Nottinghamshire SAFEGUARDING CHILDREN Board

Impact Evaluation Framework

How do we know whether the work of the NSCB is improving the safety of children in Nottinghamshire?

Training

How do we know if training is improving the competence of staff working in Nottinghamshire?

WHAT DO WE DO

- Monitor provision (single agency & inter-agency)
- Consider coverage of training applications (what % and any agency variance)
- Analysis and feedback of attendance data

IS IT WORKING

- Staff feedback (analysis of)
- QA (peer review – multi-agency published standards, observation of single and inter-agency training)
- Learning from good practice
- Multi agency quality assurance activity

Agency Performance

How do we know that agencies are practising in accordance with agreed standards?

WHAT DO WE DO

- Consider inspection findings
- Annual report
- Impact of Serious Case Reviews
- Monitor attendance at Board meetings/subgroups etc.

IS IT WORKING

- Section 11
- Single agency audit
- Performance Information
- Learning from good practice
- Multi agency quality assurance activity

Serious Case Reviews

How do we know that we are learning lessons when children die or are seriously injured and abuse or neglect is suspected?

WHAT DO WE DO

- Review cases at SSCR Sub-group
- Role of the Independent Chair in evaluating cases
- Monitoring of Action Plans

IS IT WORKING

- Ofsted evaluations
- SCR Panel and role of the full board
- Impact appraisal at PQ sub-group
- Link to Multi Agency Quality Assurance Activity
- Learning from good practice
- Multi agency quality assurance activity

CDOP

How do we know if, following the death of a child, agencies work effectively to reduce the likelihood of further similar incidents?

WHAT DO WE DO

- Analysis of the cause of child deaths and the efficacy of the ensuring response
- Feedback from the Designated Paediatrician for Unexpected Deaths and other professionals
- Identification of modifiable factors

IS IT WORKING

- Monitoring implementation of agreed recommendations
- Learning from good practice
- Ongoing analysis of data
- Multi agency quality assurance activity

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How do we know if training is improving the competence of the staff working in Nottinghamshire?

The NSCB has a responsibility to ensure that single and inter-agency training is provided across the county at an acceptable standard and that this is accessible for those in qualifying staff roles according to Working Together to Safeguard Children 2010.

WHAT DO WE DO?

The NSCB carries out this function on behalf of partner agencies via the Training Sub Group (TSG) that has representatives from the partner agencies as members, in conjunction with the work of the Training Co-ordinator. The TSG is a forum for reporting on issues relating to access to training for agencies and will be recorded in the minutes of these meetings.

The NSCB will collate information relating to the provision of single and inter-agency training regarding safeguarding children across the county. This would include the range and frequency of training, details of course content, who is delivering in this training and what qualifies them to do so. If in-house records are not available then completion of the NSCB trainer record can be used.

The NSCB publishes an annual training programme, on the internet and via partner agency representatives, that contains details of the available NSCB courses including;

- Target audience
- Eligibility criteria
- Learning outcomes
- How to apply

The NSCB will collect information provided by partner agencies about anticipated training needs for each year and the training content will also be informed by learning from local and national serious case reviews and local and national safeguarding priorities. The guidance in the training programme enables partner agencies to identify staff within their organisations requiring single and/or inter-agency training and where demand is high, prioritise who will be put forward for NSCB training.

The introduction of a content checklist for single and inter-agency Introduction to Safeguarding Children courses sets a minimum standard for training across Nottinghamshire. Some organisations will have allied professional standards that take precedence and the checklist provides guidance to those agencies without professional bodies stipulating requirements in safeguarding training and, also as a uniform way of recording this information. It is intended that this form is used by partner agencies of both the NSCB and Nottingham City Safeguarding Children Board so agencies spanning both Boards have only one set of requirements to meet and evidence consistency.

NSCB inter-agency training is provided by an established pool of trainers which is made up of colleagues from partner agencies. As the Board have determined this model of delivery, it is important that the TSG and partner agencies review their contribution to this and that the expertise and skills within the group are maintained.

The NSCB training team initially allocates places on inter-agency training courses by offering a small number of places to each agency / organisation however; as the time to notify

delegates becomes closer (some 4 or 5 weeks prior to the event), if places have not been used and there are people waiting, then additional existing applicants will be invited to the course. The event registers give details of those delegates invited to inter-agency training and the attendance reports provided to the Training Sub Group give partner agencies feedback as to who completed the training. This assists partner agencies in identifying learning and development needs and enables them to analyse the percentage of the workforce that have undertaken safeguarding children training

IS IT WORKING?

The TSG will receive quality assurance feedback from partner agencies and the Training Co-ordinator in relation to single agency training and NSCB inter-agency training. Delegates complete immediate response questionnaires following the completion of training and analysis of these will be fed back to the TSG. Following attendance at NSCB inter-agency training, it is the intention to collect and analyse this information electronically and introduce follow up surveys completed by delegates and line managers to find out if there are improved outcomes for children.

The TSG will review whether standards are being met against the content checklist for Introduction to Safeguarding Children courses by those agencies providing training. Attendance reports will give details of actual coverage of training for each partner agency/organisation. Partner agencies will provide feedback information of coverage in relation to single agency training. NSCB co-trainers provide feedback on the courses delivered in terms of issues of the day and their experiences of the training. The direction and content of inter-agency training should follow from the objectives within the training plan which should have a direct relationship with the NSCB business plan.

The content of single and inter-agency training will be revised to ensure it remains relevant and this is communicated via the TSG to partner agencies. The Training Co-ordinator will request training materials from partner agencies as part of the quality assurance process and dip sample individual training, with others (as appropriate), to conduct peer observations of single and inter-agency training and may include a dip sampling of cross authority (NSCB) inter-agency training. These processes form the main tenants of the Training Sub Group Quality Assurance Policy.

Nottinghamshire SAFEGUARDING CHILDREN Board

How do we know that agencies are practising in accordance with agreed standards?

WHAT DO WE DO

Ensuring that there is a robust, objective analysis that focuses on agency practice is one of the critical functions of the NSCB. The Performance and Quality (PQ) sub-group lead this work on behalf of the Board. The PQ has a permanent core membership and meet quarterly to consider a range of performance measures that enable it to analyse the performance of local agencies in more detail than is possible in the context of a full board meeting.

The PQ will consider the performance of individual agencies and/or sectors, e.g. Health, but will primarily be concerned with inter-agency implications and issues. Where serious concern is identified in relation to an individual agency the escalation process set out in the NSCB constitution will be followed.

To ensure the widest possible consideration of the conclusions reached by the PQ it will provide a quarterly report to the NSCB Executive. The Executive will lead on identifying issues that need to be brought to the attention of the full board.

In addition to evaluation of agency performance the PQ will evaluate agency contribution to Board processes.

IS IT WORKING

The PQ will consider in detail the findings of inspections of Board partner agencies, in so far as they have implications for the safety and well being of children and young people. The PQ will also consider an analysis of the findings of inspections of schools and early years providers.

The PQ will lead on the development of the annual Section 11 self-assessment undertaken by all Board partner agencies. It will oversee the development of the questions and areas to be covered. It will also consider the findings in order to

- Identify any thematic issues and propose a response to these
- Evaluate the implications of any areas of non-compliance and the plans in place to address these

The PQ will analyse the impact of actions taken in response to the findings of serious case reviews. It will undertake this analysis in line with the serious case review framework that is described in detail below. This will include, where appropriate, learning lessons from good practice.

The PQ will consider performance information in relation to safeguarding and promoting the welfare of children. This will include

- Private Fostering

- Allegations against people who work with children

- Child protection data that is not considered in the full board, e.g. the composition of the list of children subject to a protection plan by category of plan, age, district, etc

The PQ will lead on multi-agency audit activity. This will include the annual thematic audit and smaller scale performance audits. The PQ will agree the focus of such audits and receive detailed reports regarding the findings.

The PQ will receive quarterly reports setting out agency attendance at NSCB sub-groups and the full Board. Where concerns are identified it will ensure that the process set out in the NSCB Constitution is followed

Nottinghamshire SAFEGUARDING CHILDREN Board

How do we know that we are learning lessons when children die or are seriously injured and abuse or neglect is suspected?

WHAT DO WE DO

The NSCB leads, on behalf of partner agencies Serious Case Reviews. Proposals regarding whether a case should or should not be the subject of a serious case review are made by the Standing Serious Case Review Subgroup (SSCR) of the Board. These proposals are considered by the Independent Chair to ensure that there is objective scrutiny by someone not connected with any of the agencies involved in a case.

Where a Serious Case Review is agreed a Panel will be established to oversee the process and findings of the review. The panel will be made up of senior representatives of the agencies involved in the review, the NSCB Development Manager and the Group Manager – Safeguarding and Quality Assurance. The NSCB Development Manager will commission an independent chair for the panel and independent author for the overview report. On completion of the review the overview report, executive summary and action plans will be considered by an extraordinary meeting of the full board.

In addition to considering possible new cases the SSCR will monitor the implementation of action plans, following the process set out below:

IS IT WORKING

There will be 2 phases

- Monitoring implementation of action plans
- Impact evaluation (linked to specified outcomes)

This activity will inform the focus of the annual thematic multi-agency audit

Implementation of action plans

- After 1 month – 1st reminder sent asking for update. Each commissioner will then be required to send in monthly updates until their plan is completed
- Updates will be rag rated as follows – Green completed, Amber – in progress and on target to complete within timescale, Red – at risk of not meeting target or overdue
- Plans signed off by the panel will be identified by coding them as Blue on the master sheet
- SSCR sub will consider all plans/updates but will focus on Green – to confirm that they are satisfied with this assessment and red to identify/action remedial action
- Requests for updates will be sent once, a reminder will be sent once. Any failure to comply at that point will be discussed with the Independent Chair
- Where actions are not completed within the specified timescale the commissioner will be asked to provide an explanation and propose a revised timescale for consideration by the panel
- In principle all action plans should be completed within 6 months. At which point they are transferred to PQ sub for further evaluation

- Progress reports, highlighting key achievements and any exceptions will go to the Board after 4 months then at alternate meetings
- Information regarding implementation of action plans will be included in the NSCB Annual Report
- Any findings with regards to the nature of recommendations or action plans more generally will be incorporated into IMR training and the briefings delivered to authors at the start a serious case review process

Impact Evaluation

- The initial phase of this aspect of the framework will be based on self assessment. The findings of the self assessments will then be triangulated through the focus of the NSCB audit
- After 4 months a request will be sent to all commissioners asking for their initial evaluation of the impact of the action plans in relation to the required outcomes from their IMR and the overview report
- The PQ sub will focus on selected outcomes from each plan rather than necessarily each outcome.
- The PQ sub will use the findings of self-evaluation to identify the focus for the annual NSCB audit
- Progress reports, highlighting key achievements and any particular challenges, will go to the Board after 4 months
- Information regarding impact of action plans will be included in the NSCB Annual Report

Nottinghamshire SAFEGUARDING CHILDREN Board

How do we know if following the death of a child, agencies work effectively to reduce the likelihood of further similar incidents?

WHAT DO WE DO

The Nottinghamshire Child Death Overview Panel (CDOP) was established in line with Working Together 2010. The primary purpose of the CDOP is to ensure through multi-disciplinary reviews of all child deaths in order that the NSCB better understands how and why children in Nottinghamshire die. Procedures for the child death review function are set out within Chapter 9 of the Nottinghamshire and Nottingham City Safeguarding Children Boards' Safeguarding Children Procedures.

To facilitate the review process the CDOP has a permanent core membership drawn from key organisations; additional members are co-opted when individual cases require particular expertise. The panel meets every six weeks.

A network for the notification of child deaths and a rapid response function has been developed.

Each child death review will include:

- An evaluation of the information about the child's death
- An assessment of the preventability of the death through the identification or otherwise of modifiable factors
- Consideration of any issues relating to the effectiveness of the review
- Identification of lessons to be learnt and/or recommendations as appropriate. The reviews will contribute to an understanding of all child deaths at a national level

IS IT WORKING

Attendance at the CDOP will be monitored to ensure appropriate representation; the NSCB Development Manager will address any gaps identified.

Any recommendations made following the review of a child's death will be recorded by the Child Death Administrator and progress against those recommendations will be reported back to the CDOP until completed to the satisfaction of the panel.

The review format includes the opportunity to identify good practice. Any examples of good practice will be formally recorded and the panel will consider appropriate dissemination methods. National circulations of good practice will be assessed by the panel prior to actioning, where appropriate.

Child death review teams based in hospital settings are responsible for the notification of child deaths, initial collation of information and implementation of the rapid response process. These teams will monitor their own performance against indicators agreed with Commissioners and share their findings with the CDOP. Cross checking using information supplied by HM Coroner and the Registrar of births and deaths will be used to check the efficacy of child death notifications systems.

The NSCB Development Manager will monitor the caseload of the CDOP and ensure that there is no undue delay in cases being reviewed by the panel once the necessary information has become available.

Data relating to child deaths in the area will be collated by the Child Death Administrator in a manner that facilitates, as a minimum, the annual return of data to the Department for Education in the prescribed format. This will enable analysis of the causes of child death and the throughput of cases through the CDOP. Opportunities for further statistical analysis of trends in child deaths will be explored with the Consultant in Public Health who is a permanent member of the CDOP.

This analysis is the crucial function of the CDOP as it provides the basis for recommendations and action to:

- Reduce the likelihood of further such incidents in circumstances where modifiable factors were identified

- Ensure effective practice with regard to palliative care and family support where no modifiable factors were identified.