Isle of Man Safeguarding Board Quality Assurance and Scrutiny Framework

Purpose

The Isle of Man Safeguarding Board and the integral member agencies that make up the Board are committed to ensuring that there are effective safeguarding arrangements for children and vulnerable adults that may be vulnerable to abuse or neglect.

This Quality Assurance and Scrutinty Framework sets out the process by which the Board gains assurance about the effectiveness of safeguarding activity and the impact of this activity. An effective quality assurance framework promotes areas of good practice whilst also identifying where improvements can be made and how these can be facilitated. Understanding the impact of our services, the effectiveness of multi-agency and single agency services and celebrating success is crucial to improving safeguarding outcomes for children and vulnerable adults.

Local Context

The Safeguarding Act 2018 established the Safeguarding Board as corporate body. It sets out the Board's objectives and functions of the Board which include ensuring:

> "The effectiveness of the work done by each of those bodies (or agencies that make up the Board), in relation to children and vulnerable adults"
> Safeguarding Act Part 7 (1)(b) and 7 (2)

The guidance, Safeguarding Together 2019, sets out the role of the Board which is to:

> *"co-ordinate the framework to safeguard children and adults in the Isle of Man and monitor and challenge the effectiveness of arrangements on the Island".*
>
> *Safeguarding Together 2019 p.8*

The Board is further tasked with identifying, celebrating and the dissemination of:

> *"Best practice to support service development, innovation and change that is informed by evidenced based best practice". (Opcit p.8)*

To ensure local services for children and vulnerable adults are effective and safe, the Board may also:

> "Compile and analyse information concerning" vulnerable adults and children. (Opcit p.8)

This Quality Assurance Framework sets out **what** information is to be gathered and **how**, in order that the Board's responsibility to challenge the effectiveness of arrangements and celebrate success, can be effectively discharged.

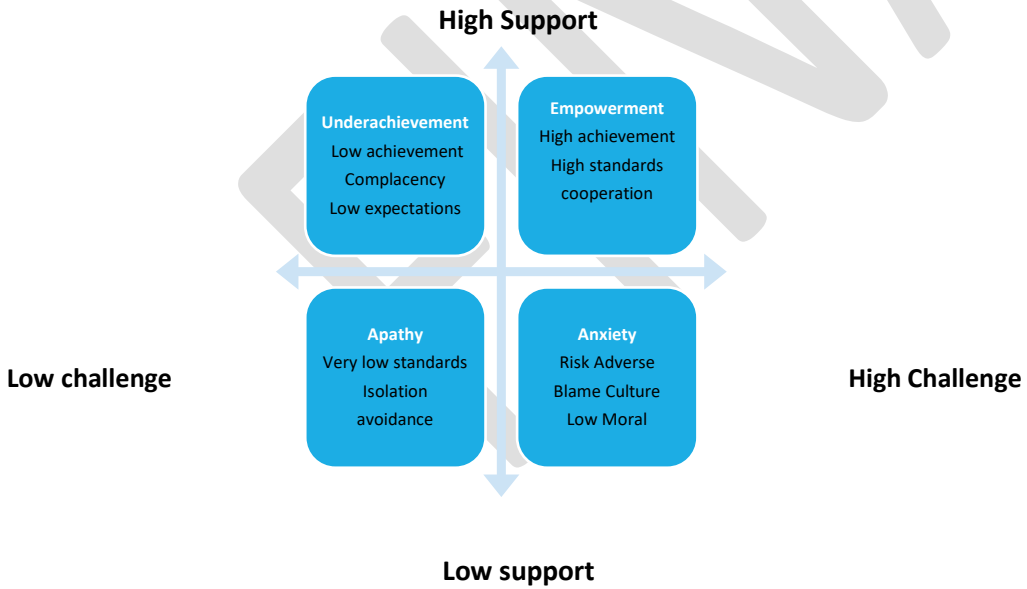
Principles

The Board is committed to continuous improvement, leading to improved outcomes for our children, young people and vulnerable adults. These shared principles that have been agreed by the Board to inform both the overarching Business Plan and the Quality Assurance Framework and provide the basis for effective quality assurance.

1. **Person Centred Practice** - ensure that children and young people and adults have opportunities to participate and collaborate in the work of the Board and that their voice is embedded in multi-agency practice.

2. **High support high challenge -** a culture of high support and high challenge to develop working environments where growth and learning is accelerated.

Fig 2.



3. **Promoting Practice leadership** – by involving front line practitioners and managers in the continuous learning process in a supportive and challenging way, to build practice leadership capacity across the Board.
4. **Promoting a culture of continuous learning –** to create the environment for learning, recognising the way systems influence each other and the benefits of working together rather than in individual agencies. We will ensure that we learn from best practice, case reviews and multi-agency audits, including the monitoring of the implementation of recommendations

Leadership

Strong leadership provides the context for constructive challenge both within organisations and across the partner organisations that make up the Board. Successes in safeguarding are less about compliance and more about culture. It is important that local leaders create a culture which promotes reflection, healthy challenge, growth and development.

To create the conditions for success in our quality assurance and scrutiny activity, local leaders will need to demonstrate important leadership behaviours such as:

- Creating trust in the system.
- Giving permission to acknowledge omissions or system failures so that learning can be taken from them.
- Holding each other to account.
- Accepting and responding when changes are not happening or not happening quickly enough.
- Acting with integrity.
- Inspiring others and build confidence that improvements will be achieved.
- Encouraging innovative thinking.
- Modelling curiosity.
- Rewarding success and achievement.

Understanding Scrutiny

Scrutiny is the activity of challenging the perceived status of performance by key agencies such as Manx Care Health and Social Care, the IOM Constabulary, Education (DESC), Prisons and Probation (DHA), and other agencies that play a critical role in safeguarding vulnerable adults or children. Scrutiny ensures that agency's self-assessments accurately reflect their performance. Scrutiny also allows for reflection on the collective performance of the Board in knowing itself and understanding the impact of practice.

By analysing information from a range of sources and triangulating these, this gives the opportunity for assumptions or inaccurate views on the effectiveness of services, to be challenged. This evidence based evaluation of services and their impact, forms the platform for meaningful and effective improvements and the celebration of good practice.

The role of scrutiny is therefore to:

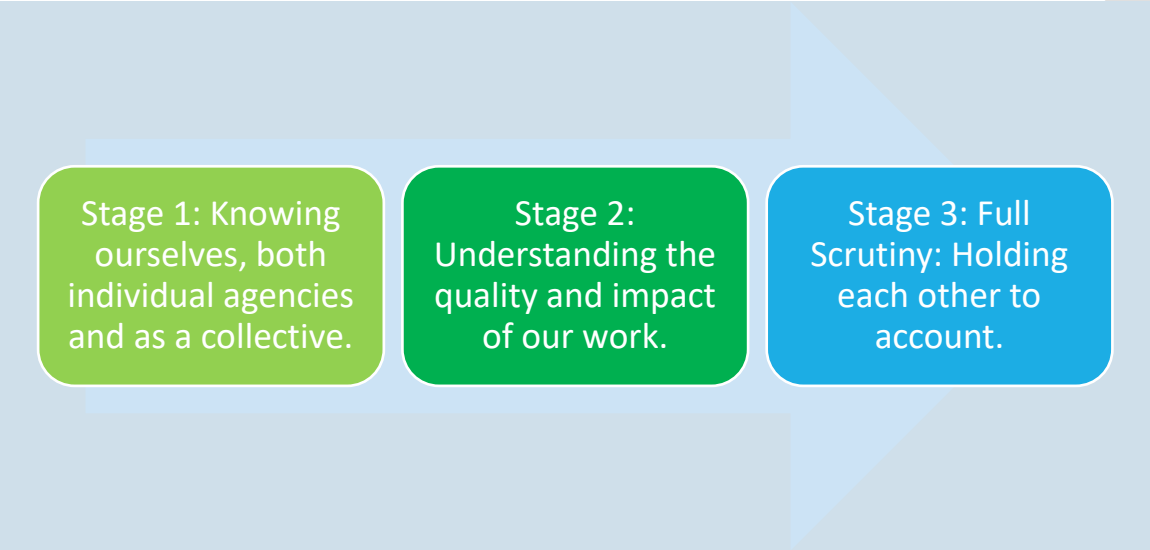
- Provide assurance in judging the effectiveness of multi-agency arrangements to safeguard children and vulnerable adults.
- Evaluate how effectively local working arrangements are experienced by frontline staff, promoting effective leadership.
- Provide objectivity, professional curiosity and promote a culture of reflection and continuous improvement.
- Formulate plans and recommendations from the findings.

Effective scrutiny offers assurance to the Safeguarding Board as a statutory body and leaders and managers in organisations that services are working well and having an impact on outcomes, whilst also bringing in the voices of practitioners, service users and carers.

The stages of effective multi-agency quality assurance

The Isle of Man Board is embarking on a journey to develop an evidenced based model of quality assurance and scrutiny. To achieve an effective quality assurance process, the following stages need to be achieved:

Fig 1.



Stage 1: Knowing ourselves, both individual agencies and as a collective.

This stage on our journey marks the beginning of quality assurance and developing a self-evaluation by individual services and the Board. By knowing ourselves we demonstrate that day to day practice is well understood, specifically:

- Are vulnerable adults and children are heard, understood and central to all assessment and service delivery?
- Do interventions keep children and adults safe?
- Have expected policies and procedures are being followed?
- Are there are adequate staff to safeguard children and adults?
- Is the workforce suitably skilled and supported to offer best practice?

- Are good enough working conditions in place to allow good practice to flourish (for example manageable caseloads, good quality supervision, access to information from effective safeguarding leads, a culture that safeguarding is everyone's business)?
  And
- Is good practice recognised and shared to promote learning?

Stage 2: Understanding the quality and impact of our work.

Understanding the impact of the work to safeguarding children and vulnerable adults is more sophisticated than solely understanding what is currently offered. This second stage builds on the understanding of day to day practice and looks at what difference or impact our interventions have made.

The difference between stage 1 and 2 can be understood from the following examples:

Knowing ourselves:

Example 1: "Sarah was referred to the Daily Exploitation meeting as there were signs that she was being sexually exploited. She was then discussed at the Risk Management meeting where her safety plan was considered"

Understanding impact:

Example 2: "*Sarah was discussed at the Daily Exploitation Meeting and Risk Management meetings. As a result of joint work between the police and children's services the person that was placing her at risk has been disrupted by the issuing of warnings. Sarah is now safer as she has formed a trusted relationship with her mentor, she has improved self-esteem, is attending school and understands more about grooming and exploitation*".

Often, in less developed quality assurance systems, there is a focus on what happened as opposed to what difference interventions or services made. Sarah's examples above show the difference between focussing on processes and gaining assurance that expected procedures have been followed versus the evaluation of the impact interventions have made.

By understanding the quality and impact of our interventions, we can understand what difference we are making to the lives of children and vulnerable adults on the Island.

Stage 3: Full Scrutiny: Holding each other to account.

With a well-developed self-evaluation process, an understanding of day to day practice and the impact of our work, we will be in a position to hold each other to account and promote learning, innovation and change, to improve services and outcomes.

This final stage in developing an effective quality assurance framework will show that the Board has developed a good understanding of the need to quality assure, that basic processes and procedures are in place and they are making a difference to children and vulnerable adults.

The mature quality assurance framework will allow open and transparent challenge, based on data, feedback and information from:

- Children
- Vulnerable adults
- Parents and carers
- Frontline staff's experiences of working in agencies
- Recruitment and retention of staff
- Organisational Standards Audits
- Single and multi-agency audit findings
- The implementation of the Board's policies and procedures
- Inspection Findings
- Reviews
- Performance data
- Best in class practice

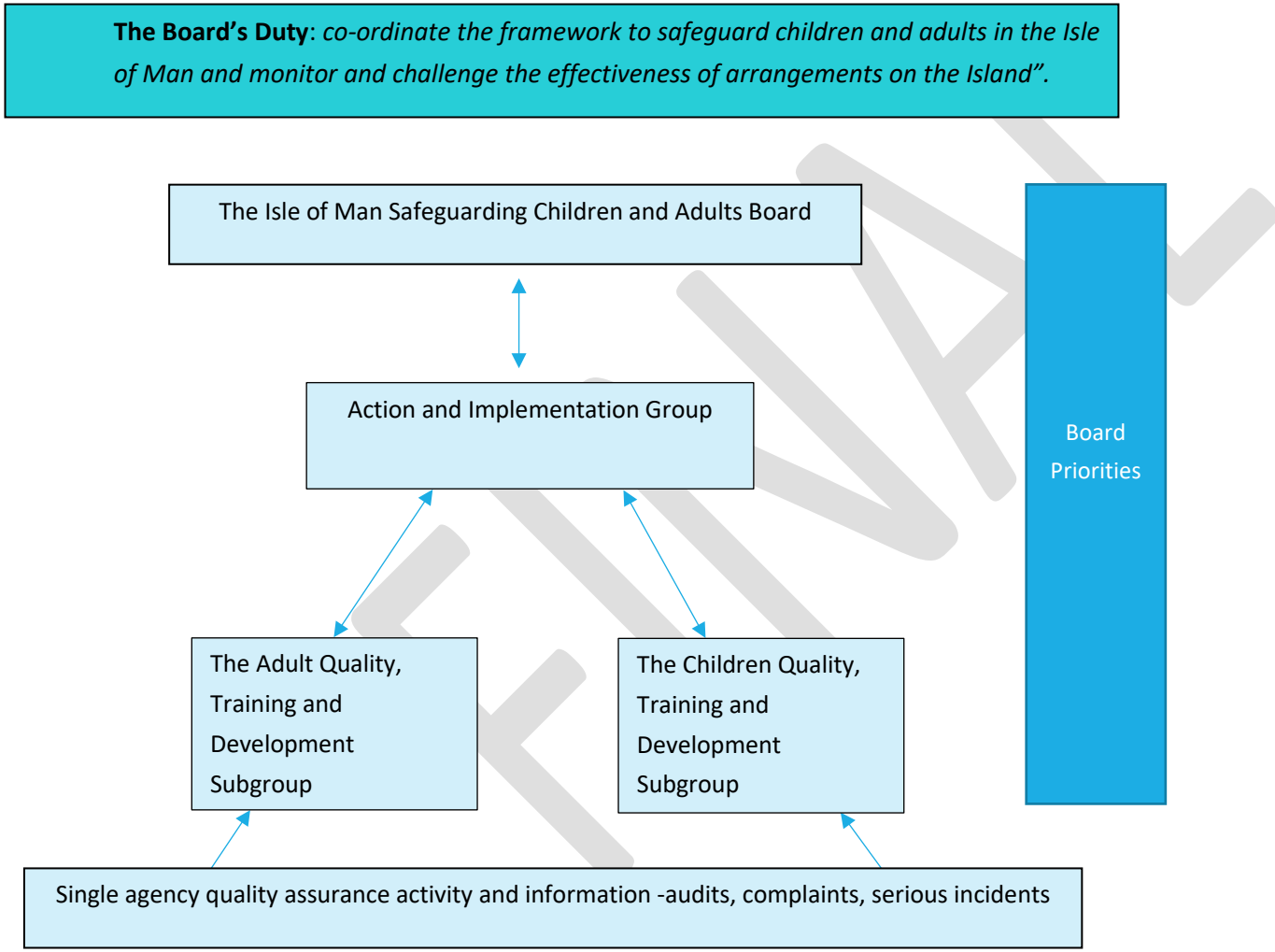
Approach to Quality Assurance

The Governance:

The Safeguarding Board is made up of individual agencies who carry out their own quality assurance activity. The Board also has a range of subgroups that work together to drive practice improvement and undertake multi-agency quality assurance activity on behalf of the Board.

The way the Board gathers information to support quality assurance is shown below in Fig 3.

Fig 3.



The above represents how the Board is designed to gather and evaluate quality assurance information, analyse trends, highlight gaps, any areas of concern as well as good practice. Fundamental to effectiveness of this activity is the demonstration of the leadership behaviours and the Board's principles in the subgroups. It will be these behaviours and the drive of the subgroups that will form the basis for effective quality improvement cycle. The relentless drive of the subgroups is supported by being clear about their roles and responsibilities as set out in the subgroup's terms of reference.

The Board will gather available information from a range of sources and analyse this information so that day to day practice and service user experiences are understood. This information will enable the Board Independent Chair and Board members to consider the effectiveness of safeguarding arrangements on the Island and be professionally curious about how well children and vulnerable adults' needs are being met. Information (where available) will be drawn from:

Fig 4

Feedback from service users:

Feedback from service users is critical to understanding ourselves. Only by listening to those that access services can we gain real time, valuable insight into how well our services meet the needs of those that require them. The Adult Quality, Training and Development and Children Quality, Training and Development groups will work closely with the Communications and Engagement subgroup to contribute to overarching plans to engage service users and their carers.

The Board will take steps to capture feedback from service users by:

- Reviewing complaints.
- Reviewing compliments.
- Speaking to service users, carers and families as part of audit activity.
- Listening to advocates.

Feedback from front line practitioners:

Understanding the conditions and support in which services are being delivered can only be understood by engaging with front line practitioners. Their voices will be listened to by:

- Staff surveys.
- Focus groups to support this Quality Assurance Framework.
- Exit interviews.

Single agency audits: This will include all single agency audits pertaining to children, young people and adults, that have been carried out by individual organisations throughout the annual quality assurance cycle. The learning from these audits will be shared throughout the year in the respective Quality, Training and Development groups and the annual scrutiny event.

Multi-agency audits: There will be a multi-agency audit per year to support the scrutiny event. The focus for each multi-agency audit will be identified based on the agreed priorities in the Safeguarding Board Business Plan or any other emergent theme that is priorities by the board.

Organisational Standards Audit

The Organisational Standards Audit is an annual audit. It requires evidence from those that work with vulnerable adults or children to show that they have arrangements in place to safeguard vulnerable children or adults and these are being effectively discharged.

Performance Data Set

The Board has developed adult focused and child focussed multi-agency Performance Datasets which show data relevant to children, adults and carers. The Performance Dataset shows information which is already known to agencies or collected. By reviewing this data trends, concerns and risks can be identified and shared with the Board. The data from the Performance Datasets is analysed in the respective Quality, Training and Development groups on an ongoing basis and will be analysed at the annual scrutiny event.

Learning from Serious Case Management Reviews and learning reviews

The Board will seek assurance from the key agencies regarding actions arising from Serious Case Management Reviews and other reviews, to ensure that agreed actions have been carried out and are impacting on day to day practice.

Learning from Findings from other Inspection Activities

Individual organisations commission inspection or reviews by Inspectorates such as Ofsted, CQC or CCG. It will be important that learning from this activity is shared with the Board and forms part of the process to help us to know ourselves and understand the impact of our safeguarding work.

Scrutiny, Triangulation and Planning for Improvements

Independent scrutiny is critical to provide assurance about the effectiveness of the Board and safeguarding practice for vulnerable residents in the Island.

Considerable commitment, time, resource and energy has gone into developing the building blocks that will enable us to know ourselves and form a view of the effectiveness of our multi-agency engagement to improve safeguarding practice.

It is crucial therefore that we have:

A systemic approach which brings together and triangulates[1] evidence of single and multi-agency practice, identifies what is working well and where there are concerns in relation to multi-agency practice both at an operational and strategic level.

Planning

The planning stage entails scoping what information is available and analysing this prior to the Scrutiny event itself. Prior to the event, the following will take place:

- Identifying the practice areas to be scrutinised and establishing what information is available to help the scrutiny of the identified areas of practice.
- Agreeing what evidence is to be gathered, analysed and presented at the half day event.
- Planning who will do what and when e.g., audit, gathering feedback from practitioners, data analysis.
- Agreeing the success measures or measures that will indicate improvements or good practice e.g.

> *"All children open to children's social care where there are concerns about exploitation had a CEAM tool completed which analysed the risk"*

> *"All adults open to the Adult Safeguarding team due to self-neglect had been offered an advocate"*

[1] Where different sources of information or evidence are used to check out the basis for judgements. For example, the police may report that their detection rates have improved. This can be triangulated by looking at detection rates data and asking local front line officers if they feel this is reflected in their day to day experience.

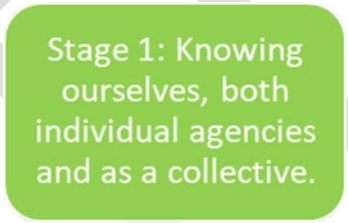
Analysing the evidence

Bringing together the evidence is a critical stage in the scrutiny process. Information will be collated from a range of sources and themes, patterns, trends, gaps in service and unanswered questions will be drawn together from:

- Feedback from service users, their carers, children and parents.
- Practitioner feedback.
- Single and multi-agency audits.
- Performance data.
- The datasets.
- Learning from case reviews.
- Inspections and Organisational Standards Audits.

The Scrutiny Event

By having an annual scrutiny event this provides the opportunity to bring together a range of sources of evidence, single and multi-agency audits, feedback from practitioners, service users and performance information together. The analysis of this information and formulation of views about what this tells us, will enable us to achieve our first step in effective Quality Assurance, namely:



The Scrutiny event itself will be chaired by the Independent Chair of the Isle of Man Safeguarding Board and will take place over a full day, with half day dedicated to considering the effectiveness of safeguarding children and the other half considering the effectiveness of adult safeguarding practice.

The following agencies will be expected to contribute and attend the scrutiny event. These are:

Children's Scrutiny	**Adult Scrutiny**
Named Nurse for Safeguarding Children	Housing Manager Housing DOI
Safeguarding Officer, DESC	Senior Inspector, R&I DHSC
SIRO, C&F, Manx Care	Head of Adult Safeguarding, Manx Care
Chief Inspector IOM Constabulary	Named Nurse for Safeguarding Adults
Senior Inspector, R&I DHSC	Senior Practitioner Probation
Third Sector Representative Director of Safeguarding Independent Safeguarding Board Chair	Third Sector Representative Chief Inspector IOM Constabulary Director of Safeguarding Independent Safeguarding Board Chair

An example of a multi-agency audit and scrutiny timeline is shown in Appendix 1.

Evaluating the information and planning

The Independent Chair will provide a report setting out the findings from the Scrutiny event. This will include a judgement on the effectiveness of practice for children and young people and vulnerable adults. The report will set out findings of good practice examples and areas of concern. From this an action plan will be developed, addressing any areas of concern that were identified.

Conclusion

By creating a culture of curiosity, respectful challenge and embedding a framework which allows us to scrutinise and examine our practice, we will create the basis for evidence based reflection and continuous improvement.

Leaders on the Island have accepted and endorsed this Quality Assurance Framework and are committed to creating an environment of high challenge, high support and promoting a culture of openness and transparency for the delivery of service improvement and the celebration of good practice.

Multi-agency audit schedule children and adults

DATASET SUBMISSION DATES: April 2023 Q4 2022, July 2023 Q1 2023, October 2023 Q2 2023, January 2024 Q3 2023.

JULY 2023 – MARCH 2024
Quarterly multi-agency audit sessions:
AQTDG – (1) Adults' Baseline Audit; (2) self-neglect.
CQTDG – Children Exploitation

05 December
Practitioner Event

AM – Children

PM – Adults

01 – 19 January

Collation of evidence:

- **single agency**
- **multi-agency**
- **dataset**
- **practitioners**
- **Service users/children and their families**

06 February

Scrutiny Event

AM – Children

PM – Adults

Pull together learning from:

- **Single agency audits**
- **Multi agency audit(s)**
- **Trends from data and dataset, inspection**
- **Responses to reviews & SCMR**
- **Service User and practitioner feedback**

Scrutinise information, form views of what is working well, needs action and devise action plans.

Actions plans are owned by Adult and Children QTD groups and progress is reported on to AIP on a rolling basis