



**Hounslow Safeguarding Children Partnership**

# **Safeguarding Effectiveness Framework**

**2019 - 2021**

## 1) Introduction

Working Together to Safeguard Children 2018 states that the purpose of local arrangements is to support and enable organisations and agencies to work together in a system where:

- children are safeguarded, and there is welfare promoted
- partner organisations and agencies collaborate, share and co-own the vision for how to achieve improved outcomes for vulnerable children
- organisations and agencies challenge appropriately and hold one another to account effectively
- there is early identification and analysis of new safeguarding issues and emerging threats
- learning is promoted and embedded in a way that local services for children and families can become more reflective and implement changes to practice
- information is shared effectively to facilitate more accurate and timely decision making for children and families.

### How we will operate

The HSCP has developed one vision, two values and six principles which it will operate to.

#### Our Vision

- All partners are committed to working together so that every child in Hounslow is safe, well and able to reach their full potential.

#### Our Values

- A child centred approach for services to be effective they should be based on a clear understanding of the needs and views of children.
- Safeguarding is everyone's responsibility: for services to be effective each member of Hounslow's community, its practitioners and organisations should play their part.

#### Our Principles *(The six principles adopted from Adult Safeguarding Boards)*

1. **Empowerment:** People being supported and encouraged to make their own decisions and with informed consent.
2. **Prevention:** It is better to act before harm occurs.
3. **Proportionality:** The least intrusive response appropriate to the risk presented.
4. **Protection:** Support and representation for those in greatest need.
5. **Partnership:** Local solutions through services, organisations and communities working together.
6. **Accountability:** Accountability and transparency in safeguarding practice.

### How we will achieve these

The HSCP aims to promote high standards of safeguarding work and to embed a culture of continuous improvement, whilst each partner retains its own existing line of accountability for safeguarding. We are committed to learning from work that has been successful in

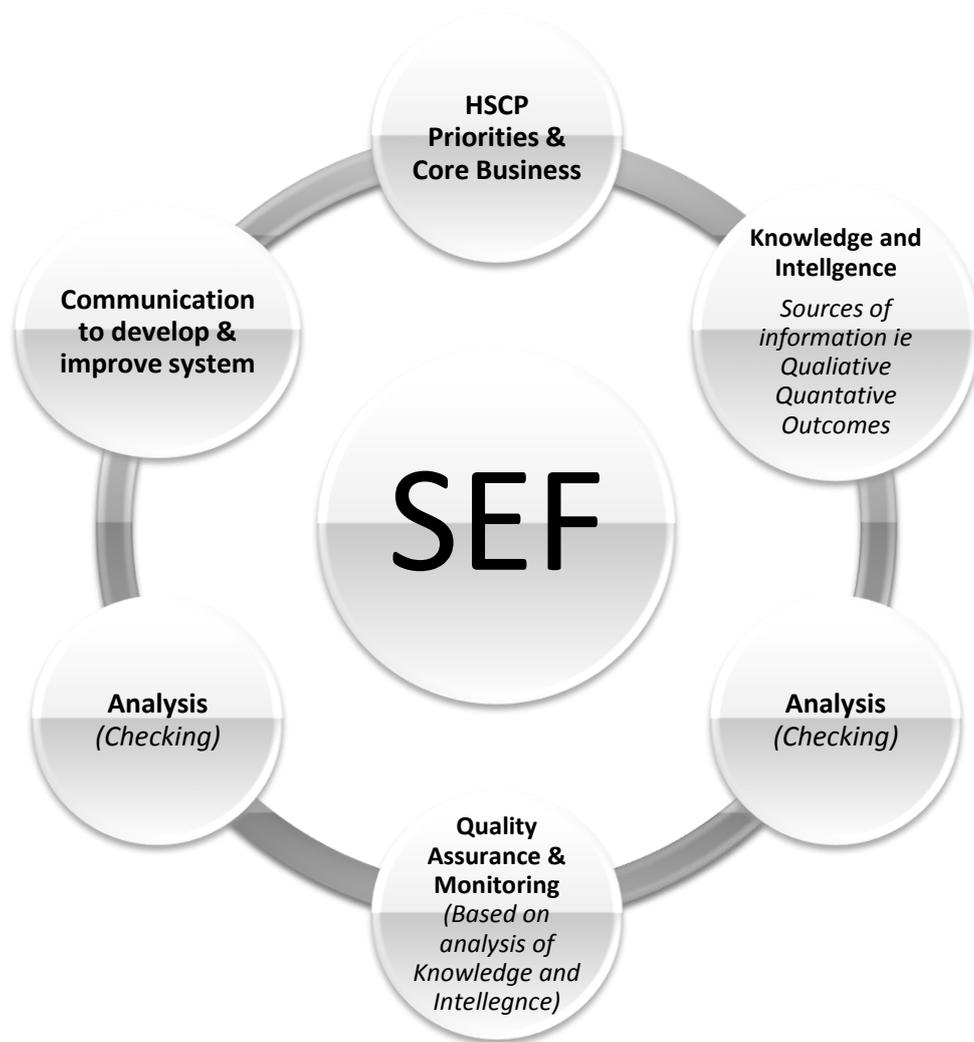
safeguarding children and risks they face, as well as reviewing and reflecting on poor practice to facilitate improvements. The partnership has a solid foundation to continue to achieve this aspiration as identified by inspectors during the JTAI.

## **2) What is the Safeguarding Effectiveness Framework?**

The framework is designed to ensure that the HSCP effectively meets its requirements and it is guided by the principles for learning and improvement. It also seeks assurance that we are as effective as possible, using a range of mechanisms to co-ordinate, monitor, challenge and improve both our services, and outcomes for children and young people.

There are many dimensions to safeguarding which is why the partnership must focus on a targeted number of defined thematic priorities which it agrees are the most important. The priorities will be set out in the partnerships two-year business plans and will be determined by local need following consultation with all partner agencies and informed by evidence such as findings from research, audits, management information and learning from historic serious case reviews, national serious case reviews and local safeguarding practice reviews.

The steps outlined in the diagram below can be applied to the HSCPs thematic priorities, using a range of information sources and methods to assess the quality of work undertaken to safeguard children and its effectiveness in helping to keep children and young people safe.

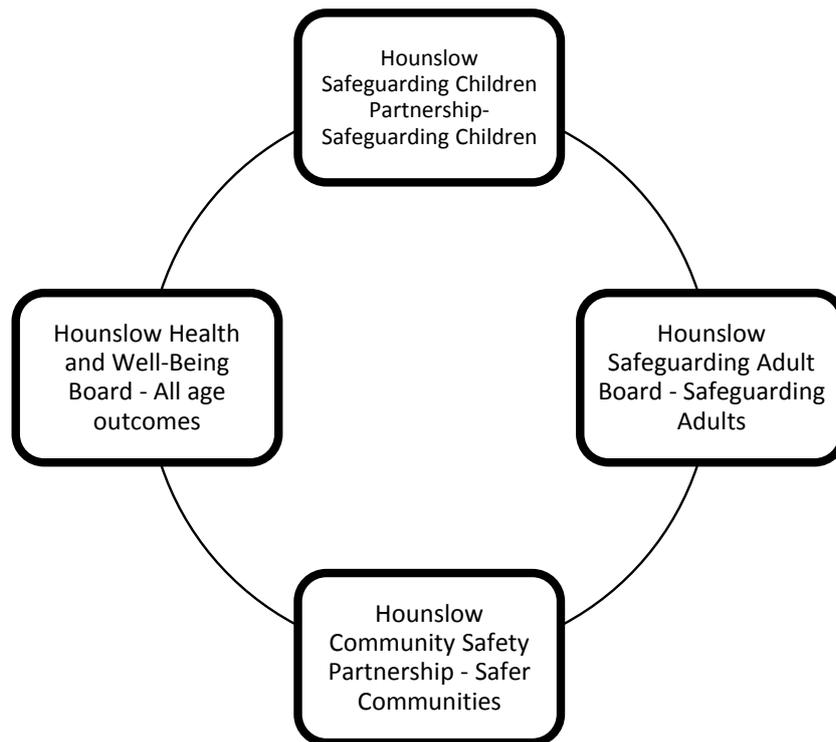


### 3) Governance and Accountability

Whilst every sub-group is expected to understand performance and assurance within its own remit, detailed multi-agency performance scrutiny will take place in the Safeguarding Effectiveness (SE) Sub-Group. With responsibility for implementing the Safeguarding Effectiveness Framework, the group will bring together a range of knowledge and information using the methods outlined in the framework and undertake Section 11 audits, develop a quality assurance programme and triangulate learning from a range of evidence.

The group will be responsible for setting up time limited themed task and finish groups that are responsive and address areas of abuse such as Neglect and monitor a multi-agency focused workplans on each theme or area of improvement.

Information will be received from other sub-groups and agencies in the form of assurance reports, and areas for learning passed to the Training Sub-Group. The sub-group will also link with other partnerships and Boards sub-groups and task and finish groups to achieve the best outcome in the most efficient way.



The SE sub-group at a minimum, prepare twice yearly overview reports to be shared with the partnership Board of the safeguarding effectiveness activity, identifying where improvements have been made, where there are ongoing challenges and informing them of emerging areas of potential focus.

#### **4) What “good” looks like and making a difference**

What “good” looks like cannot be generically applied to all areas of the safeguarding system and thematic priorities however for each of our targeted areas we will articulate what ‘good’ would look like in terms of the quality and outcomes.

##### **How will we know we have made a difference?**

##### **Children, Parents and Carers**

We will know, as a partnership that we have made an impact when, children, parents and carers tell us that they have felt listened to, respected and valued and not judged and that their personal stories were heard, and services supported them by intervening in a proportionate (**principle 3**) way.

The messages from children and parents can be gathered from:

- reports of quality and outcomes statements, for example, ‘the percentage of parents who reported that they had a good relationship with their health visitor’
- more detailed account of the service users’ ‘story’ so that meaning of their experience is communicated.

## Frontline Staff

We will know that staff and frontline managers are supported when they tell us that they feel that there is a clear line of sight between leadership decision making and frontline practice and there is a feedback loop that keeps senior management and those with governance responsibilities 'reality-based'; in terms of what is or is not working and to share ideas for improvement so that changes can be made systematically.

It is important that organisations develop a culture, which demonstrates that the views of staff are valued and taken seriously including issues of challenge.

The messages from frontline staff can be gathered from:

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

## Community

We will know through our representatives and lay members on the partnership, that the community feels that we are responsive to the safeguarding needs of our families, children and young people and that strategic leaders have listened to their voice in setting Hounslow's direction and they have contributed to the strategic work of the partnership and providing a critical challenge.

The messages from the community can be gathered from:

- Adequate community and voluntary sector representation on the HSCP, partnership task and finish groups and sub groups
- Listen to challenge from speakers at relevant meetings
- Attendance at existing community-based forums

## Organisations

We will know that organisations in Hounslow are working well together in a coordinated way to effectively safeguard children when it can be evidenced that there is a clear strategic vision, aligned to the **six principles** of the HSCP and they are striving to quickly address areas of improvement, identifying and sharing good practice, they are always striving to achieve better outcomes for children and young people and they have listened to and embedded what children young people, parents, carers, front line staff and our community are telling us. Evidence from organisations can be gathered via the methods and mechanisms identified in the Safeguarding Effectiveness Framework.

## 5) Knowledge and Intelligence

### Sources of Information

To judge our effectiveness within our targeted priorities and “core business” function we will define the kinds of performance information and measures we need for each area. To support this, we will use a range of performance information and measures such as:

**Quantitative information** provided by the HSCP Dataset and when required utilise underpinning scorecards from across the multi-agency partnership, with good supporting analysis will help to inform what we do and will enable us to answer the initial questions of “how much/how many?”

For example:

- how many children were made subject to a child protection plan for neglect?
- how many assessments did we complete?
- how many days training did we provide?
- how many incidents of domestic violence were referred by the police?

**Qualitative information** will add to our analysis of quantitative information giving us a richer understanding about the functioning of our partnership organisations and the quality of what was done.

For example:

- Were the child protection plans for children and young people in neglectful circumstances SMART and of a good enough quality to target the risks?
- Were assessments child focussed and inclusive of parent’s views?
- What percentage of staff trained thought their skills had improved as a result?
- Was the multi-agency response to domestic violence effective?

**Outcome information** supported by numbers, analysis and professional judgement we will understand the difference that we have made through our services, strategies and interventions to the lives of children and their families.

For example:

- The percentage of children being subject to child protection plans for neglect has decreased
- There is an increase in the number of Quality of Care Assessments being completed for children and young people in neglectful circumstances
- What difference did our interventions and assessments make and how were outcomes improved for children and young people in neglectful circumstances?
- the percentage of cases in which domestic violence has ceased

- the percentage of children who feel safer as a consequence of the intervention they received.
- The number of staff who are able to demonstrate that they are better equipped to respond to specific needs as a result of being better trained.

All partner organisations have the responsibility to consider how they collate quantitative, qualitative and outcome-based information to inform improvement activity in respect of the effectiveness of their safeguarding practice and share this with the HSCP.

## 6) Quality Assurance

Quality assurance information in safeguarding is focused largely on quantitative information, with some qualitative information and very little outcome information. Over time, we will work to increase the proportion and importance of outcome information as it tells us what really matters, supported by qualitative information and then quantitative information.

To get a full picture of what is really happening, it is important to capture the experience of children and parents/carers, and the experience of frontline staff and managers. Therefore, the information for quality assurance will always consider:

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

### Methods and Systems

Applying the principle of **proportionality**, the partnership will not seek to replicate quality assurance standards or activity that has already been undertaken in single agencies. It will consider organisations' own methods and will gather and utilise existing evidence and support agencies to consider key messages from quality assurance activity and undertake a range of targeted activity such as multi-agency audits.

The Safeguarding Effectiveness Sub-Group will also access and or direct and request from other partnership sub-groups and task and finish groups to additional sources of information to inform learning and improvement and use methods such as:

- Single agency safeguarding audits
- Peer reviews
- Multi-agency audits
- Quality assurance reports from the statutory partners
- External audits and inspection reports of safeguarding or related issues from bodies such as HMIs, Ofsted and CQC
- Single agency QA activity plans to identify overlaps or opportunities for collaboration and undertake internal quality assurance activity to evaluate practice.

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

## **7) Monitor Performance**

All sub-groups will take a role in monitoring performance of their specialist area and to determine impact of the work the HSCP is undertaking and how we can improve. As the “engine room” of the HSCP the Safeguarding Effectiveness sub-group will be responsible for:

- A high-level multi-agency dataset
- The triangulation and scrutiny of performance and effectiveness across the system enables us to test out assurance or identify where additional activity or assurance may be required.
- Requesting single agencies to carry out quality audits or ‘deep dives’ on themes where performance is considered to be a significant risk.
- Management of the multi-agency quality assurance programme.
- Triangulate knowledge, information and evidence from across the partnership.

## **8) Reviews of Practice**

Policies and processes are in place for a range of practice reviews, which may be thematic and not individual cases alone. The Cases Sub-Group has the remit for considering all cases where a referral for any type of review of practice may be made, including cases of good practice to share learning. The type of review and most appropriate person to undertake the review will be determined by the sub-group members. Not all instances where scrutiny is required will need an external independent reviewer, and it is expected that a range of senior professionals in Hounslow will be able to undertake impartial scrutiny.

All Rapid Reviews under the new legislation will adhere to our process for Notification of Serious Incidents. Where an external independent reviewer is required, for example for Safeguarding Practice Reviews, they will be commissioned using regional and national information on known reviewers and their expertise. These reviewers will be selected by representatives of the HSCP and the Cases Sub-Group. Reviews will be published as outlined in Chapter 4 of Working Together 2018 and each review will result in an action plan which will be monitored to ensure that recommendations are embedded in practice, and appropriate methods of learning applied and sustained.

## **9) Learning**

The Safeguarding Effectiveness Framework ensures that there is a direct link between safeguarding effectiveness and workforce development. Learning needs are captured

through the safeguarding assurance process of the partnership as well as learning needs analysis ensuring that we have a skilled workforce who have access to up to date, relevant information to help them to keep children safe and happy.

The HSCP has a well-established pool of multi-agency trainers who deliver much of the course programme using local expertise and knowledge which provides on-going and valued support to deliver and evaluate learning and improvement.

Opportunities for professionals to develop knowledge and skills are varied. Training courses, newsletters, briefings, learning events, blogs and the partnership website all form part of our communication methods to ensure opportunities for learning are maximised. Other methods include:

- Training
- Team Meetings
- Workforce planning and development
- HSCP Communication Plan
- Policy & procedure
- Commissioning
- Supervision
- Partner Agency Improvement Plans
- HSCP Strategies and Business Plan
- Workshops and/or Interagency Forums

## **10) Evaluation**

The HSCP will evaluate practice and its impact through the range quality assurance activities outlined in the framework and will monitor performance of the system and impact on outcomes for children and young people, to provide an assurance that we are working as effectively and efficiently as we can, to identify areas for improvement, and to celebrate success by evidencing impact, improve outcomes and achieve best practice and consistency, and testing the effectiveness of our priorities and 'business as usual' in terms of legislative duties and best practice.

## **11) Independent Scrutiny**

The role of independent scrutiny is to provide additional assurance in judging the effectiveness of multi-agency arrangements to safeguard and promote the welfare of all children in a local area and should provide added value to what we already know and do. The partnership's Independent Advisor will provide independent scrutiny and challenge to the executive partnership.

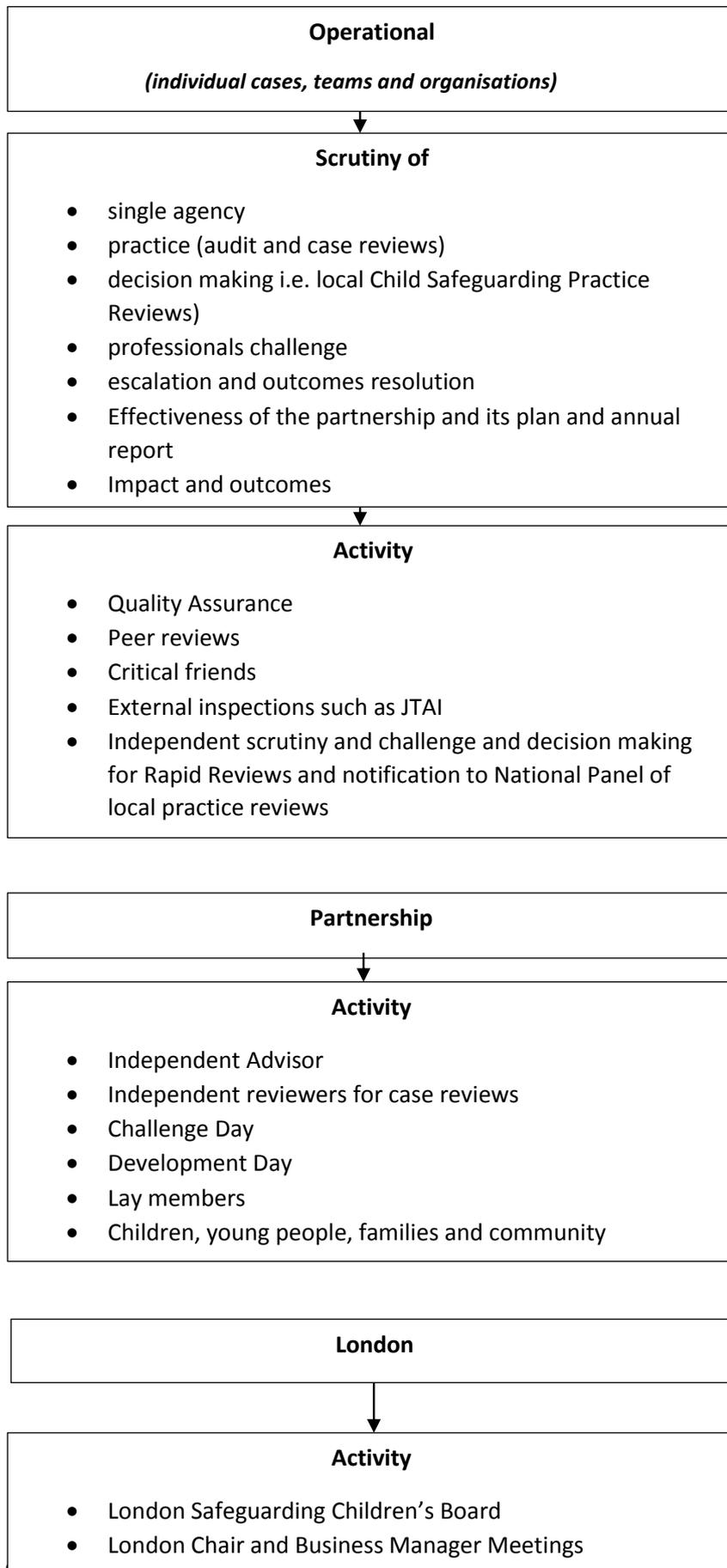
The Local Authority Lead Member for Children's Services also provides a wider perspective and link to Local Authority scrutiny and holds key political accountability for ensuring that the needs of all children and young people, including the most disadvantaged and vulnerable and their families and carers, are addressed. In doing so, the Lead Member will work closely with other local partners and will also continue to be a part of the new arrangements, in a challenge role to maintain independence.

Some additional forms of scrutiny will need to be independently commissioned, for example local child safeguarding practice reviews, however there is impartial or peer scrutiny within the local area and the region, which once arrangements are better embedded could provide scrutiny in future.

Independent scrutiny will:

- Be based on clear standards
- Be based on evidence, impartial and not rely on any single person
- Consider the effectiveness for children and families as well as for professionals
- Provide challenge and as well as recognising good practice
- Be cost effective and proportionate
- Include service users and the public (lay members, children and families)
- Be subject to moderation if required, overseen and reviewed by the Safeguarding Effectiveness Sub-Group.

Safeguarding Effectiveness Framework includes independent scrutiny of:



## **12) Review of the Safeguarding Effectiveness Framework**

The Safeguarding Effectiveness Framework, led by the Safeguarding Effectiveness Sub-Group, on behalf of the partnership board, will be reviewed every two years to ensure that it continues to meet the needs and requirements both locally and nationally to effectively monitor the safeguarding system and practice in Hounslow.

Appendix 1

Safeguarding Effectiveness Framework Flowchart

