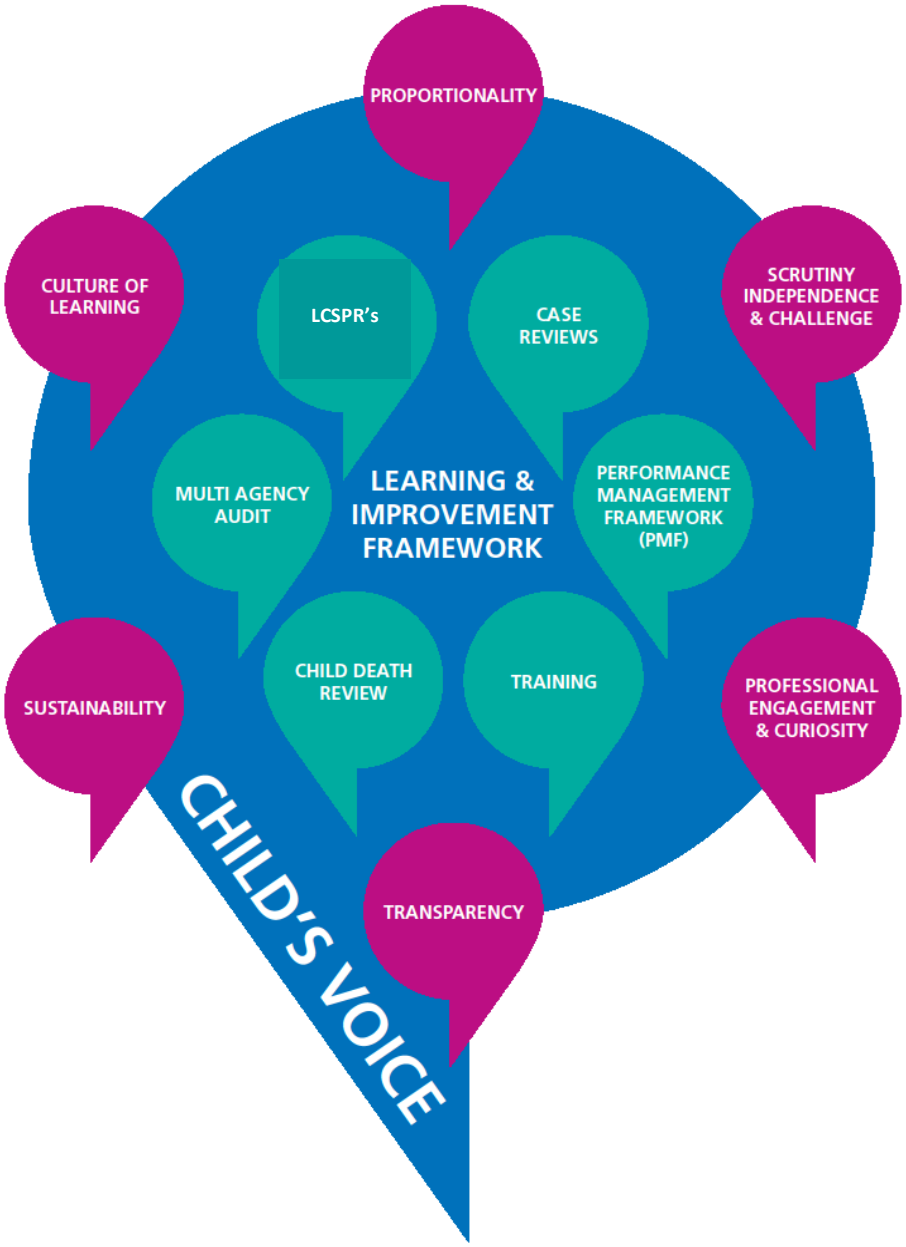
South Tees Safeguarding Children Partnership

Learning & Improvement Framework



Enhancing Outcomes **Improving Practice**

Introduction and Aims

This Learning and Improvement Framework sets out a structure within which the South Tees Safeguarding Children Partnership will deliver its priorities. It is not intended to be a prescriptive document as it is acknowledged that the flexibility of approach allows the best response to individual circumstances. It is however underpinned by two main aims:

1. To make the voice of the child central to everything that they do,
2. To achieve the two outputs of;
    - Enhancing outcomes for children/young people, and
    - Improving practice.

These aims will be achieved by:

- Consolidating what works well, and
- Improving what needs to improve.

This framework is split into three sections. Firstly it outlines the principles of the framework before moving on to an outline of each of the components. Finally it considers the effective dissemination of learning.

Principles

1. **Culture of Learning**
   Learning and improvement should be seen as a continuous process across all organisations both individually and collectively. Individual practitioners and organisational representatives should take every opportunity to identify specific cases and areas of practice from which the Boards or their partners potentially could learn and improve.

   For this to be effective a culture of self and inter professional challenge is needed. Professional challenge and curiosity is a sign of a healthy and robust system and is welcomed in both Middlesbrough and Redcar and Cleveland.

   In addition learning is only effective if it is disseminated to practitioners and influences practice. Sometimes demonstrating changes in practice through traditional routes such as case file audit is challenging and other creative flexible approaches need to be adopted.

2. **Proportionality**
   When exercising the component parts of this Framework it is important to be mindful of its intended outputs:
   - improved outcomes for children/young people
   - promoting and supporting improvements in practice

   The approach taken in any case needs to be proportionate to the scale and complexity of the issue being examined. For example:

   - There is often little value to future practice in examining historical incidents in great detail particularly when related to structures or processes that are no longer in place.
   - Except where a review is required to be carried out by virtue of statutory guidance, consideration should be given to other work in progress or recently completed with the same or similar themes. This will ensure consideration of whether additional learning is likely and therefore determine whether a review would be proportionate.
   - Opportunities to work with each other or with other partnerships should be considered when appropriate. Thereby reducing duplication of effort and making the best use of public resources.

3. **Scrutiny and Independent Challenge**
   Working Together to Safeguard Children 2018 requires that Child Safeguarding Practice Reviews (Regulation 5) are carried out by individuals who are independent of the case and of the organisations whose actions are under review. The financial implications of an independent reviewer means it is unlikely that this would be proportionate in the case of other types of review. However there are ways in which scrutiny and critical analysis of cases can be supported. For example it may be that a senior member of an organisation, not involved in a given case, could act as a critical friend during a review. In addition careful consideration of the terms of reference of a review or of the scope of an audit can improve scrutiny and critical thinking encouraging those participating to look beyond the obvious.

4. **Professional Engagement and Curiosity**
   Practitioners should be fully involved in reviews and enabled to contribute their perspective and experiences openly without fear of blame for actions they took or did not take in good faith. This is an important step in asking, and answering, the all-important 'why' question.

5. **Transparency**
   Final reports of serious case reviews and local child safeguarding practice reviews must be published and written in a way that does not require redaction. Whilst other reviews need not be in the public domain it is vital that the learning from reviews is shared with relevant organisations if it is to impact on practice. In addition there is a requirement that the partnership annual report describes the impact on practice of reviews in reducing deaths or serious harm to children/young people.

6. **Sustainability**
   There has been much criticism that agencies have failed to learn the lessons from reviews throughout the years, that the same lessons are 'learnt' again and again. It is vital that the right lessons are learnt through proportionate, critical reviews and that those lessons are embedded in practice along with sustained improving outcomes for children and in professional practice.

Components

1. **Local Child Safeguarding Practice Reviews**
   Working Together 2018 includes the requirement for partnerships to undertake reviews of serious cases in specified circumstances. A serious case is one where:
   (a) Abuse or neglect of a child is known or suspected; and
   (b) Either (i) the child has died (including by suspected suicide); or
   (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their partners or other relevant persons have worked together to safeguard the child. Where a case is being considered under this criteria (regulation 5(2)(b)(ii)) there must be definitive evidence that there are no concerns about interagency working before a decision is made not to initiate a LCSPR.

   Additional criteria which must always trigger a LCSPR are
   - a child dies in custody,
     - police custody,
     - on remand
     - following sentencing, in a Young Offender Institution,
     - in a secure training centre
     - a secure children's home.
   - detained under the Mental Health Act 1983
   - A child aged 16 or 17 was the subject of a Deprivation of Liberty Order under the Mental Capacity Act 2005.

   The STSCP may still decide to commission a LCSPR even where none of the above criteria are met. The final decision on whether to conduct a LCSPR rests with the STSCP. LCSPR's must

thoroughly, independently and openly investigate the issues. All LCSPRs should result in a report which is published and readily accessible on the STSCP's website for a minimum of 12 months.

No one methodology is superior in all cases. LCSPR's (and other case reviews) should be conducted in a way which:

- recognises the complex circumstances in which professionals work together to safeguard children;
- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- is transparent about the way data is collected and analysed; and
- makes use of relevant research and case evidence to inform the findings.

2. Case Reviews

Where the criteria for a local child safeguarding review are not met the STSCP should consider initiating an alternative form of review. In deciding on the nature and scale of this review the STSCP will be mindful of other processes (e.g. critical learning reviews, domestic homicide reviews) as well as the principles outlined in this framework. These non-statutory reviews are not required to be published however it is important that the learning from the review is effectively disseminated to relevant services and agencies.

3. Tees Performance Management Framework

The STSCP utilises the Tees Performance Management Framework (TPMF). This quarterly report provides data on a wide range of performance measures in relation to safeguarding and promoting the welfare of the children/young people in the Tees area. In addition the TPMF provides a quarterly summary report for both Middlesbrough and Redcar & Cleveland. Work of the STSCP Quality & Performance group will scrutinise the trends and findings and agree further investigation audit if required.

4. Interagency training

Each organisation is responsible for ensuring its staff are appropriately trained for their role with children and families. In addition to this single agency training interagency agency training is provided for practitioners. This training ranges from e-learning through short drop in sessions to delivered full day sessions. In addition day conferences and specific training is provided on the issues identified in LCSPR/SCR's/Case reviews.

5. Multi agency audit

Single agency case file audit is an important form of assurance that each agency's safeguarding practice is robust and improving outcomes for children. However, multiagency audit provides for monitoring and evaluation of shared working with the purpose of assuring standards of safeguarding practice across agency boundaries. The findings from multi agency audits inform the work programmes of other sub groups.

6. Inspection

The various inspection frameworks across agencies working with children in particular Ofsted ILAC and, JTAI etc……

7. Child Death review

Child Death Overview Panels (CDOP) were established in April 2008 to review all child deaths (excluding those babies who are stillborn and planned terminations of pregnancy carried out within the law). The primary function of CDOP, as set in Working Together 2015, is:

- Collecting and collating information on each child and seeking relevant information from professionals and, where appropriate, family members.

- Discussing each child's case, and providing relevant information or any specific actions related to individual families to those professionals who are involved directly with the family so that they, in turn, can convey this information in a sensitive manner to the family.
- Determine whether the death was deemed preventable, that is, those deaths in which modifiable factors may have contributed to the death and decide what, if any, actions could be taken to prevent future such deaths.
- Making recommendations to the STSCP or other relevant bodies promptly so that action can be taken to prevent future such deaths where possible.
- Identifying patterns or trends in local data and reporting these to the STSCP.
- Where a suspicion arises that neglect or abuse may have been a factor in the child's death, referring a case back to the STSCP for consideration of whether a Local Child Safeguarding Practice Review (LCSPR) is required.

The Tees Partnership's discharge their duties in relation to Child Deaths together through a single Child Death Overview Panel.

Dissemination of Learning and Changes to Practice

Part of the role of a STSCP member and of those who sit on a STSCP sub group is to promote and facilitate the dissemination of learning within their own organisations. How this is done will be dependent on structures and processes within that organisation. In addition partnership members are strategic leaders who will influence internal policy, practice and training in line with lessons learnt.

The STSCP business unit will ensure that learning is disseminated to the multi-agency partnership using a variety of methods including, but not limited to

1. STSCP newsletters
2. Via STSCP website
3. Additions/alterations to training programmes
4. Documents such as '7 minute briefings'
5. Changes to multiagency procedures

How this dissemination is to occur should be considered from the earliest point in any process to ensure it is integral and not an afterthought.

Conclusion

Ensuring that each organisation individually and the multi-agency partnership together acts effectively to safeguard and promote the welfare of children is the core function of an STSCP. Continuous improvements in practice in safeguarding and promoting the welfare of children are a central tenet of an STSCP which this Framework aims to describe.

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On:	
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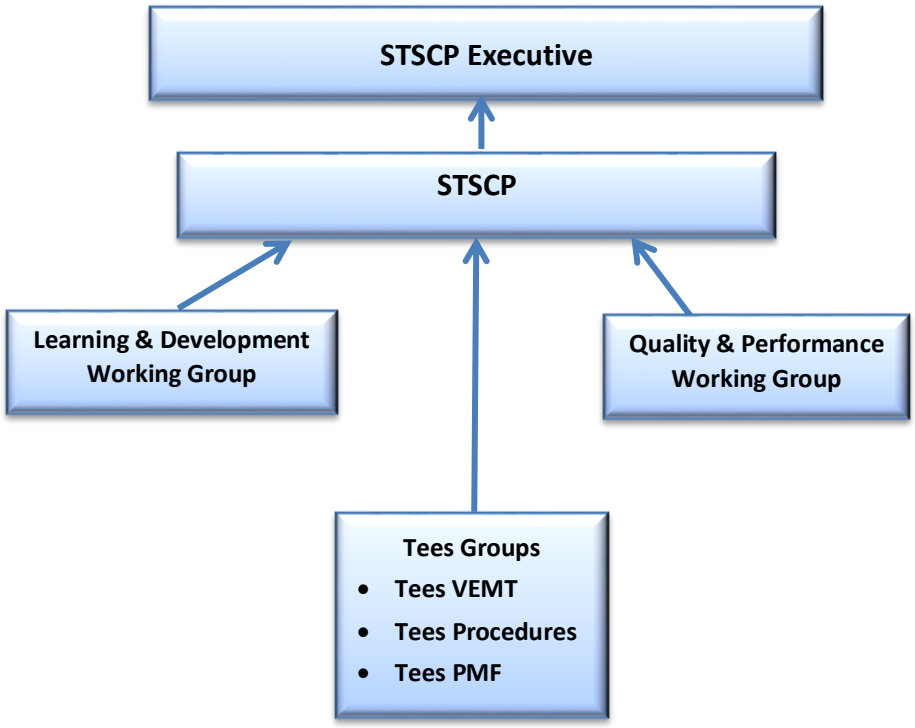
APPENDIX 1: STSCP STRUCTURE



Links to Relevant Strategic Partnerships

- Children & Young Peoples Partnership (R&C)
- Children's Trust (Middlesbrough)
- Corporate Parenting
- Strategic MARAC
- Strategic MAPPA
- Youth Justice Board
- Community Safety Partnerships
- South Tees Health &Well Being Board
- Tees Safeguarding Adults Board
- Tees Child Death Overview Panel

APPENDIX 2: STSCP LEARNING STRUCTURE