city & hackney safeguarding children board

Learning & Improvement Framework

April 2016

1. Introduction

1.1 The world of safeguarding is complex, demanding and absolutely necessary; and nothing is more important than helping and protecting our children and young people.

1.2 Working together to make children and young people safer is the primary aim of the City & Hackney Safeguarding Children Board (CHSCB) and it is essential that both professionals and organisations learn lessons when things don't go right and equally importantly, when they do. Learning, however, is not enough

1.3 With each lesson we learn, we need to make sure that this drives and sustains improvement in front-line practice. The CHSCB is committed to making sure this happens.

1.4 At the core of our safeguarding and child protection work is the commitment to ensuring children and young people are **seen, heard and helped** and that we truly understand the quality of their experiences. We want to learn from these experiences and have a positive impact upon young lives. We want our work to be characterised by an attitude of constructive professional challenge and we want to foster a culture of continuous learning and review that inspires innovation, whilst always making sure we're doing the basics right.

1.5 The CHSCB is a learning organisation and our job is to review, scrutinise and challenge local safeguarding arrangements; reflecting on the quality of services and learning from practice in order to improve it.

1.6 To do this, we have introduced this local learning and improvement framework as endorsed in the statutory guidance, Working Together 2015.

"*Local Safeguarding Children Boards (LSCBs) should maintain a local learning and improvement framework which is shared across local organisations who work with children and families. This framework should enable organisations to be clear about their responsibilities, to learn from experience and improve services as a result*"[1]

1.7 This framework is the mechanism by which the CHSCB will address these statutory requirements and also describes elements of the quality assurance process of practice. Where identified, the CHSCB will go beyond the parameters of this framework to ensure that all sources of learning are considered, recognised and used to drive improved outcomes for children and their families.

1.8 Whilst some aspects of this framework are defined, the CHSCB will remain flexible, dynamic and responsive to emerging safeguarding trends. We have high ambition across the City and Hackney and to keep our "finger on the pulse"; we will engage with children and families, tap into professional expertise and use local knowledge to better understand what is happening and what needs to improve. To ensure that this framework is effective, the CHSCB will monitor its impact and review its content on an annual basis via the Quality Assurance (QA) Sub Group of the CHSCB.

Jim Gamble
Independent Chair, CHSCB

[1] DfE (2015) *Working Together to Safeguard Children*, page 65.

2. Our Principles for Learning and Improvement

2.1 This framework is based on the following principles for learning and improvement as set out in Working Together 2015:

- there should be a **culture of continuous learning and improvement.**
- the approach taken to reviews should be **proportionate** according to the scale and level of complexity.
- reviews of serious cases should be led by individuals who are **independent**;
- **professionals must be involved fully** in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- **families, including surviving children, should be invited to contribute to reviews**. This is important for ensuring that the child is at the centre of the process.
- final reports of SCRs must be published, including the LSCB's response to the review findings, in order to achieve **transparency**.
- **improvement must be sustained** through regular monitoring and follow up so that the findings from these reviews make a real impact on improving outcomes for children.

2.2 The local CHSCB framework operates as a "feedback loop" and is explicit in describing how learning and areas for practice improvement are:

- **IDENTIFIED**
- **DISSEMINATED**
- **EMBEDDED**; and
- **EVALUATED** for direct **IMPACT** on outcomes for children and young people.

3. Identifying Learning

3.1 "*The local framework should cover the full range of reviews and audits which are aimed at driving improvements to safeguard and promote the welfare of children.*"[2]

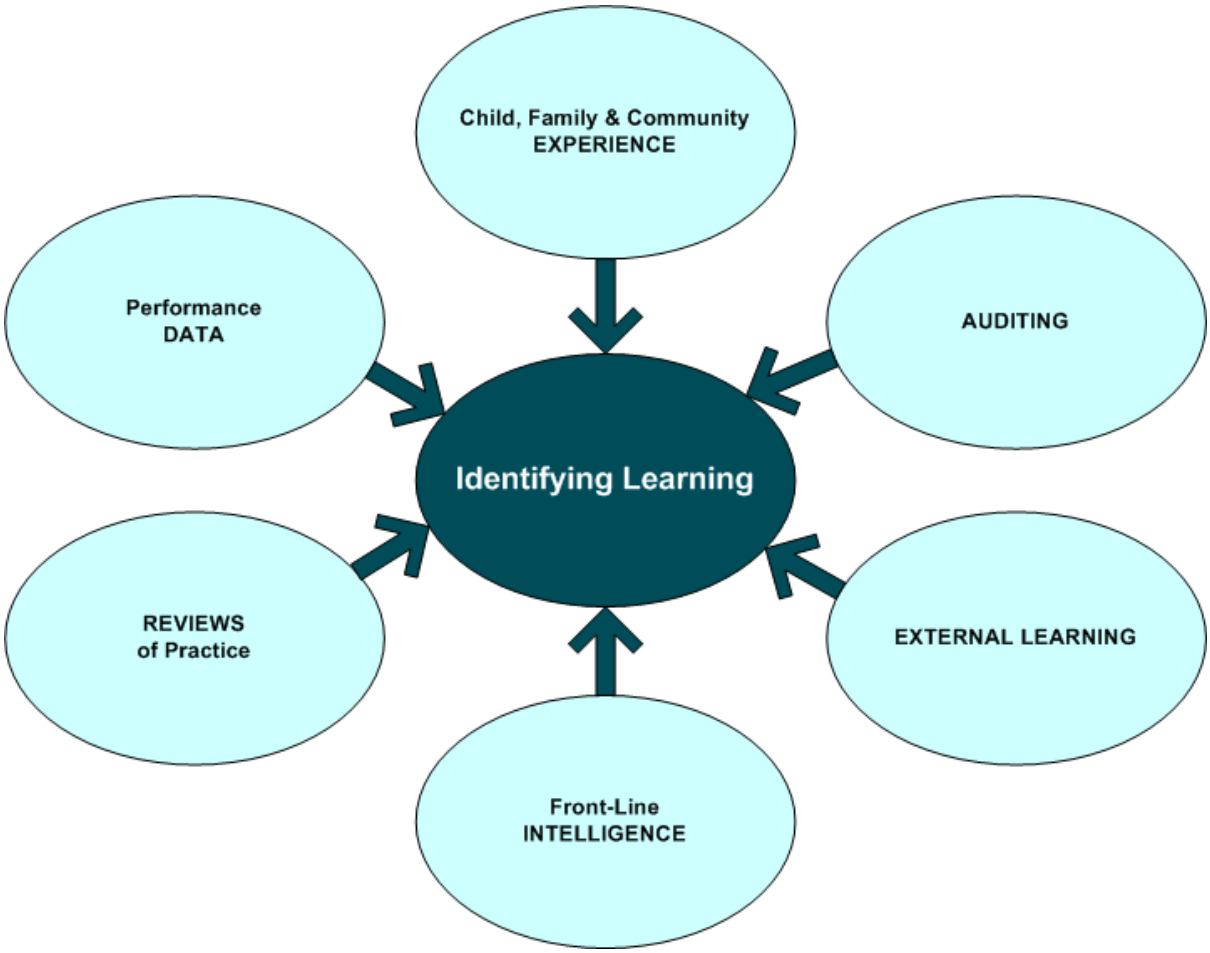
3.2 Learning opportunities from safeguarding practice arise from a variety of sources. This framework sets out the key practice reviews and learning opportunities that the CHSCB, partner agencies and other local organisation will use to look at what is working well, what isn't and what needs to happen to improve practice.

3.3 At the forefront of all of these mechanisms will be a focus on ensuring the **child's experience** is captured (including views of parents and family members). The starting point will be the CHSCB attempting to understand what life is like for the child and what could be improved from their perspective to influence better practice and service delivery in the future.

3.4 Further details on how the CHSCB identifies learning are set out in the Appendices.

[2] DfE (2015) *Working Together to Safeguard Children.*

3.5 How the CHSCB identifies learning



4. The Child, Family & Community Experience

4.1 An effective learning and improvement framework will bring together in a joined up way the various views and experiences of the people using services; and not just from the review / audit processes that might be in operation.

4.2 There is a wide range of information already collected from children, young people, families and communities. In addition to its own activity directly speaking with children and young people, the CHSCB will systematically gather information collected by partner agencies and use it to influence the design and delivery of services relating to safeguarding children and young people. At the heart of this work is trying to understand what children and families themselves believe could have made a positive impact on their lives had agencies worked differently or indeed, what worked well, so this can be sustained.

4.3 How the CHSCB understands the Child's Experience

- **Direct engagement by the CHSCB Chair**
- **Children in Care Feedback**
- **Feedback via Hackney Youth Parliament & "The City Gateway"**
- **Complaints & Compliments**
- **Advocacy & Independent Visiting**
- **IRO feedback**
- **Targeted engagement and consultation with children, families and communities**
- **Lay member feedback**
- **Community Partnership Advisor Feedback**

5. Reviews of Practice

5.1 Reviews are undertaken to learn from past events. The CHSCB will use this learning to improve practice and services for vulnerable children and their families.

5.2 Reviews consolidate learning about what is working well and what presents challenges to organisations (both child and adult-facing) within City and Hackney. Central to all review processes will be an unswerving focus on trying to understand events from a child's perspective.

5.3 How the CHSCB reviews practice

- **Serious Case Reviews**
- **Multi-Agency Case Reviews**
- **Single Agency Case Reviews / Investigations**
- **Child Death Reviews**
- **Domestic Homicide Reviews**
- **Reviews undertaken by the City & Hackney Safeguarding Adults Board**

6. Auditing

6.1 Having a systematic auditing process in place allows the CHSCB to monitor the quality of practice and judge where there is a need to target areas for development.

6.2 The auditing process provides one of the best learning opportunities for both workers and organisations. Auditing will assess and measure the quality of professional practice and test:

- Whether the child / young person's voice has been heard through intervention.
- Whether multi-agency practice is making a difference for children, young people and their families – captured in large part by involving them in the audit process.
- Whether or not what is happening ought to be happening
- Whether current practice meets required standards, procedures and published guidelines
- Whether current evidence about good practice is being applied.

6.3 **How the CHSCB audits**

- **Multi-Agency Case Audit**
- **Single Agency case Audit**
- **Section 11 & Section 175/157 Audits**

7. Front-line Intelligence

7.1 Engagement with front-line staff, first-line managers, CP Chairs and Independent Reviewing Officers to understand their experiences of what is working well and what isn't is key to the CHSCB in gaining a transparent understanding of the realities of front-line child protection / safeguarding work. Critical will be the examination of staff feedback in respect of the knowledge, skills, experience and opportunities they have for direct work and engagement with children and young people.

7.2 **How the CHSCB receives staff feedback**

- **Front-line visits / listening events**
- **Feedback through CHSCB training**
- **CHSCB Staff Surveys**
- **IRO feedback**

8. CHSCB Dataset - Performance Management Information

8.1 The CHSCB will oversee an agreed dataset that monitors key points in the "journey of the child" and enables the CHSCB to provide appropriate support and challenge to partners for their performance, on both an individual and multi-agency perspective.

8.2 The CHSCB will utilise the Children's Safeguarding Information Framework and the suggested metrics for safeguarding contained with the Munro Review of Child Protection. The Quality Assurance Sub Committee will review these metrics alongside qualitative and quantitative information as part of a rolling cycle of quality assurance, performance management learning and improvement.

9. External Lessons

9.1 Opportunities for learning from national reviews, feedback from corporate structures and other forums external to the CHSCB are equally relevant to how our system improves. The CHSCB will take account of such learning and ensure it is appropriately disseminated or included in related action plans targeting service improvement.

9.2 **How the CHSCB receives external lessons**

- **National Research and Serious Case Reviews**
- **Strategic Partnership Feedback**
- **Overview and Scrutiny Feedback**
- **Agency Reports**

10. Disseminating and Embedding Learning

10.1 Disseminating and embedding good practice, what works well and learning from when things go wrong is an important part of supporting a culture of continuous learning and improvement. Integral to the success of this framework will be the sharing of learning across organisations to ensure transparency, accountability and consistent improvement to practice.

10.2 Senior leaders across all organisations will be expected to drive a culture whereby learning is effectively disseminated and embedded into the day to day practice of front-line staff. The delivery of key learning messages is the "easy bit" to some extent and the processes available to the CHSCB to do this are outlined below.

10.3 How the CHSCB shares lessons

- **CHSCB Training Programme and Annual Conference**
- **Single Agency Training**
- **CHSCB TUSK (Things You Should Know) briefings**
- **Single Agency Briefings**
- **Campaigns and promotional material**
- **Communications through CHSCB Web / Twitter**
- **Publication of SCRs and Case Reviews**
- **CHSCB Annual Report**

10.4 In terms of embedding learning, **culture outweighs strategy every time**, and together with strong leadership, this can be achieved through:

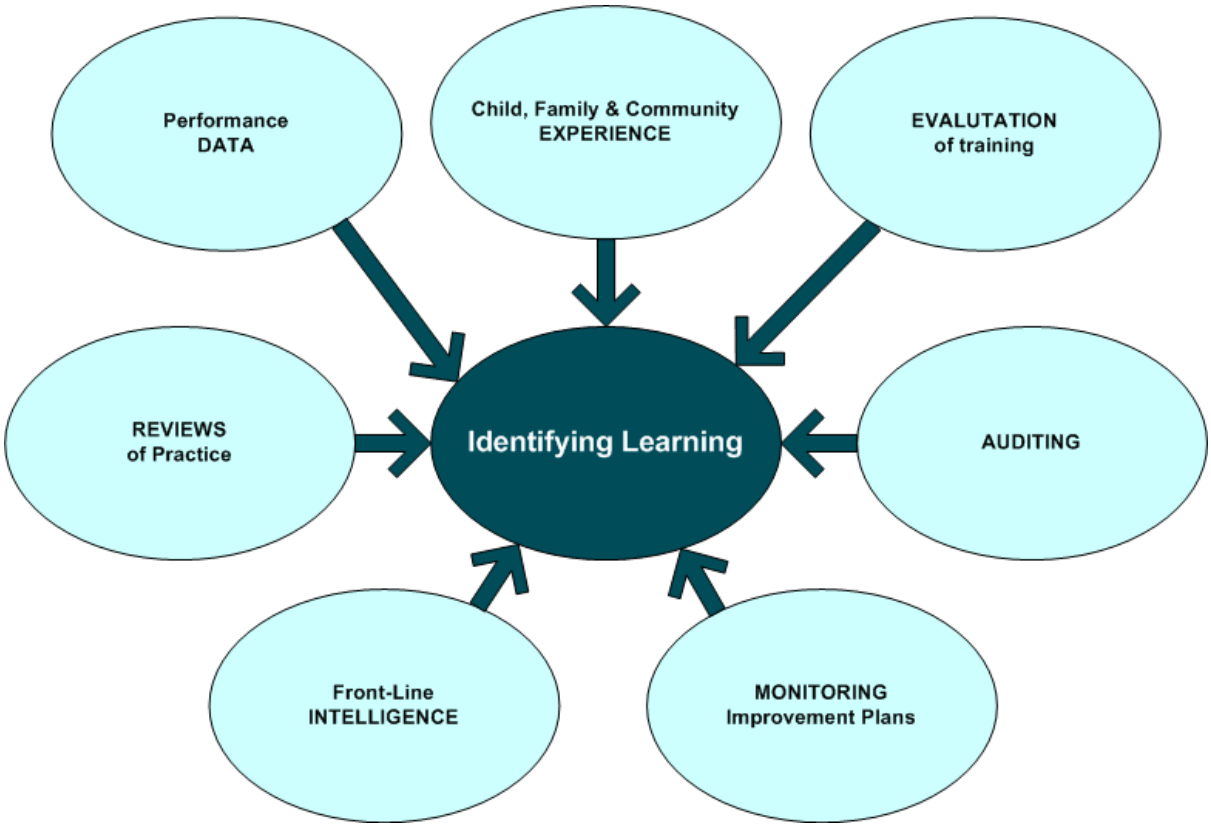
- **Policy and Protocol Development**
- **Reflective Practice and Supervision**
- **Collaborative Joint Working Arrangements**
- **Service Team Meeting structures that focus strongly on how identified improvements will be implemented and make sense for individual staff on the front-line.**

11. Evaluating Learning & Evidencing Impact

11.1 The aim of the activity outlined in this framework is to make a positive impact on frontline practice and in turn improve outcomes for children and young people in the City & Hackney. Our most frequent question will be "*what difference have we made to children's safety and wellbeing as a result of identifying learning, disseminating lessons and embedding those lessons in day to day practice."*

11.2 There will be a variety of mechanisms by which we will achieve this, using new and existing approaches, however the most important evaluation will be the targeted tracking of individual children and being clear about the difference that any learning would have made to the child, if applied at the time of intervention.

11.3 How the CHSCB evaluates learning and evidences impact



Appendix 1 - Child, Family and Community Experience

1. Direct Engagement by the CHSCB Chair

In discharging his or her role, the Independent Chair of the CHSCB will meet with a number of children, young people and their families to directly speak with them about their experiences of the multi-agency safeguarding system across the City and Hackney.

Engagement will aim to involve children and young people who live in families where identified risk factors are the same as those prioritised in the CHSCB business plan.

2. IRO Feedback

The Independent Reviewing Unit provides independent scrutiny of cases and plays a role in identifying practice themes emerging from the cases that they review. The IRU provides intelligence and learning themes in respect of responses to individual children and families, issues pertinent to single agencies and learning in respect of how the partnership work together to improve outcomes for children subject to child protection planning and child in care processes.

3. Children in Care Feedback

The members of the Children in Care Council are supported and encouraged to provide feedback on existing service delivery and views about future directions directly to the Head of Service for Corporate Parenting.

The CHSCB will ensure that either through direct meeting or through relevant Board members, the feedback from children in care forms a key part of the business of the CHSCB.

4. Feedback via Hackney Youth Parliament & "The City Gateway"

The Independent Chair will provide the CHSCB Annual Report and proposed priorities to the Hackney Youth Parliament and City Gateway each year for scrutiny by the young people involved.

5. Complaints / Compliments

Feedback from children and families along with information obtained from complaints investigations, provides an insight into how well the safeguarding system is working. Relevant lessons established through the statutory complaints process overseen by Hackney Council will be shared with the CHSCB for analysis and identification of learning for the system.

Direct complaints made to the CHSCB and any cases escalated to the Chair will provide further intelligence in respect of related safeguarding issues / themes / lessons.

6. Advocacy / Independent Visiting

Independent advocacy services will, as appropriate, ensure they communicate the views of children and young people to the CHSCB – either directly or via a Board member agency responsible for that service.

The CHSCB may, through these arrangements, approach specific children and young with known risk factors relating to CHSCB priorities to independently capture their wishes / feelings / views and opinions with regards to the safeguarding system.

7. Targeted engagement and consultation with children, families and the community

The CHSCB will remain on the front-foot with regards to seeking the experiences of children, families and the community. Targeted face to face engagement by the Chair and by CHSCB representatives will be facilitated where the CHSCB identifies specific issues / groups of children / families / communities with whom it needs to engage. This might arise based on identified learning that requires further exploration with children, families and communities themselves.

Targeted engagement may also take the form of specific surveys. The CHSCB will seek to utilise the expertise of the voluntary and community sector, via Hackney CVS, when initiating work in this regard.

8. Lay member feedback

The four Lay members for the CHSCB will, through their work plan, ensure that there is opportunity for them to meet directly with children, young people and their families to ascertain their views about their experiences of safeguarding responses across City and hackney.

Lay members will be involved in specific CHSCB projects and will provide a transparent and independent / non-professional account of their opinions about children's experiences.

9. Community Partnership Advisor Feedback

Through his / her work, the Community Partnership Advisor to the CHSCB will provide feedback, detailing the work undertaken, the community groups engaged, the nature of the work of the CPA and key messages raised by the community in respect of safeguarding children and young people.

Appendix 2 - Reviews of Practice

1. Serious Case Reviews

Serious Case reviews (SCRs) are a statutory requirement and key source of learning in helping to understand what happened and why when things go wrong for a child or young person. It is a multi-agency review of a case and looks at how professionals and organisations worked together with the child or young person at the centre of the review.

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the statutory requirements for LSCBs to undertake SCRs in specified circumstances. LSCBs must carry out a SCR where:

(a) abuse or neglect of a child is known or suspected; and
(b) either - (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

In addition to the above a SCR should always be carried out when a child dies:

- In custody, police custody, on remand or following sentencing.
- In a Young Offender Institution, a secure training centre or secure children's home.
- Where the child was detained under the Mental Health Act 2005.

Where a case is being considered under regulation 5(2)(b)(ii), unless it is clear that there are no concerns about inter-agency working, the LSCB must commission a SCR.

Each LSCB will determine the most suitable process to use in deciding if a case meets the criteria for a SCR. The final decision as to whether a case meets the SCR criteria will rest with the LSCB's Independent Chair.

All reviews of cases meeting the SCR criteria result in a report which is published and readily accessible on the CHSCB website.

2. Multi-Agency Case Reviews

Multi-Agency Case reviews are reviews of all cases falling below the Serious Case Review threshold. Cases can involve incidents where a child has been harmed and there are concerns about multi-agency practice, or involve incidents where multi-agency practice is considered to be good (after a child has been harmed or where a child has been prevented from being harmed) and agencies seek to identify the characteristics and enablers of that good multi-agency practice.

Where the CHSCB considers the criteria for a Multi-Agency Case Review is met the CHSCB will decide the most appropriate methodology for conducting the review.

3. Single Agency Case Reviews

Individual agencies will on occasions be required to undertake their own internal reviews of practice involving near misses and/or serious incidents that did not involve other agencies.

In the interests of joint learning and transparency, the CHSCB will expect any relevant lessons arising from single agency reviews to be considered under the Learning and Improvement Framework.

4. Child Death Reviews

Child Death Reviews are required in statute and are a crucial source of understanding working practices. Regulation 6 of the Local Safeguarding Children Boards Regulations 2006 outlines LSCB responsibilities in relation to a child death. LSCBs are accountable for:

(a) collecting and analysing information about each death with a view to identifying

- any case giving rise to the need for a review mentioned in regulation 5(1)(e);
- any matters of concern affecting the safety and welfare of children in the area of the authority;
- any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area; and

(b) putting in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

The CDOP conducts a comprehensive review of the circumstances surrounding a child's death. Qualitative and quantitative data is collected including all single agency reporting, critical incident reports, serious incident reports and the Coroner's inquisition. The CDOP Co-ordinator meets quarterly with CHSCB Board Managers to report on learning from CDOP which is then disseminated to the respective CHSCB member organisations for onward dissemination to staff. The CDOP also produce an annual report identifying themes, trends and learning for the CHSCB.

5. Domestic Homicide Reviews

When there has been a death of an individual of 16 years or over which has, or appears to have, resulted from violence, abuse or neglect by a person to whom s/he was related to, had been in an intimate personal relationship or was a member of the same household then a Domestic Homicide or Serious Incident review will be undertaken (if the deceased person was 16 – 18 years then a Serious Case Review will be undertaken, with the Domestic Violence fully considered).

The CHSCB is involved in all reviews where there are children living in the house and the findings and recommendations are considered by the CHSCB.

6. Reviews by the City & Hackney Safeguarding Adults Board

Relevant opportunities to establish joint learning across both the CHSCB and the CHSAB will be established through SCR, Case Review and DHR processes

Appendix 3 - Auditing

1. Multi-Agency Case Audits

Multi-Agency Case Audits (MACA) provide a valuable means of identifying key lessons for improvement alongside informing the CHSCB about the effectiveness of frontline practice.

The CHSCB has developed a MACA programme that will run throughout the year.

MACA's are scheduled and will involve a multi-agency audit team auditing a number of cases following a set structure. The selection of themes for audit are guided by the knowledge arising from the identified learning as part of this framework; including local professional knowledge and feedback from children, families and communities that identifies possible practice issues.

Frontline practitioners and managers will be involved. Parents and young people will be involved wherever possible. The MACA process focuses on the child's lived experience, the quality and impact of practice and involves 'appreciative elements', to highlight what worked well in cases as well as areas for action.

Lessons for dissemination will be identified and reported via the QA Sub Group to the CHSCB.

2. Single-Agency Audits

The multi-agency case audit work is complimentary to single agency case auditing that should occur in most organisations as part of their assurance of their duties under section 11 of the Children Act 2004.

Agencies should present the findings from these case audits, with particular emphasis on the lessons for the effectiveness of multi-agency working via the QA Sub Group.

3. Section 11 of the Children Act 2004

Section 11 of the Children Act 2004 requires a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children[3].

Partner agencies are required to self-evaluate their compliance against the standards and submit a safeguarding improvement plan for the coming 12 months. Agencies can assess their compliance using an audit tool reflecting the Children Act 2004 requirements or complete a one-day safeguarding peer review undertaken by a small number of members from the CHSCB and then submit the report of findings, or sign a declaration of compliance.

[3] Statutory guidance on Section 11 of the Children Act 2004 sets out the standards and can be accessed at http://webarchive.nationalarchives.gov.uk/20130401151715/https://www.education.gov.uk/publications/standard/publicationdetail/page1/dfes-0036-2007

Agencies are also expected to report on progress of improvements to safeguarding during the previous 12 months.

Additionally, under the Section 11 assurance process, the CHSCB expect front line staff working directly with children and their immediate managers, to provide their views about their agencies policies, procedures and practices related to the safeguarding of children and comment on how to improve safeguarding children practice by responding to the Staff Safeguarding Children Survey.

The results from these surveys provide further assurance of agency compliance and the CHSCB with an indication of overall safeguarding children practice. The individual agency survey reports present leaders of such agencies with comparative information and feedback from their staff on where safeguarding children practice is considered good and in place and where weaknesses exist and need improvement.

The CHSCB will also undertake peer reviews as part of the S11 audit process to establish reassurance and identify further areas of learning as appropriate.

4. Section 175 and 157 of the Education Act 2002

Section 175 of the Education Act 2002 came into effect on the 1 June 2004. Section 175 requires school governing bodies, local education authorities and further education institutions to make arrangements to safeguard and promote the welfare of children. Similar requirements are in place for proprietors of Independent Schools under Section 157 of the Education Act 2002.

The CHSCB is required to monitor the effectiveness of safeguarding arrangements in schools and undertakes an audit cycle consistent with the Section 11 audit process. The findings are analysed with suggested improvements made to assist schools who have not yet reached the required standard.

Appendix 4 – Front-line Intelligence

1. CHSCB front-line visits / listening events

The Chair and Board members will undertake a range of visits to front-line staff from a range of agencies across the course of the year. The Chair will also host a set of "listening events", where staff will be invited to discuss safeguarding matters in respect of their own agency or as part of inert-agency work.

The intention is to provide front-line staff with visible leadership from the Board; together with opportunities to share their perspectives on what is working well and what isn't.

2. CHSCB Training Feedback

Feedback from front-line staff will also be captured through formal feedback at CHSCB training events. CHSCB events will be used to capture professionals' views in respect of specific issues alongside the evaluation of the training event itself.

3. CHSCB Staff Surveys

The CHSCB will employ the use of a staff survey to support the Section 11 process and further use targeted surveys to staff to elicit feedback.

4. IRO feedback

The Independent Reviewing Unit will provide intelligence in respect of its independent view as to how the safeguarding system operates – specifically in respect of the most vulnerable children across City and Hackney.

Appendix 5 – External Lessons

1. National Research and Serious Case Reviews

The CHSCB will use identified learning from research and published Serious Case Reviews to assist in improving local safeguarding arrangements. Key learning and themes will be disseminated to staff consistent with this framework.

2. Strategic Partnership Feedback

The CHSCB works closely with the Health & Wellbeing Boards across City and Hackney, the Community Safety Partnerships and the City & Hackney Safeguarding Adult Board through a defined protocol that enables challenge, scrutiny and feedback to be given to the CHSCB on its priorities and performance. This feedback will be used to help identify areas of learning that improve the quality of practice and service delivery.

3. Overview and Scrutiny Feedback

The safeguarding system receives scrutiny and challenge from the democratic functions of Overview and Scrutiny within The London Borough of Hackney and via the Safeguarding Sub Committee in the City. These forums also form an important part of the framework in terms of identifying lessons and areas for improvement.

4. Agency Reports

During the course of each year, relevant reports will be produced for the CHSCB, providing a narrative account of the work being undertaken in particular areas. These reports will be expected to identify any relevant learning that has been identified in respect of their specific safeguarding themes.

The following list is not exhaustive and the CHSCB may request additional reporting on specific areas based on its analysis of what areas require focus.

- LADO – Management of Allegations against Professionals and Volunteers working with children.
- Private Fostering

Appendix 6 - Quality Assurance

1. As well as providing effective opportunities for the safeguarding system to learn and improve, the functions required to deliver this Learning and Improvement Framework, will also provide evidence to the CHSCB in its **assurance** role – i.e. forming a view as to the effectiveness of the system and being assured that through the co-ordination of services, agencies and their staff work effectively to minimise risks of harm to children and young people and improve their wellbeing and life chances.

2. The CHSCB should be able to, on an on-going basis, **assess the health** of the safeguarding children system within their area, ensuring effective leadership connects with font line practice, children and their families, through focus on quality, performance management and an ability to learn.

3. For quality assurance to be effective there needs to be the following elements:

   - Planned and annually reviewed multi-agency case auditing and single agency case auditing.

   - Regular performance reporting, on a selected number of critical measures linked to safeguarding priorities, from across the safeguarding system, where analysis has been undertaken prior to reports presented to the CHSCB which enables the CHSCB members to understand how their area is performing comparatively as well as local information that highlights differences in service standards and outcomes.

   - The production of the CHSCB Annual Report on safeguarding children which provides a rigorous and transparent assessment of the performance of local services, identifies areas of weaknesses, the causes of those weaknesses and the action being taken to address them as well as other proposals for action. It should contain lessons from all reviews undertaken within the reporting period.

   - Reporting of performance and any failure to meet standards, from the Independent Review Unit, and other key service areas as appropriate.

   - The view of parents and children subject to safeguarding plans, for example, complaints and compliments, views gathered from the advocacy service, feedback from children in care.

   - The views of staff working within the children's workforce, gathered through agency surveys or through the Staff Safeguarding Children Section 11 survey.

   - The quality assurance activities to be reported should be reviewed annually.

4. In addition, quality assurance assumes a number of quality management principles including:

   - a strong focus on the experiences of children, young people and their families;
   - the motivation of senior leaders, top management and the children's workforce; and
   - a process approach to continually improving the safeguarding children system.

5. Quality assurance will enable the CHSCB to monitor front-line practice, identify gaps in and provide effective challenge to all partners.

6. It will facilitate the CHSCB in bringing robust independent scrutiny and challenge to safeguarding issues, processes and systems and help ensure the quality and effectiveness of single agency and multi-agency work within the safeguarding arena.

7. The CHSCB must demonstrate good practice by[4]:

- having comprehensive and integrated systems to allow the scrutiny of performance in key areas, at different levels and in geographical localities;
- involving frontline workers in audit processes;
- using independent audits and inspection findings to drive improvement;
- employing a variety of techniques and taking a very thorough approach to auditing;
- adopting a thematic and planned approach to auditing;
- using the outcomes of audits to learn and improve practice;
- assessing the impact of changes resulting from audit findings on children and young people and their families rather than confining attention to changes in processes;
- agencies challenging each other's practice and hold each other to account;
- scrutinising not only their own agency activities but also those of other bodies, including young offenders' institutions.

8. The elements that comprise quality assurance will be annually reviewed to ensure that the most appropriate qualitative, quantitative and outcome performance measures are utilised, mapped against the key priorities so that the members ensure that a regular flow of information is reported to the Board.

Approved by:	City & Hackney Safeguarding Children Board
Date Approved:	June 2014
Date revised / adopted:	June 2014 / April 2016
To be reviewed:	Annually
Available:	www.chscb.org.uk

[4] Ofsted: Good Practice by Local Safeguarding Children Boards (Sept 2011) p 22