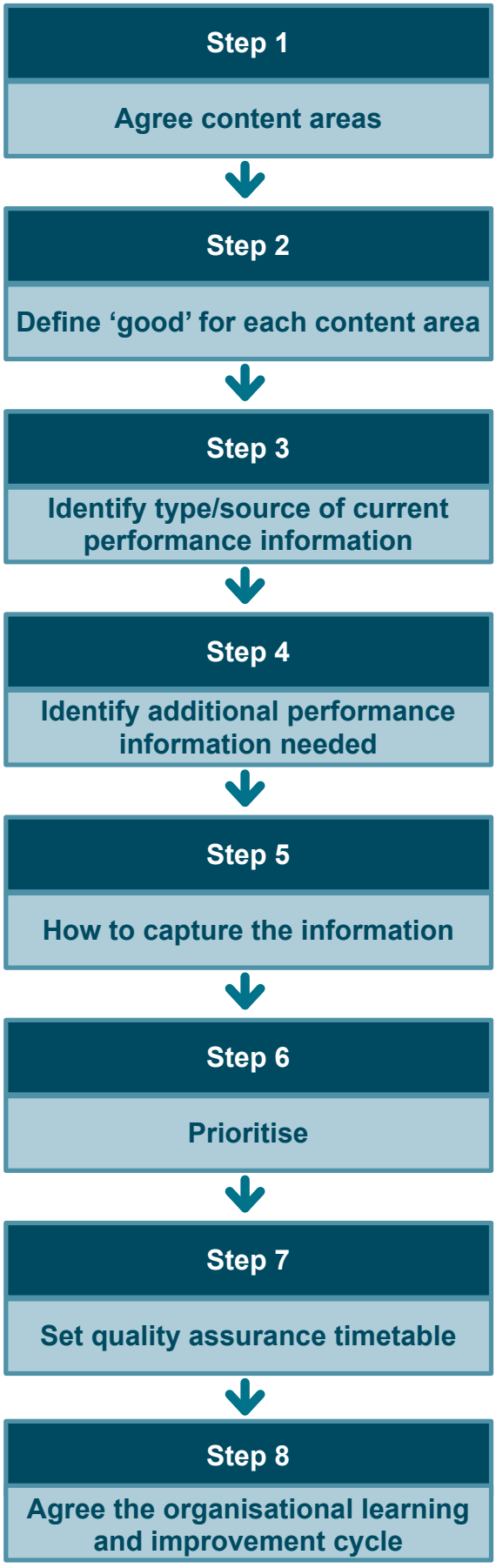
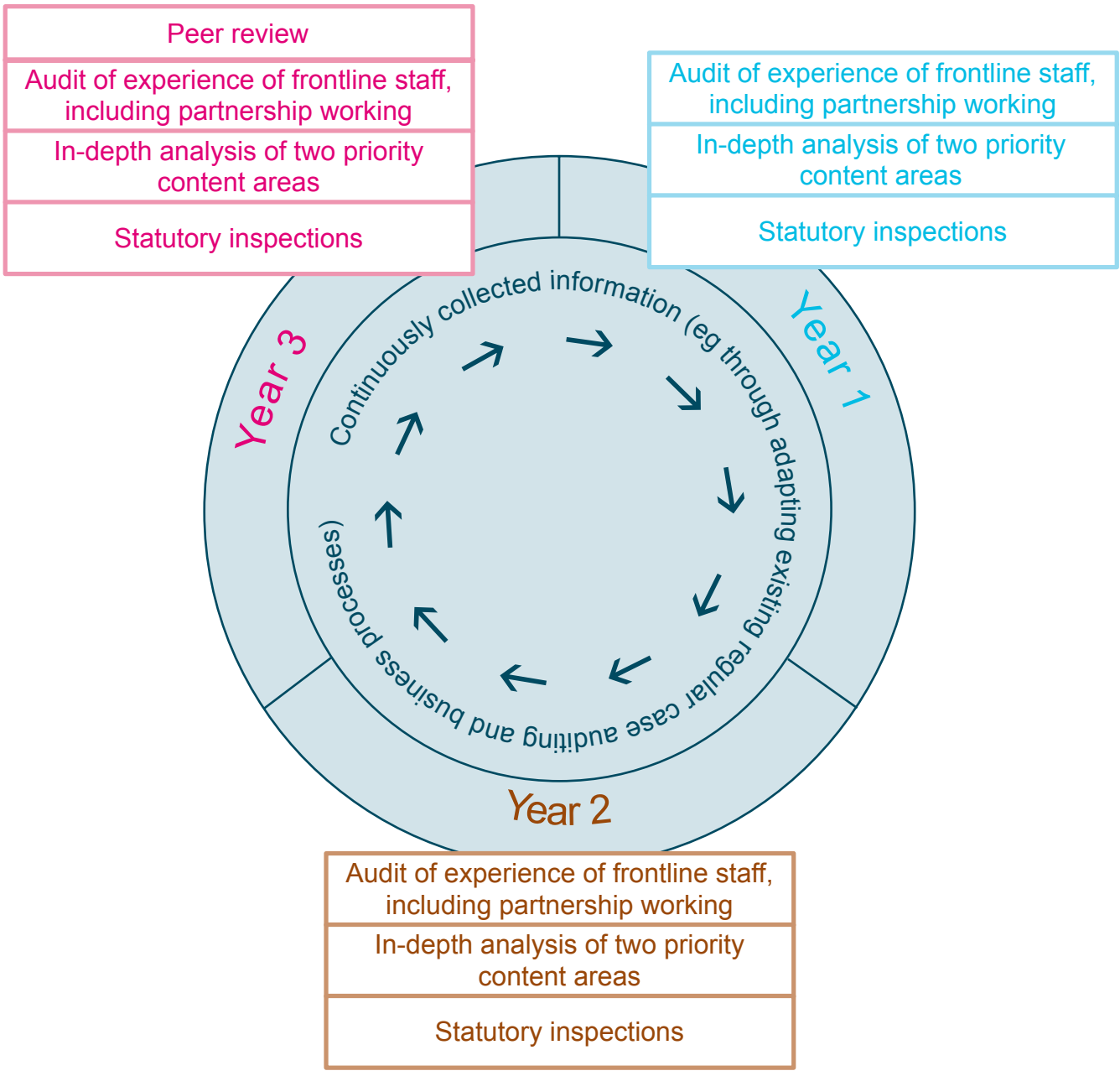


Figure 6: Example of possible quality assurance timetable for single agencies



How the framework can be used by an 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).

In order to do this LSCBs can use this framework to structure their quality assurance activity. LSCBs could do this by:

- Agreeing what the 'content areas' should be for the LSCB to focus on. It is anticipated that there will be considerable crossover between the content areas identified by the LSCB and individual organisations. This will enable the LSCB to draw together the information from its partner organisations into a **collective overview** of safeguarding quality and effectiveness across its whole area.
- Working with, and offering challenge to, partner organisations when defining their content areas, priorities, balance of sources and types of information – to ensure they are evidence-based, outcomes-focused and draw on child/parent, staff experiences.
- Developing its own **quality assurance timetable** in which it will undertake or commission additional quality and outcome exercises which have a cross-agency or thematic focus. For example, whilst a number of individual agencies will want to know how well they are working with parents who have mental health needs or experience domestic violence, the LSCB could commission a more in-depth cross-cutting review.

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 (See Section three) and work with the Children's Trust Board to make a difference (see Mark Friedman, 'Trying Hard is Not Good Enough', 2005)
- every three years commission an **external peer review** of a content area/collection of content areas
- every two years use the elements of the framework to reflect on their own **impact**.

'Use of resources' is a suggested content area for the framework. It needs to be co-ordinated in the same way that operational practice is. Children's Trust Boards are in a good position to provide this co-ordination and coherence. LSCBs need to maintain an oversight over budget planning and decision making, and offer constructive challenge to both individual agencies and the Children's Trust.

Section three
Governance frameworks/ learning and improvement cycle

The end product of the above steps should be that each organisation will have, over time, an improving picture of the quality and impact of its safeguarding services and arrangements. The LSCB, by drawing on the information from the single-organisation frameworks will develop a picture of the quality and impact of safeguarding arrangements and services across the area as a whole.

The key questions then are:

- To whom does this 'picture' go?
- When does it go?
- In what form?
- How is it considered?
- How is it linked to improvement?

Ultimately these decisions are for local partnerships and organisations to take. The main thing is that each organisation and partnership has a transparent/published **safeguarding governance framework** in place which addresses these questions to ensure proper consideration of the information emerging from the framework, and its feeding into a **learning and improvement cycle** that results in real change affecting children.

Tip

Reflecting and acting on the story: a test for managers and leaders
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.

Avoid 'audit for audit's sake' so you can tick the audit box in the return to your regulatory body.

Management/leadership/scrutiny groups should test themselves:

- Do we really think about the information we are presented with, or do we just accept it?
- Do we allow enough time for reflection/discussion?
- Do we ask the difficult and uncomfortable questions? (see Module 3)
- Do we give the impression to our staff that we only want to hear 'good news'?
- What's our track record for ensuring performance information leads to improved outcomes?

Tip

Reflection space ('thinking' is work) and modelling behaviour: your daily 20 minutes
If leaders and senior managers want their staff to be more reflective, they must model good reflective behaviour themselves. This is not easy. But thinking time is real work, as much as writing a report. Maybe everyone in the organisation could make sure they have 20 minutes each day not in a meeting, or on the phone or on a computer, just thinking through some aspect of what they are doing?

Governance framework: single organisations

Single organisations need to decide and state clearly which of their senior management, leadership and scrutiny bodies the information derived from their QAF 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 or full Council.

Annual reporting
It is recommended that once a year there should be a full safeguarding report based on the QAF going to these senior leadership and management groups.

This formal reporting process would include the performance measures chosen by the organisation, expressed in percentage terms to track improvement over time, supplemented by:

- summaries of the messages from children, parents and frontline staff of their experience of quality and outcome
- the direct quality assurance activity of those in the senior management/leadership teams for whom there would be an annual programme enabling them to meet with parents/children and frontline staff.

Monthly and quarterly reporting
The performance measures that agencies decide to include in their QAF should, where possible, be reported monthly or quarterly to the senior operational management teams. Monthly reports might not be possible for all measures; for example for those where the method for collating the information is through annual audit or customer experience exercises. These monthly and 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.

Frontline teams
The information that emerges from an organisation's QAF will also be relevant to frontline operational teams and individual professionals. They need to know, for example, how parents, children and professionals experience what they do, and whether what they do is making a difference to people's lives. The information can help generate discussion in team meetings and supervision that keeps the focus on customer experience and outcomes. This helps to make quality assurance a dynamic process which can have an immediate impact. Moreover, this provides a mechanism for generating the ideas of individual professionals and teams on what can be done to improve effectiveness in keeping children safe.

Safeguarding supervision
There is much debate now about what a model of supervision would look like that would better equip and support staff to work with the complexity of safeguarding work more effectively.

Tip

Many reports to boards and committees, though technically accurate, can 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 QAF. Each section would comprise an A3 sheet containing:

- A summary of why the area is important and what 'good' would look like.
- Graphs setting out the priority quantitative, qualitative and outcome information – with any relevant comparative information, and year-on-year figures to show the trends.
- The story explaining the information – the analysis.
- Actions to achieve improvements in quality and outcomes.

In addition, for each section there could be a story sheet, capturing some of the experiences of parents, children and frontline staff that lie behind the figures and bringing the issues alive.

Asking some of the questions in respect of individual cases that it is recommended whole agencies ask ("What impact is what you are doing having on this family?" "How will you know if you are making a difference?", "How does the parent/child experience the service?", "What's the evidence base for what you are doing?") could lead to an overall movement in organisational culture towards a focus of the customer experience and wellbeing outcomes.

Tip

Being curious/asking the right questions
It will be important that the boards and committees to which annual reports are made allow enough time for proper reflection on, and learning from, the information. They need to be curious, not to accept things on face value and know the key questions to ask to get below the surface of the information. Members of such boards need to have had training on safeguarding issues.

Module 3 contains examples of questions to ask for the different content areas.

Tips

Shifting the paradigm to outcomes
Paradigm shifts in organisations are more likely to be achieved through the repeated asking of thousands of small questions and the making of repeated small actions/ statements rather than a conference, strategy document, protocol, vision statement or director's letter.

Keeping things human
For annual reports, monthly and quarterly management reporting and discussions by teams or individuals in supervision, the actual stories of children's and parents' experiences – as well as the aggregated outcome and qualitative information – should be shared.

Governance framework: LSCBs

Quality reports based on the QAFs of single organisations and its own quality assurance programme would be presented to the LSCB. This will enable the LSCB to evaluate the information and offer constructive challenge. By considering the reports from single agencies alongside each other, the LSCB would be able to identify relationships, dependencies and cross-cutting issues and themes. It would thus build up an overview picture of safeguarding in the area. This would be brought together to constitute its **annual report** (Figure 7). The annual report would then have a stronger focus on outcomes and impact, rather than a more traditional focus on activity. (The LSCB could adopt the same format as the single agency 'Safeguarding Children Report Book' above).

This report would then be taken to:

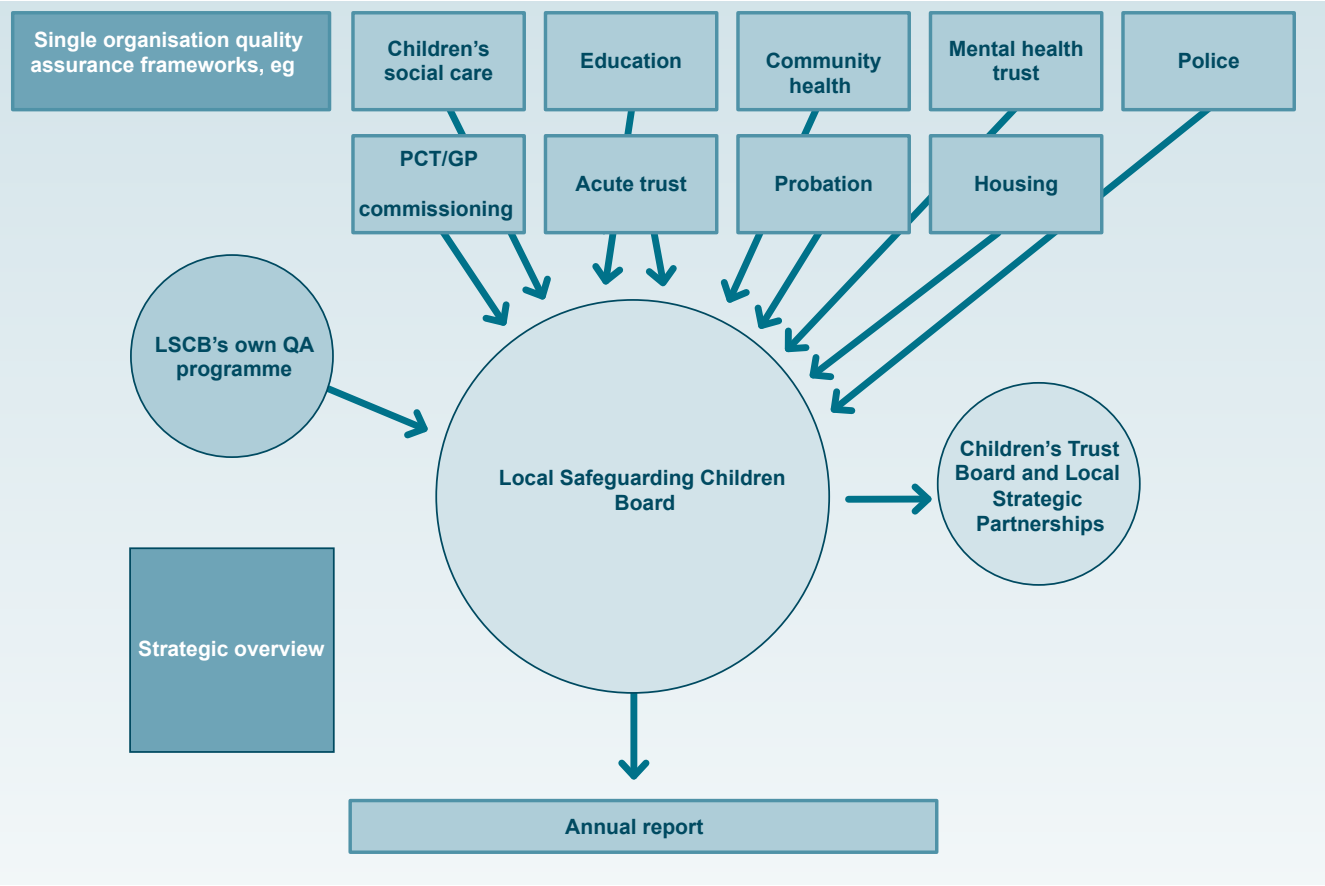
- the relevant governance bodies in partner organisations
- the Children's Trust Board (or equivalent)
- the Local Strategic Partnership.

Tip

How to stop reports to LSCBs becoming administrative
The danger of presenting any report to any board is that it can become a dead, administrative process, whereas what is needed is reflection, curiosity and learning. For the Board to handle reports from several partner agencies in this spirit, it might want to, as part of its forward plan:

- consider one content area shared by several partners at each of its meetings
- focus on all the content areas for one or two particular partners at each meeting, or a sector such as health
- have **an annual quality assurance event** where the main messages from the single agency reports are shared and considered.

Figure 7: Developing a strategic overview of safeguarding in an area



Learning and improvement cycle

The fundamental purpose of this framework is to improve outcomes for children. It therefore needs to be part of a clear improvement process:

The **single organisation annual reports** and **the annual report** of the LSCB should contain the key actions to be taken to improve quality and outcomes over the next 12 months.

- The actions should be evidence-based (ie based on of good practice in other areas or research findings eg C4EO validation).
- It's better to concentrate on doing a **few actions** well enough to make a difference to outcomes, rather than trying to complete an ideal 'to-do' list.
- To increase the chances of achieving the desired end results for the actions, a consistent **project management** approach and methodology should be adopted.
- The LSCB annual report should also feed into the development and reviews of the **Children and Young People's Pla**n (**CYPP)** (or equivalent).

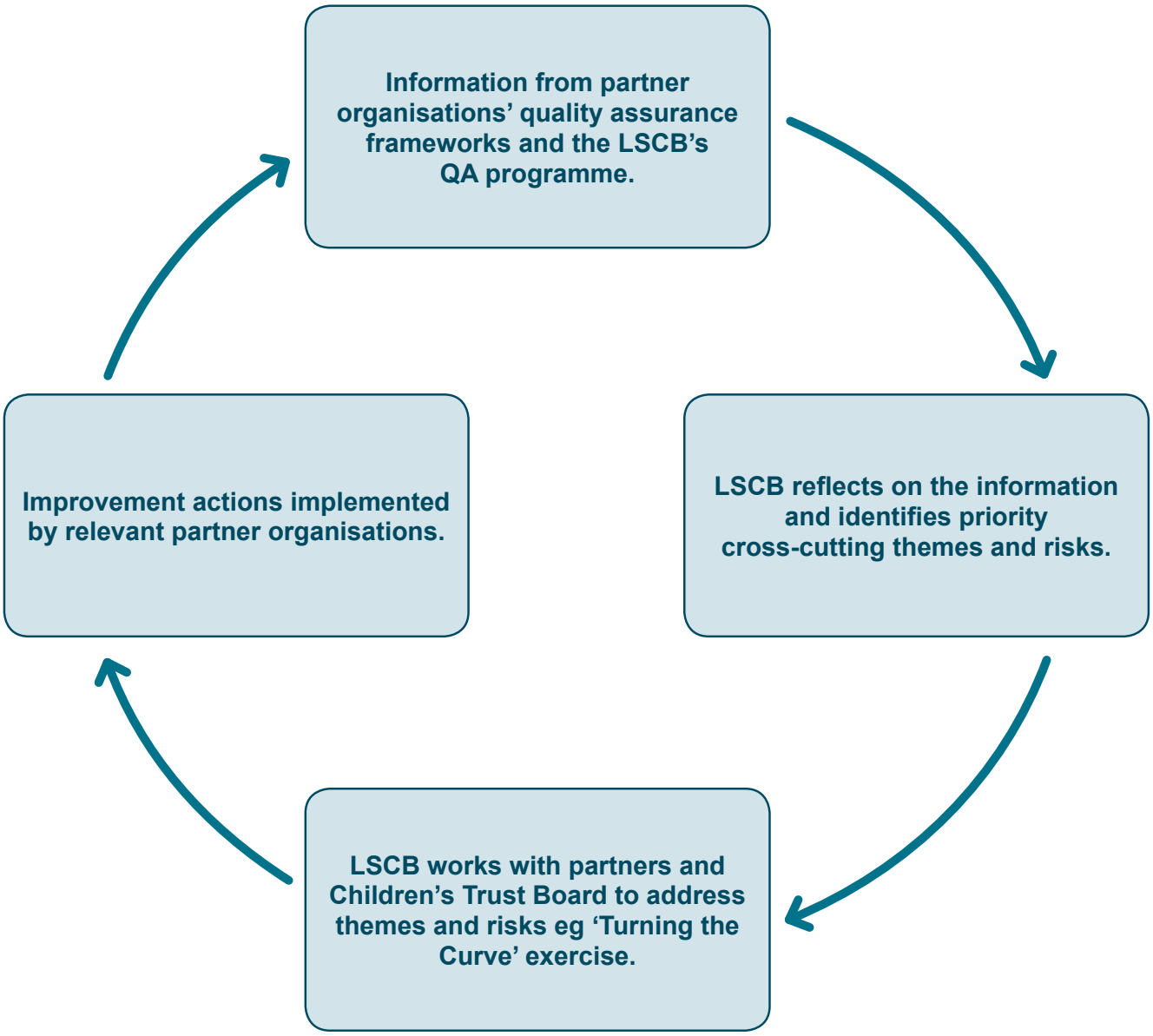
For the **single organisation monthly and quarterly reports**, the idea would be to bring the information from the QAF to the relevant management meetings, and during the meeting **reflect** on the information, determine what the **story** is behind the figures, and agree on what immediate **action** is necessary to deliver improvements.

Consideration of quality assurance information at **team level** should generate ideas for improvement that can both be acted on by the teams but feed into the organisation's action planning.

Making change happen

LSCBs (Figure 8), because they will have an overview of the position in single agencies, are now in a good position to provide challenge to partner agencies and to monitor their improvements, focusing their time and attention on the areas of highest concern – which will then inform the LSCB's quality assurance programme/time-table and multi-agency learning and development plans. For example, the LSCB might initiate a **'Turning the Curve' exercise** to focus down on, and lead improvement in, an area of particular concern eg domestic violence or neglect.

Figure 8: LSCBs and improvement



Module 2
What does ‘good’ look like?

Explanation

This section sets out examples of statements of what ‘good’ might look like in the content areas in terms of quality and outcomes.

They link with the performance measures in Module 5 which are used to determine the progress the organisation or partnership is making in reaching the ‘good’.

These statements should paint the desired picture for the content area, so that those with scrutiny and senior management responsibility can compare it with the performance information presented about the actual reality.

As with all the Modules, these are examples only; organisations and partnerships need to determine for themselves what good looks like for them and to use as many, or as few, of such statements as is appropriate for their position and needs.

The views of children, parents and frontline staff should inform the organisation’s ‘good’ statements – they’re also more likely to express ‘good’ in language that keeps the human focus.

Practice content areas

Priority service areas

(examples taken from various service areas)

In this area **good** could look like:

Outcome statements

- Child protection plans and ‘children in need’ plans result in objective, tangible improvements in the wellbeing and safety of children and their families.
- Children and parents identify positive improvements in their safety and wellbeing as a result of the work arising from the children in need/child protection plan.
- Parents feel – and can support with concrete examples – more empowered and effective in their parenting as a result of the involvement of the midwifery service/ CAMHS/children’s social care/police service.
- Parents report that contact with the service has made a positive difference to their and their children’s lives.
- Highly vulnerable young people (and their parents) in receipt of adolescent mental health services evidence and report improvements in their mental health or reduction in risk taking behaviour.

- Risk factors are reduced and protective factors increased in vulnerable families on health visitors' caseloads.
- Ante-natal midwifery services are effective in identifying, engaging, assessing and helping those mothers who are vulnerable. This is evidenced by a reduction in the original concerns and levels of vulnerability.

Quality statements

- Plans for children arising from assessments (single or multi-agency) are framed in terms of the measurable wellbeing and safety outcomes to be achieved.
- Parents report that they are treated empathetically and with respect by staff in A&E, Children Social Care's 'front door' service etc.
- Those making referrals to the front door of Children's Social Care are able to talk directly with an experienced social worker with minimal intervening steps.
- Children remain the focus of professionals' attention.
- The involvement and impact of fathers and partners is understood by practitioners.

Vulnerable groups of children

In this area, what **good** looks like would depend on the particular group. However, one element in common for a number of these groups is that they are worked with by workers and teams with a specialism – for example, non-school attendance, youth offending, fostering, leaving care, disability. In the same way that agencies and partnerships need to be confident that professionals in adult mental health, drugs services etc. are taking a 'Think Family' approach, so they also need to be assured that professionals in specialist services are thinking about the whole world of the child, not just the area of specialism. Thus an example of 'good' that might apply to all would be:

- **Professionals working in specialist children's services are effective in identifying and responding to safeguarding concerns.**

In this area **good** could look like:

Gangs

Outcome statements

- Violent crime by young people is decreasing.
- The number of young people joining gangs is decreasing/the number of young people leaving gangs is increasing.
- Young people in the area feel safe in their community/to walk the streets.

Young people in the secure estate

Outcome statements

- The number of incidents involving physical restraint in the Secure Training Centre (STC)/Young Offender Institution (YOI) is decreasing.
- The number of incidents of self-harm/acts of violence in the STC/YOI is decreasing.
- Young people in the STC/YOI feel safe.

Quality statements

Young people enjoy positive relationships with staff.

Looked after children

Outcome statements

- Looked after children feel and are safe.
- Looked after children have at least one trusted adult in their lives who they confide in when they are unhappy, and this relationship/s contributes to their feeling of safety and security.

Quality statements

- Fostering panels in their approval and re-approval functions, are rigorous in their consideration and challenge in respect of potential safeguarding concerns.
- Looked after children have a consistent relationship with a social worker, who they see regularly and on their own.

Children missing education/not attending school/educated at home

Outcome statements

- The average period children are missing education or not attending school is decreasing.
- Those missing education or not attending school establish settled attendance in a suitable education facility within a term.
- Those who have been out of school or not attending are now catching up on their educational outcomes.

Quality statements

- Children missing education or not attending are all known to the Education Service.
- The local authority is aware of, and responds appropriately to, the safeguarding needs of children missing from education or not attending school.
- The local authority has arrangements in place to collate details of children known to be educated at home, and has in place a policy for proactively promoting the safety of those children within the limits of current legislation.
- Those young people now attending school are positive about it and report good relationships with staff

Children who regularly miss health appointments

Outcome statements

- Patterns of missed appointments improve, and the health issue or concern is addressed satisfactorily.

Quality statements

- Poor attendance at appointments is monitored and results in systematic professional activity to engage.

Children not registered with a GP

Quality statements

- There is a proactive strategy in place.
- The strategy results in a reduction in the number of children not registered/not permanently registered with a GP.

Specific risk issues

In this area, **good** could look like (in respect of **domestic violence**):

Outcome statements

- Arrangements and services designed to address domestic violence (eg Multi-agency Risk Assessment Conferences (MARACs), Independent Domestic Violence Advisers (IDVAs), perpetrator programmes) are evidencing a positive impact on the incidence of Domestic Violence (DV).
- Domestic violence ceases in those families where it was identified as a risk factor.
- Children in families which have experienced domestic violence are doing well in key Every Child Matters (ECM) wellbeing areas eg attending or doing well at school.
- Perpetrators of DV are ceasing their violence.

Quality statements

- The impact of, and risks posed by, domestic violence inform professionals' assessments and plans.
- Perpetrators of DV are receiving evidence-based help.
- Specialist domestic violence services operate and practice a 'Think Family' approach.
- Families report that police attending DV incidents treat them with respect, involve the children, and provide clear information.
- Police exercise professional judgment before referring DV cases to other agencies.

In this area, **good** could look like (in respect of **adult mental health**)

Outcome statements

- Assessments, care plans and service provision result in positive objective outcomes for all family members. These outcomes are confirmed by parents and children.
- The detrimental impact of adult mental health on children's safety and wellbeing is reduced in cases where it is identified.
- Children whose parents have mental health needs are doing well in the five ECM outcome areas.
- Children whose parents have mental health needs do not feel isolated, know where to get help from and feel well-supported.
- Parents using Sure Start Children's Centre Services (or other family support services) say they are less depressed and better able to cope.
- Fewer parents need admission to hospital for treatment for depression.

Quality statements

- Assessments, care plans and service provision take into account and address the needs of **all** family members.
- All children whose parents have mental health needs that impact on the children's wellbeing or who have caring responsibilities for their parents, are known to relevant agencies and their needs are assessed and planned for.
- There are in place screening, assessment, care planning, provision and review arrangements in children's and adult mental health services that are based on a 'Think Family' approach.
- There are models of service provision and arrangements in place that are based on evidence of what works/best practice from other areas.
- The content of SCRs and Sudden Untoward Incidents (SUIs) reveal that local adult mental health services operate successfully a 'Think Family' model.
- There has been a comprehensive review of the interface between, and outcomes achieved by, adult mental health and children's services – involving commissioners and providers – identifying strengths and areas requiring development. The review draws on the experience of parents, children and frontline staff, and uses the criteria developed by SCIE for successful services as benchmarks. (Think child, think parent, think family: a guide to parental mental health and child welfare. Social Care Institute of Excellence, July 2009).
- On the basis of the review, there is a locally agreed 'Think Family Strategy' designed to develop and deliver services and processes characterised by the SCIE criteria.

Partnership working: how well professionals and organisations work together

In this area **good** could look like:

Outcome statements

- Partnership working is delivering concrete positive outcomes for children and their families.
- CAF is delivering improved outcomes for children and their families.

Quality statements

- Children, young people and parents do not experience disjointed and uncoordinated involvement by different agencies.
- Professionals in different organisations in the area know and trust each other, report positive working relationships, and converse with each other in a way that communicates a shared understanding.
- Professionals **within** agencies report that they have effective, creative relationships with other professionals/teams within their agency.
- Professionals know the range of services available and match them appropriately with the needs of children and families.
- Professionals are confident: to be the lead professional, to challenge, to share information.
- Professionals use escalation processes effectively to achieve desired outcomes.
- Children's and adults' services have a 'Think Family, Act Family' mindset reflected in an holistic approach to assessment and care planning.
- Referrals to Children's Social Care are appropriate in terms of agreed eligibility criteria and reach an agreed quality standard.

Organisational/practitioner content areas

Workforce: relationships, clear thinking, capacity

In this area **good** could look like:

Outcome statements

- Parents and children say that the work of the social worker/health visitor/midwife has improved their wellbeing eg improved parenting skills, family relationships.

Quality statements

- Parents and children experience consistency of professionals.
- Parents do not feel stigmatised by or fearful of services.
- Parents and children report that they have a positive relationship with their social worker, health visitor, midwife or teacher.
- Professionals in universal services have the skills and confidence to speak with children directly around issues that may contribute to maltreatment, and do so.
- There are sufficient numbers of professionals with the right competencies, knowledge, qualifications, skills and experience to meet the needs of people who use services at all times.
- The most complex areas of work in terms of safeguarding are staffed by the most experienced and competent professionals.
- Professionals are able to spend an adequate proportion of their working time in direct contact with children and families.
- Professionals have manageable case/workloads (ie caseloads that support clear thinking and allow an adequate level of relationship building and maintenance for the role).

- Professionals and their managers have time-management arrangements which build in time for calm reflection during the working day.
- Professionals and managers have the necessary level of experience for the particular task in hand.
- High proportion of permanent staff, low proportion of agency staff.
- Low level of vacancies, staff turnover and staff sickness
- There is compliance with safe recruitment policies and procedures
- An appraisal system that is valued by staff as promoting their professional development.
- Clear standards of competence which are taken seriously.
- High morale.
- Good working environment and conditions of service.
- Effective responses to allegations against staff.

Safeguarding wisdom, supervision and support

Safeguarding wisdom

In this area **good** could look like:

Outcome statements

- The learning and development strategies of single agencies and partnerships do result in improved practice, which in turn translates into improved outcomes for children and their families.
- Professionals report, and can evidence, that the learning and development they receive has improved their practice and outcomes for the children and families they work with.
- Practice deficits identified in SCRs and practice audits have been addressed and outcomes has been demonstrated to have improved.

Quality statements

- Professionals within the service are operating at the required level of safeguarding children practice competence.
- Single agencies, Children's Trust Boards and LSCBs have up-to-date safeguarding learning and development strategies, based on needs analysis.
- All professionals for whom learning and development inputs are provided as part of single agency or partnership learning and development strategies do receive and take up those opportunities within required time-periods.
- Learning and development inputs are based on latest evidence from research.
- All professional groups are well-represented on multi-agency safeguarding training courses (including professionals from adult services such as domestic violence, adult mental health and substance misuse)
- Learning and development inputs help to develop critical thinking skills which are reinforced in supervision.

Safeguarding supervision and support

In this area **good** could look like:

Outcome statements

- Professionals can evidence the impact of supervision on their practice and outcomes for children.

Quality statements

- Professionals look forward to coming to work.
- Professionals report that the supervision they receive supports their ability to make sound professional judgments.
- Staff feel they are well-supported, especially to deal with the emotional and psychological stresses of the work.
- All relevant professionals are receiving safeguarding supervision of the quality and quantity necessary for them to keep children safe and promote good outcomes.
- Whilst the exact form of safeguarding supervision may vary between professional groups, there are shared core elements agreed by the local partnership.
- Partner agencies in Children's Trusts and Local Safeguarding Children's Boards
  - have identified which professionals and managers in the children's and adults' workforces require safeguarding supervision – both employed and contracted eg health visitors, designated Child Protection (CP) teachers, social workers, GPs, A&E staff, children's centre staff, adult mental health professionals, domestic violence services, drugs and alcohol services.
  - agree and publish a safeguarding supervision policy.
  - evaluate the impact of supervision as well as its frequency.
  - ensure that those delivering supervision are appropriately trained.

Organisational culture

In this area **good** could look like:

Outcome statements

- The outcomes achieved for children and families is the dominant priority for the organisation.

Quality statements

- Children and parents experience the service as one which delivers what it promises, that treats them with respect.
- Professionals report that the organisation they work for supports and values them; listens and responds to their concerns and ideas; helps them to deal effectively with stress; and develops their skills and knowledge.
- Senior managers take a personal and visible interest in what's happening on the frontline: they meet and talk with frontline staff, they observe what's happening, they accompany staff on visits, and they meet with service users to hear their experience.
- There are arrangements in place to help staff deal with the emotional stress of the work. Staff are able to share their anxieties and feelings (eg such as feeling fear when visiting certain families) without being labelled inadequate.
- There are high standards in terms of competence, and poor competence is addressed.
- Calm reflection and positive challenge are evident at all levels in the organisation.
- Effective practice is highlighted and rewarded; there is a culture of praise.
- Continuous learning and improvement at all levels is expected and supported.
- Safeguarding work has high status in the organisation.
- Constructive challenge of other professionals is supported and encouraged.

Use of resources and evidence-based practice

In this area **good** could look like: (evidence-based practice)

- Managers, commissioners and frontline staff know the latest messages from research, and can evidence how this has impacted on their management, commissioning and practice.
- Individual agencies, partnerships and professionals are using or commissioning service models which are relevant to the needs of children and families in the area, and have been formally evaluated elsewhere through robust research methodologies as being effective in delivering desired outcomes.
- Individual agencies, partnerships and professionals are using or commissioning service models which are relevant to the needs of children and families in the area, and although these have not been formally evaluated through robust research methodology, they have been practised elsewhere and been through an external validation process (eg as used by C4EO) or are being evaluated locally.
- Single agencies, partnerships and professionals are 'outward looking' and have a good understanding of good/best practice in other areas.
- Professionals are using a clear theoretical framework as a basis for their work.

In this area **good** could look like: (use of resources)

- Services and safeguarding arrangements that are commissioned or delivered have a known, demonstrable positive impact on the safety and wellbeing of children/parents.
- There is a logical and transparent balance between investment in services that have an early intervention and prevention focus designed to reduce the likelihood of abuse and neglect starting or developing further, and those 'treating' the impact of such abuse or neglect.
- Funding proposals and decisions carefully consider and articulate the short and long-term impact on the safety and wellbeing of children.
- Funding decisions by organisations affecting safeguarding are being made with reference to the funding decisions of partner organisations so that any cumulative or knock-on effects of those decisions are identified.
- The balance between funding of frontline and support or 'back-room' services results in frontline staff having more time to undertake direct work with families, and managers to ensure effective managerial oversight and support.
- Available resources and partners in our community that could be engaged in the safeguarding of children have been considered and are involved.
- Improved safeguarding outcomes that have no or low cost have been considered and identified.

Wider picture content areas

The impact of poverty and poor housing

In this area **good** could look like:

Outcome statements

- The number of children in poor housing or poverty is reducing.
- Parents living in poor housing report that services are helping to reduce the adverse impact of that housing.
- Children in poverty and poor housing are achieving well in the five ECM outcomes.

Quality statements

- There are proactive arrangements to prevent homeless children and those who move frequently going 'off the radar' of universal services.
- The impact of poverty and poor housing on the safety and wellbeing of children is understood by, and part of the assessment and care planning of, professionals.
- There are local initiatives to reduce the number of children in poverty or poor housing which are having a positive impact.

In other wider picture content areas, **good** could look like:

Outcome statements

- All children have received required vaccinations/immunisations.
- Children are not obese.
- There is a reducing proportion of children killed/injured in traffic accidents/through house fires.
- Accidents in respect of children requiring attendance at A&E are decreasing.

Quality statements

- All properties in which children live have smoke detectors fitted.

Module 3
Examples of questions for leadership/scrutiny bodies to ask

Explanation

When senior management, leadership and scrutiny Boards/Committees have safeguarding performance reports and information presented to them (such as in Module 5), then to make sense of them they will need:

- a clear picture in their heads of what 'good' would look like in terms of the quality and outcomes aspired to (Module 2), so they have a benchmark
- confidence to ask the kinds of questions that can get below the surface of the information in reports.

This will make the reflection more empowered and constructive – and therefore increase the chances that any development that is needed will take place.

As in the other Modules, the questions set out below are just **examples** to get people thinking and discussing; individual organisations may well come up with more useful ones.

The questions can be framed in terms of **'you/your'** or **'we/us/our'** depending on who or which body is asking the question.

Practice content areas

Priority service areas

- What are the safety and wellbeing outcomes for children and families that you are trying to deliver in this area?
- What are the kinds of outcomes that the 'child protection' and 'children in need' care planning arrangements are effective in delivering, and what are the ones they are not?
- In CP/Children in Need (CIN) cases where good outcomes have been achieved, what have been the reasons?
- What are parents saying about their experience of the Children's Social Care 'front door'/health visitor/midwifery services in terms of how they were treated and whether they were helped?
- How many stages do referrers to the Children's Social Care front door go through before they speak with a social worker?
- What's the average length of post-qualification experience of social workers in the Children's Social Care front door /midwives working with vulnerable mothers/health visitors working with vulnerable mothers/supervising officers in the Child Abuse Investigation Team (CAIT)/ nurses in A&E?

- Are antenatal assessment and support arrangements the same in all acute trusts in the LSCB area?
- If mothers' attendance at antenatal appointments is poor, is the response systematic professional activity to engage?
- How do staff in A&E find out information about children held by Children's Social Care (ie do they have a conversation with a professional or is it an administrative process?)
- Does A&E have paediatric nurses on 24 hours per day?
- What are the strengths and weaknesses of health visiting services for vulnerable parents/antenatal assessment and support services identified by partner agencies?
- From point of referral to completion of a CP/CIN plan, how many different social workers would a parent have to speak with or get to know as a result of the service's organisational arrangements or business processes? (ie not taking in account changes arising from staff leaving).

Vulnerable groups of children

- What are the safety and wellbeing outcomes for children and families that you are trying to deliver in this area?
- Which are the priority vulnerable groups that your agency or partnership should be focussing on and why?
- Do all health providers proactively follow up children who do not attend appointments?
- How many children are you aware of who are being educated at home? What do you do proactively to promote their safety and wellbeing?
- How confident are you that professionals in specialist services (eg education welfare, fostering and adoption, leaving care, YOS) have the skills and knowledge to identify and respond to safeguarding concerns?

Specific risk issues

Domestic violence

- What are the safety and wellbeing outcomes for children and families that you are trying to deliver in this area?
- What are the trends in respect of reported incidents of domestic violence and what do these tell us?
- What's the evidence that the local domestic violence strategy, LSCB business plan and CYPP are co-ordinated and integrated with each other? Do they contain measurable outcome objectives – are these outcomes achieved?
- Are there apparent resource or service gaps eg programmes for perpetrators?
- If domestic violence has been identified as an area requiring action in previous SCRs, what's the evidence that required developments have resulted in improved outcomes for adult victims and children?

Adult mental health

- What are the safety and wellbeing outcomes for children and families that you are trying to deliver in this area?
- Have recent SCRs or serious incidents highlighted concerns about adult mental health and the safeguarding of children; have these concerns now been addressed in that there is evidence children whose parents have mental health needs are now safer?
- What are adults with mental health needs and their children telling us about what we're doing well and what we need to improve on?

- What are other areas doing to promote a 'Think Family' approach, and with what results?
- How many children in the local authority area do you know are living with carers who have mental health needs?
- What are frontline professionals saying about the strengths and weaknesses of partnership working between children's services and adult mental health services?
- To what extent is adult mental health a feature of Children in Need or Child Protection cases? (Children's services)
- Are you confident that you know whether the adults you are working with have responsibility for the care of children or regular contact with them eg lodging in a household with children, working with children, grandparent, sibling or 'babysitting'? (Adult mental health services)

Partnership working: how well professionals and organisations work together

- What partnership working issues were raised as causes for concern in our last three SCRs; what's the evidence that practice and outcomes for children are now different?
- Which are the services (both inside and outside of our organisation) that your staff report having positive working relationships with; which are the services where relationships are poor?
- What do professionals say gets in the way of effective partnership working?
- How do professionals in other agencies experience our service?
- What are the opportunities for professionals in this area to build direct relationships with each other?
- Are there particular professions or services which are not engaging adequately in inter-agency safeguarding activity (eg non-attendance at conferences, inter-agency training).

Organisational/practitioner content areas

Workforce: relationships, clear thinking, capacity

- Which are the most important professional groups to focus on in this organisation or partnership in terms of safeguarding?
- How can you be confident that staff are showing the proper respect and empathy to form effective relationships?
- What proportion of social workers', doctors' or police officers' time is spent in face-to-face contact with children and families?
- What are the arrangements for ensuring that frontline staff and managers have time during their working days for calm reflection?
- Which are the areas that require the most experienced staff and managers? How experienced are the staff and managers in these areas?
- Does another local authority/health trust/police team have a higher level of permanent staff than you, and if so how have they achieved this?
- What's the variation in terms of experience, turnover and permanence of staff between different teams/areas?
- Do some teams/services/schools/GP practices have relatively higher level of allegations against staff/complaints than others?

- Do any of the services depend excessively on the contribution of one or two people, whose absence would then have a disproportionate impact on the safe and effective running of the service?
- Do the specialist safeguarding staff in our organisation (eg Designated Doctors and Nurses, safeguarding lead for education) consider that they have adequate capacity to fulfil their role to the required standard?
- Does the safe running of the service depend on managers and professionals consistently working excessive hours?

Safeguarding wisdom, supervision and support

Safeguarding wisdom

- Do children and parents contribute to the shaping and delivery of learning and development inputs?
- What range of methods are used to achieve the desired learning outcomes in addition to classroom based training courses?
- Which elements of our learning and development strategy do you evaluate and to what level?
- Are there professional groups or particular service areas where staff are not receiving (or not taking up) the learning and development opportunities the agency or partnership specify as necessary?
- Which professionals are best represented on multi-agency training courses, and which are least?
- What are the practice improvements that the learning inputs have delivered?
- What are the wellbeing outcomes for children and families that the improved practice has delivered?
- What is the evidence that the practice weaknesses identified in our SCRs are no longer risk areas?
- Do we have a complete picture of the learning and development received by all relevant members of staff?
- Do your learning and development strategies equip staff to develop effective engagement and relationships with parents (especially hard-to-reach or change parents) and children – including being able to speak directly with children around the issues that may contribute to maltreatment and asking child-focused questions?

Safeguarding supervision and support

- What's the evidence that safeguarding supervision is having an impact on the quality of practice and the outcomes being achieved for children and families?
- Which are the staff and management groups in your agency and contracted services and professionals that require safeguarding supervision?
- Are there any staff groups not receiving safeguarding supervision to the required quality and quantity?
- Is the frequency of supervision in your policy based on an evaluation of what is needed, or existing capacity?
- What are supervisees saying they experience as positive about their supervision, and what are they saying needs improvement?
- When was your safeguarding supervision policy last reviewed?
- What level of safeguarding supervision are newly qualified social workers, midwives, health visitors and CAIT officers receiving compared with more experienced staff?

- How well integrated are 'learning and development' and 'safeguarding supervision' so that they are mutually re-enforcing?
- What are the arrangements for GPs/ designated teachers etc to receive safeguarding supervision?

Organisational culture

- What kind of organisational culture do we want?
- How do lead councillors/board members/ chief executives/senior managers get a first-hand understanding of how children and families experience the organisation?
- How do lead councillors/board members/ chief executives/senior managers get a first-hand understanding of how frontline staff and managers experience the organisation?
- What do children and families like about how we treat them? What do they think we could do better?
- What do frontline staff and managers say is positive about the culture of this organisation/their service? What do they think we could do better?
- How do you know if the values and behaviours you espouse are manifested at all levels in the organisation and in all sections?
- What hours are staff and managers routinely working in this organisation?
- What are the main messages about our organisation's culture from the last 20 exit interviews?
- What are examples this year of how the ideas of frontline staff have been implemented by the organisation?
- How do you highlight, praise, reward and promote good practice?

Use of resources and evidence-based practice

Resources

- Which of your services and safeguarding arrangements do you know are having a positive impact on the safety and wellbeing of children? Where you don't know this, what can you do to build up your knowledge?
- What balance do we want between investment in services that have an early intervention or prevention focus designed to reduce the likelihood of abuse and neglect starting or developing further, and those 'treating' the impact of such abuse or neglect?
- What will the impact of this funding decision be on the safety and wellbeing of children?
- What funding decisions affecting safeguarding are being made by our partner agencies, and what is the cumulative or knock-on effect of those decisions?
- What is the balance between funding of frontline and support or 'back-room' services? What is the impact of resource decisions regarding support services on frontline services?
- Are there resources or partners in the community that could be engaged in the safeguarding of children?
- Are there things that could be done to promote good safeguarding outcomes that have no or low cost?

Evidence-based practice

- Do you have a good enough understanding of the nature of 'safeguarding children's need' in this area?
- Which are our main services/processes for responding to this need (eg the 'front door service of children's social care; the police response to domestic violence calls, parenting programmes, antenatal care, A&E, parental substance misuse services)?
- Which of these services are using models which have been formally evaluated through robust research or external validation elsewhere as being effective in delivering the desired outcomes?
- For those services which have not had such independent and formal evaluation or validation, what work has been done locally to evaluate their effectiveness?
- What are your future plans to evaluate the impact of your services?
- What models do other areas use – what is seen as good or best practice?
- To what extent do the major safeguarding related strategies (eg Hidden Harm, domestic violence strategy) start from a clear statement of desired outcomes, and then set out **evidence-based** lines of work and development to deliver the outcomes?
- What is the evidence that our training and development inputs are based on the latest messages from research?
- Do staff have adequate time to identify research relevant to their current cases?
- In addition to traditional training, how else does the organisation ensure that its managers at all levels and frontline staff have an up-to-date understanding of messages from research, and translate these into practice?
- Do we have staff with the skills to undertake evaluations of services?
- What's the theoretical framework that our practitioners use in their work?

Wider picture content areas

The impact of poverty and poor housing

- What are the safety and wellbeing outcomes for children and families that you are trying to deliver in this area?
- How do local services keep a track of and engage families who move a lot, and ensure that homeless families do access universal services?
- What are parents and children in homeless families saying about their experience of being homeless and the support and services they receive?
- What is the evidence that staff dealing with homeless families, families living in non-decent or overcrowded housing conditions are alert to signs of abuse and neglect?
- What work is the fire service undertaking to reduce the dangers to families living on poor housing?
- Give examples of the worst housing conditions that you know children for whom you are responsible are living in, and the stories of their experience.
- What initiatives are taking place locally to reduce the number of children living in poverty or poor housing, and what is its impact?
- What evidence is there that your staff understand the impact of poverty and poor housing on parenting and the safety and wellbeing of children?

Module 4
Examples of sources of information/methods

Explanation

The purpose of this module is to give some suggestions about the different sources of information for the different types of performance information in each content area and some possible methods for collecting it.

Practice content areas

Priority service areas

Children's social care front door

Nature of information	Source/method
Quantity	Management information reports.
Quality	Case record audits. Experience of parents/children. Experience of staff in the service; 360 degree feedback from professionals in other agencies who refer to it. 'Leaders', senior managers spending one or two days per annum on the front door. Management information reports. Ofsted unannounced annual inspections.
Outcome	Case record audits. Experience of children /parents (eg phone survey at point of closure, six months after closure). Experience of referring professionals.

Vulnerable groups of children

Nature of information	Source/method
Quantity	Management information reports eg missed health appointments, children missing from school etc.
Quality	Management information reports about children resuming education, becoming registered with GP, visits to looked after children etc. Audit of Fostering Panel records to evaluate if safeguarding issues being identified/challenged. Audit of health provider records to evaluate response to missed appointments. Audit of leaving care cases where the young people have children. Ofsted three yearly safeguarding/LAC inspection. Children in Care Council feedback.
Outcome	Report back from looked after children regarding their sense of being safe and happy as a result of the intervention or service. Report back from children in the secure estate regarding their sense of feeling safe because of how staff run the establishment.

Specific risk issues

Domestic violence

Nature of information	Source/method
Quantity	Management information reports from police and other agencies
Quality	Experience of parents and children. Experience of professionals (police, Children's Social Care (CSC), health, probation) in respect of specialist DV services. Management information reports. Case record audits. SCRs.
Outcome	Case record audits. Experience of children, parents and staff – at end of service involvement or review point, or six, 12 months after closure. SCRs – are same issues repeating?

Adult mental health

Nature of information	Source/method
Quantity	Management information held by mental health and community health trusts, children's social care.
Quality	Experience of parents and children. Experience of frontline staff and managers in adult mental health, community and acute health services, children's social care services, GPs. Case record audits.
Outcome	Case record audits. Experience of children and parents. Experience of staff in children's and adult mental health services – joint focus groups and action planning exercises?

Partnership working: how well professionals and organisations work together

Nature of information	Source/method
Quantity	
Quality	Experience of children and parents. Annual staff survey: experience of the agency's staff in respect of working with other agencies, and with other teams within the agency. Management information eg about attendance at, reports to CP conferences, inter-agency training attendance. Case record audits. SCRs.
Outcome	Case record audits. Experience of children, parents and staff. SCRs

Organisational/practitioner content areas

Workforce: relationships, clear thinking, capacity

Nature of information	Source/method
Quantity	HR management information. Complaints, LADO management information.
Quality	HR management information. Complaints, LADO information. Staff surveys, focus groups, exit interviews. Senior managers 'walking the floor', talking with staff. Audit of 'safe recruitment' practice. Experience of children and parents eg whether staff have treated them with respect and kindness.
Outcome	Experience of children and parents (do they think the staff have made a difference to their lives because of their advice, knowledge, understanding etc).

Safeguarding wisdom, supervision and support

Safeguarding wisdom

Nature of information	Source/method
Quantity	Management information reports from HR, agency training sections and LSCB training section.
Quality	Management information reports from HR, agency training sections and LSCB training section. Staff who have received the learning input would be asked to identify the gains in skills and knowledge they have made, and to evidence from their work how their practice has changed as a result of the learning input. Audit: identifying evidence from case records of practice change – comparing the position before and after the learning input. Appraisals: for information about competence levels.
Outcome	Staff who have received the learning input could be asked to evidence from their work how their changed practice has impacted on the wellbeing of children/families they work with. Families and children using services whose staff have received training.

Safeguarding supervision and support

Nature of information	Source/method
Quantity	Management information reports re: frequency of supervision, number of supervisors trained etc.
Quality	Report back from supervisees regarding their experience of supervision including impact on their practice. Audit of supervision records.
Outcome	Report back from supervisees who would be asked to evidence from their work whether the impact of supervision on their practice has had consequential impact on the wellbeing of the children/families they work with.

Organisational culture

Nature of information	Source/method
Quantity	HR data: staff turnover
Quality	Leaders and senior managers 'walking the floor', observing and talking with parents, children and staff. Reports from children and families through surveys, focus groups. Reports from staff through surveys, focus groups. 360 degree exercises by leadership team. Exit interviews.
Outcome	

Use of resources and evidence-based practice

Evidence-based practice

Nature of information	Source/method
Quantity	
Quality	Report back from commissioners, managers and professionals on how they keep up-to-date with research and apply to practice. Critique of draft strategy documents in terms of: • starting from outcomes to be achieved • a comprehensive picture of need • action planning that is routed in an evidence-base or has a clear evaluation methodology. Survey/focus groups of staff in which they evidence the theoretical framework they have applied in their work.
Outcome	'Service evaluation' reports outlining quality and wellbeing outcomes that have been achieved.

Wider picture content areas

Impact of poverty and poor housing

Poor housing

Nature of information	Source/method
Quantity	Data from local authority housing needs service.
Quality	Visits by councillors or managers to families in bad accommodation. Survey of homeless families living in temporary accommodation. Training data re: housing staff. Audit of initial and core assessments. Fire service.
Outcome	Data from local authority housing needs service and housing providers. Housing conditions survey. Data from housing, community health service and education welfare service.

Module 5
Examples of quantitative, qualitative and outcome performance measures

Explanation

Don't panic! Don't be alarmed by the number of examples given in the next few pages – it is not suggested that an organisation uses all of these; these are just given here to provide examples and to stimulate local discussion and decision making. Your organisation might well come up with far better measures and decide to run with two or three to start with.

Understanding the percentages: where a per cent is referred to under the Quality and Outcome headings, this could refer to the percentage of a complete group (eg the percentage of **all** children subject to a CP plan) or it could refer to the percentage of a sampled group (eg the per cent of parents interviewed in a user feedback exercise; the per cent of case records audited).

Practice content areas

Priority service areas

Quantity	Quality	Outcome
CP and CIN planning Number of children subject to a child in need plan or child protection plan. Number of children who ceased to be subject to a CP/CIN plan in the year. Number of staff carrying CP/CIN cases.	% of CP/CIN cases which specify the desired safety and wellbeing outcomes for the child/family. % of CP/CIN case children visited and seen at required minimum times. % of visits where child seen alone. % of cases audited in which the child remained the focus of professionals' attention. % of cases audited in which the involvement and impact of men is addressed.	% of CP/CIN cases in which the most important desired safety and wellbeing outcomes are achieved at point of closure. % of CP/CIN cases in which the most important desired safety and wellbeing outcomes are still being achieved/maintained six, 12, or 18 months after closure. % of closed cases subsequently re-referred in the next 12 months for the same reasons.

Quantity	Quality	Outcome
	% of CP/CIN cases reviewed within timescales. % of cases where children and young people report they have a positive relationship with their Social Worker (SW). % of cases where parents report they are treated well by the professionals involved. % of cases with up-to-date chronologies. % of staff carrying CP/CIN cases who are positive about the quality and safety of CP/CIN work in their service.	% of cases where the children and parents identified positive improvements in their safety and wellbeing as a result of the work arising from the CP/CIN plan. % of children subject to CP plan who had previously been subject to a CP plan.
Antenatal support for vulnerable mothers Number of mothers receiving antenatal services in the year. Number of identified vulnerable mothers worked with by midwives (eg those for whom 'Concern and Vulnerability' form completed). Number of mothers with poor attendance at antenatal appointments.	% of vulnerable mothers seen at least once in their home by midwife. % of vulnerable mothers keeping 80% of antenatal appointments. % of cases of vulnerable mothers in which midwives evaluate the involvement and impact of the father or other men. % of cases in which 'Concern & Vulnerability' form quality audited as good. % of midwifery staff who are positive about the safety and quality of antenatal services. % of cases where midwives report appropriate level of engagement by GP. % of vulnerable mothers who reported they were satisfied with the way they were treated by the service.	% of vulnerable mothers' cases in which the original concerns and areas of vulnerability had significantly reduced by the point of transfer to community services or where appropriate protective factors were in place. % of vulnerable mother cases where: • the baby is healthy • there is evidence of positive bonding starting. % of vulnerable mothers who, at point of transfer to community health services, report and can evidence that the work of the antenatal service had a positive impact on them and their child.

Quantity	Quality	Outcome
	% of surveyed professionals in partner agencies who spoke positively about the quality of the service. % of mothers with poor attendance at appointments who were successfully re-engaged.	
Children's social care front door Number of referrals to the service. Number of initial or core assessments. Number of initial or core assessments completed in timescale.	% of parents who said they were well treated by the service. % of professionals in partner agencies who spoke positively about the quality of the service. % of assessments reaching the organisation's quality standards. % of cases where the referrer is given written confirmation of the outcomes of their referrals within agreed timescale. % of referrals that were 'appropriate' in terms of agreed thresholds for children's social care. % children and young people who felt their stories were considered seriously (and believed) when they reported them to the authorities.	% of children and young people who reported they felt safer as a result of social work contact. % of parents who reported that their contact with the service was helpful. % of referrers who report the safety and wellbeing of the child improved as a consequence of referral. % of assessments that resulted in concrete improvements to the wellbeing and safety of the children.

Vulnerable groups of children

Quantity	Quality	Outcome
Missed appointments Number of children missing appointments.	% of these children attending appointments regularly following proactive action.	% of children resuming appointments whose health outcomes are achieved.
Registered with GP Number of children identified in the year as not being permanently registered with a GP.	% of these children who became permanently registered during the year.	
Missing from education Number of children identified as missing from education or seriously absconding at start of term.		% of these children who were in education or attending regularly by end of term.
Secure estate Number of young people in STC/YOI. Number of acts of violence in the year. Number of acts of self harm. Number of incidents involving physical restraint.		% of young people who self-harm. % of young people who report they feel safe. % increase/decrease in: • acts of violence • acts of self-harm • incidents involving physical restraint.
Looked after children Number of looked after children. Number of care leavers aged up to 21 who have a child.	% of children visited by social worker at the frequency specified by care plan. % of visits where children seen alone. % of care leavers whose children's needs have been assessed.	% of looked after children who say they feel safe in their placement, school and community. % of looked after children who: • say they are happy • say they have someone to turn to when they are unhappy. % of children of care leavers who are thriving.

Specific risk issues

Quantity	Quality	Outcome
Domestic violence Number of CP/CIN plan cases where DV was identified as a significant risk factor in the assessment.	% of victims of DV who thought their situation was taken seriously and understood by professionals.	% of CP/CIN plan cases where, at point of closure, DV had ceased to be a cause of concern. % of CP/CIN plan cases where victim parent reports at closure that they feel and are safe from DV. % of CP/CIN plan cases where children and young people report that they are safe from DV and feel safe. % of these cases where there were no repeat referrals for DV within subsequent six, 12, 18 months. % of families receiving help in respect of DV where the children are doing well in terms of main areas of development eg education.
Number of DV reports to police in 12 month period. Number of different families involved in reports to police in this period. Number of children involved in reports to police.	% of these families who received the following forms of help: • MARAC • Independent Domestic Violence Adviser • Initial, core assessment and CAF. % of cases quality audited by police that demonstrate the police considered the impact of the DV on the children and young people, and responded appropriately. % of DV situations attended by police where victim/children felt well treated.	% of cases where MARAC held that DV ceased. % of cases involving IDVAs where DV ceased. % of families where there have been repeat reports to police of DV. % of DV incidents attended by police, where the victim or children experienced police intervention as helpful.

Quantity	Quality	Outcome
Number of perpetrators of DV in 12 month period. Numbers of cases supervised by probation officers where DV is an issue.	% of perpetrators accessing recognised DV programmes. % of perpetrators completing DV programmes. % of perpetrators prosecuted. % of probation cases where the risk of harm from domestic violence is assessed and planned for to a good standard.	% of perpetrators completing DV programmes: • who are not reported for committing DV in the subsequent six, 12, 18 months • whose partners report no further DV is the subsequent six, 12, 18 months • % of cases supervised by probation officers where DV is a known risk, in which DV does not re-occur. % of prosecutions which result in an outcome that stops the DV.
Adult mental health Number of adults receiving mental health services who have caring responsibility for children or frequent contact with children. Number of children whose parents are in receipt of mental health services. Number of cases which are open to both children's social care and adults' mental health services. Number of referrals to Children's Social Care where adult mental health is a primary/significant issue.	% of adult mental health assessments or care plans which take account of the whole family and possible risks to children. % of children's social care initial and core assessments which take account of the whole family and impact of adult's mental health. % of children's social care operational managers and staff who reported effective working relationships with professionals in adult mental health services (and vice versa). % of adult carers with mental health needs who experienced adult mental health and children's services working well together.	% of children whose parents are receiving a mental health service who: • feel well supported by services and have the information they need • have someone to talk to/get help from in an emergency • do not feel isolated. % of cases where adult mental health is assessed as impacting adversely on the wellbeing and safety of a child in which at point of closure: • the adverse impact has ceased • the desired positive outcomes for adults and children set out in the care plan have been achieved • children and parents report positive improvements.

Quantity	Quality	Outcome
Number of initial or core assessments and CAFs where mental health is a primary or significant issue. Number of mothers, with a child of specific concern to health visitors, who have depression.	% of adult carers with mental health needs who reported that their children had received the help they needed. % of children of parents with mental health needs who reported that adult mental health staff listened to and involved them, and gave them helpful information and support. % of children with CP/CIN plans where CPA is progressed for parent(s). % attendance of adult mental health staff (including substance misuse staff) at CP conferences/core groups. % of occasions where social worker invited to discharge meetings. % of staff in adult mental health who feel confident in parenting or family initial assessments. % of staff in children's services who feel confident in undertaking parenting assessments where parents have mental health needs.	% of children who are young carers of parents with mental health needs who feel supported and are able to achieve five ECM outcomes. % of parents with low level mental health needs who feel supported and report positive improvements.

Partnership working: how well professionals and organisations work together

Quantity	Quality	Outcome
	% of parents who think that the different agencies involved in their lives work well together. % of cases demonstrating evidence of 'good' partnership working (by agreed criteria eg appropriate information sharing).	% of parents who are receiving help from several agencies who report the impact is positive for them and their children. % of cases demonstrating evidence of partnership working delivering positive outcomes for children and parents.
	% of staff within the agency that expressed concerns/positive experience of partnership working with X, Y, Z **external** agencies. % of staff within the agency who expressed concerns/ positive experience of partnership working with A, B, C services **within** the agency. % of staff who feel confident to: • challenge other professionals • escalate concerns • share information • step outside of their 'traditional role' • take the lead in ensuring a child's needs are met.	
Number of cases open to both the mental health trust or drug and alcohol service, and children's social care.	% of cases evidencing 'Think Family' assessment and care planning practice in both services.	% of cases in which desired outcomes for parents and children were achieved.
Number of CAFs completed.	% of CAFs specifying lead professional. % of CAFs completed by different agencies.	% of CAFs in which the desired outcomes for the child and family are achieved.
Number of CP conferences to which 'x' professional group asked to attend or contribute report.	% of CP conferences 'x' professional group attended or contributed to.	

Organisational/practitioner content areas

Workforce: relationships, clear thinking, capacity

Quantity	Quality	Outcome
Number of Whole Time Equivalent (WTE) posts: • A&E nurses • social workers carrying CP/CIN cases/managers • social workers • social workers/ managers in 'front door' • health visitors/ managers • school nurses/ managers • police CAIT officers/managers • midwifery posts/ managers.	% of staff time spent in face-to-face contact with families/ children. % of parents/children saying they are treated with respect: • not judged • were given time • were listened to • felt cared for • were treated as an equal. % of parents and children surveyed saying that they have a positive relationship with their social worker/health visitor/ midwife. % of CP/CIN plans in which there was one/two/three change/s of SW/HV. % of parents with a child under the age of six months who reported they had never seen a health visitor. % of posts filled by permanent/ agency staff/vacant. % filled by staff with more than three years post-qualifying experience. Number of health visitors as a ratio to weighted head of child population; school nurses as a ratio to weighted head of school population; and midwives as a ratio to new births.	% of parents and children surveyed saying that the work of the social worker, health visitor or midwife has improved their wellbeing eg improved parenting skills, family relationships, changed behaviour or attitude.

Quantity	Quality	Outcome
	% of SW posts carrying CP/CIN caseloads which have been agreed as being at a level that enables effective practice to take place. % of health visitors/midwives/ detectives/probation officers and CAFCASS guardians carrying caseloads (or numbers of vulnerable/high risk cases) which have been agreed as being at a level that enables effective practice to take place. % of SWs/HVs/midwives with an appropriate balance of caseload to enable effective practice to take place. % of SWs/HVs/midwives/CAIT detectives/CAFCASS guardians – and their operational and senior managers – who report that work management arrangements enable them to have time for calm reflection during the working day.	
Number of staff in post/who left in the year.	% of staff who describe their morale as good or very good. % of staff who are positive about the organisation. % of staff who believe their working environment and equipment is supportive of their work.	
Number of GP practices in the area.	% of practices with a nominated safeguarding lead.	
Number of staff requiring Enhanced CRB checks, GSCC registration etc.	% of staff with up-to-date CRB checks, GSCC registration etc.	

Quantity	Quality	Outcome
Number of staff recruited in the year. Number of staff recruited in the year where the recruitment process was audited for compliance with safe recruitment policy and practice.	% of cases audited where safeguarding policy and practice was followed to a good standard.	
Number of teaching staff in the schools.	% of teaching staff against whom allegations were made in the year. % of allegations in which investigations were completed within recommended timescales.	% of cases in which the investigation did identify a risk to children and where that risk was removed.

Safeguarding wisdom, supervision and support

Safeguarding wisdom

Quantity	Quality	Outcome
Number of learning inputs (eg a training course). Number of learning inputs that are evaluated.	% of evaluated learning inputs that resulted in: • positive learning outcomes • improved practice.	% of evaluated learning inputs that resulted in improved outcomes for children/families.
Number of staff and managers with safeguarding children responsibilities.	% reporting that they receive the right quality and quantity of learning to do a good job.	
Number of staff and managers with safeguarding children responsibilities.	% practising at the required level of competence.	
Number of staff requiring safeguarding children training to a specific level.	% of staff who are up-to-date with their required level of safeguarding training.	

Quantity	Quality	Outcome
Number of multi-agency safeguarding training courses.	% of multi-agency training courses on which all relevant professional groups were adequately represented.	
Number of staff qualified for more than five years.	% of staff qualified more than five years who have attended multi-agency safeguarding training in previous year.	

Safeguarding supervision and support

Quantity	Quality	Outcome
Number of people in the professional group requiring safeguarding supervision eg number of social workers, midwives, GPs, DV workers.	% of professionals within the group receiving safeguarding supervision at the frequency the organisation's policy requires. % of professionals receiving supervision who report it results in clearer thinking and improved practice. % of professionals who report being confident in exercising their professional judgment in cases. % of staff whose direct work with children/families has been observed at least once in the year by their supervisor.	% of professionals who are able to evidence how the improved practice arising from supervision has had a positive impact on the wellbeing of the families worked with.
Number of supervision sessions conducted in the year for a particular professional group.	% of supervision sessions audited by the organisation. % of sessions audited that reached the organisation's quality standards.	
Number of safeguarding supervisors.	% of supervisors trained in effective safeguarding supervision.	

Organisational culture

Quantity	Quality	Outcome
Number of staff in organisation or service area. Number of staff responding to survey.	% of staff who experience the organisation as: • calm • safe • supportive • taking poor practice seriously. % of staff who feel valued by the organisation. % of staff who believe their ideas have helped shape services. % of staff who believe any concerns they raise, including concerns about the welfare of children, will be taken seriously. % of staff who experience managers at all levels as being accessible.	
Number of assistant directors/directors/ councillors/board members.	% of senior leadership team who, in previous 12 months, have met with frontline staff, parents and children on: • one occasion • two occasions • three occasions.	
Number of parents, children and young people receiving a service in the year. Number of parents/ children surveyed.	% of parents, children and young people who said they were treated well or very well by the organisation.	
Number of staff leaving in the year. Number of completed exit interviews.	% of exit interviews indicating concerns about organisational culture.	
Number of staff.	% of staff subject to formal competence process. % of those staff whose practice improves	

Use of resources and evidence-based practice

Quantity	Quality	Outcome
Number of frontline staff and managers in the service.	% of staff /managers who can evidence: • they base their practice on a clear theoretical framework • they are aware of latest relevant research findings which they apply in their practice.	% of staff who can demonstrate how evidence-based practice resulted in improvements to the wellbeing of children.
Number of senior managers or commissioners in the service.	% of senior managers or commissioners who can evidence they are aware of latest relevant research findings which they apply in their practice.	% of senior managers or commissioners who can demonstrate how evidence-based practice resulted in improvements to the wellbeing of children.
Number of safeguarding service areas and processes within the agency.	% which are based on an established model of effectiveness. % which are being evaluated locally.	% which deliver desired outcomes.
Number of learning and development inputs.	% of learning and development inputs that reflect latest research findings.	

Wider picture content areas

The impact of poverty and poor housing

Quantity	Quality	Outcome
Number of households and children living in local authority area. Number of dwellings in LA area. Number of fires in domestic premises.	% of housing needs staff and housing officers who are up-to-date with their safeguarding training. % of initial and core assessments that analyse the impact of poor housing. % of parents who speak positively about the support they receive and how they are treated whilst homeless. % of families in poor condition housing which the fire service has visited or have alarm fitted.	Number or % households with children or children living in overcrowded accommodation. Number or % households with children or children living in non-decent housing conditions. Number or % households with children/children who are homeless and in temporary accommodation. % of children in temporary accommodation who are: • registered with a GP • attending school regularly • up-to-date with immunisations vaccinations. % of children in overcrowded, non-decent housing or homeless and in temporary accommodation who move to accommodation that is: • of acceptable quality • permanent • non-overcrowded during the year. % of fires in domestic premises which were in poor condition.
Number of children in local authority area. Number of school age children.		% of children in workless households. % of children living in poverty. % receiving free school meals.

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Notes

Local Government Improvement and Development
Layden House
76–86 Turnmill Street
London EC1M 5LG

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

www.local.gov.uk

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