Dudley Safeguarding People Partnership (DSPP)

Joint Learning and Improvement Framework (LIF)

2020

The priorities for the partnership for 2020/2022 are:

1. Neglect across the life course
2. Preventing harm across the life course
3. Exploitation across the life course

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Introduction

Professionals and organisations protecting children and adults with care and support needs (hereafter called adults at risk) have to make difficult decisions every day which can have a profound effect on their welfare. To do this job well they need to reflect on the quality of their services and learn from their own practice as well as the practice of others. Good practice should be shared so there is a growing understanding of what works well. Also, when things go wrong there needs to be analysis of what happened and why, so that important lessons can be learnt and services improved to reduce the risk of further harm to children or adults at risk. This needs to be an open and transparent learning process so that the public can see where improvements are being made to protect children and adults at risk from harm in the future.

Each 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 and adults at risk. Some of these reviews (i.e. Safeguarding Adult Reviews and Child Safeguarding Practice Reviews) are required under legislation. The framework should support the work of the Dudley Safeguarding People Partnership (DSPP) in line with the relevant legislation.

Legislation

Children's Legislation

In May 2016, the Department for Education published the Wood Review into the Role and Functions of Local Safeguarding Children Boards, together with the government's response, the recommendations included proposals to reform the statutory framework that underpins the model of Local Safeguarding Children Boards (LSCBs), Serious Case Reviews (SCRs) and Child Death Overview Panels (CDOPs). The framework is underpinned by legislation and statutory guidance in the form of the Children and Social Work Act (2017) and the publication of the updated Working Together (2018) statutory guidance.

The new two-tier system, comprising of a National Panel, which will be responsible for commissioning and publishing reviews into the most serious and complex cases which will lead to a national learning. These reviews will be known as a National Serious Case Inquiry (NSCI).

The government will use the planned What Works Centre to analyse and disseminate lessons from both local and national reviews. https://www.gov.uk/guidance/what-works-network

With the establishment of the new national Child Safeguarding Practice Review Panel local areas will no longer conduct serious case reviews. Instead, they will need to consider whether to conduct a local child safeguarding practice review in cases where abuse or neglect of a child is known or suspected and the child has died or been seriously harmed.

These reviews will be known as Child Safeguarding Practice Reviews. The requirement that reports are as far as possible, published in full, remains. Local arrangements must ensure that a (15 day) rapid review will be undertaken on all cases.

The framework sets out the ways in which we will review practice and ensure that we identify positive practice and that which requires improvements through regular monitoring and follow up to ensure that learning makes a real impact on improving outcomes for children.

Adult Legislation

Under the 2014 Care Act, Safeguarding Adults Boards (SABs) are responsible for Safeguarding Adults Reviews (SARs)

DSPP will promote, develop and embrace a culture which adheres to the requirements and expectations of the Care Act 2014, reflection, learning and transparency when conducting a SAR. The Board will ensure effective systems have been developed and maintained to share the learning within Dudley from SARs. Best practice will be established through a lens of education acquiring knowledge from local/regional and national levels along with any relevant legislation.

Legislation requires Local Safeguarding Adult Boards (SABs) to arrange a safeguarding adult review when:

- An adult in its area dies as a result of abuse or neglect, whether known or suspected and,
- There is concern that partner agencies could have worked more effectively to protect the person at risk.
- The SAB must also arrange a safeguarding adult review when an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect.

In addition, the Care Act 2014 also enables SABs to carry out reviews in other cases where it feels this would be appropriate in order to promote effective learning and improvement action to prevent future deaths or serious harm occurring again. These may be cases which provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults but which may not meet criteria for a safeguarding adult review for example.

Aims and Objectives

1. Reviews are not ends in themselves, rather a means of identifying improvements which are required and to consolidate good practice. Learning from reviews should be translated into actions that will ensure sustained improvements and the prevention of death, serious injury or harm to children, young people or adults at risk.

2. Adherence to this framework will:

   - Ensure that Dudley Safeguarding People Partnership (DSPP) fulfils its statutory obligation
   - Ensure that the workforce is suitably skilled
   - Assist all partner agencies understand and commit to the principles of continuous learning through active participation
   - Ensure that training and development opportunities are quality assured and that the impact is evaluated.
   - Ensure that lessons to be learned and good practice are clearly communicated, relevant and accessible and lead to better outcomes for children, young people and adults at risk.

Children's Learning Reviews

Rapid Reviews

Deciding whether to convene a child safeguarding practice review (CSPR) or alternative learning review.

Referral

If the Local Authority become aware of a **serious safeguarding incident,** using the definition set out in Working Together (2018) they should inform the National Panel. Notifications must always be made if abuse or neglect is a cause of, or a contributory factor to, the serious incident, or where it is suspected.

The exception to this is the local authority must notify the Secretary of State and Ofsted where a looked after child has died, whether or not abuse or neglect is known or suspected.

Any organisation can make a CSPR referral, this should be agreed by the referring organisations safeguarding lead. They should then inform the DSPP Business Manager of any serious incident which they think should be considered for a child safeguarding practice review, using the Child Safeguarding Practice Review referral form available at https://safeguarding.dudley.gov.uk/safeguarding/partnership/reviews/csprs-and-scrs/

Rapid Review

When notified about an incident that might be subject of either a national or local child safeguarding practice review, the safeguarding partners are required to promptly undertake a Rapid Review of the case.

The Rapid Review must be completed within the timescales outlined in guidance from the national Panel. (This should be within 15 working days of becoming aware of the incident. A flow chart setting out the key stages and timescales is included at the end of this section.

Historically, all learning from serious incidents was established through the SCR process which had become very lengthy and expensive and which was not necessarily matched by the learning gained. Safeguarding partners should also consider that rigorous and comprehensive rapid reviews can offer a new mechanism through which the key learning may be identified and disseminated quickly within a matter of weeks. A well-conducted rapid review can form the basis of a local child safeguarding practice review (CSPR) and, in some cases, may avoid the need for an additional lengthy process with limited additional learning.

Initial Scoping, Information Sharing and the Securing of Records

All agencies that have had involvement with the subject child or family will be required to contribute to a Rapid Review. An initial scoping of agencies' intervention will,

therefore, need to be completed and other relevant information will need to be rapidly gathered.

The purpose of the initial scoping and information sharing is to gather the basic facts about the case, including determining the extent of agency involvement with the child and family. More detailed information will be sought if the Rapid Review concludes the case has the potential to identify national or local learning and a decision is made to progress to a formal Child Safeguarding Practice Review or alternative Learning Review.

The template for Initial Scoping and Information Sharing should be sent out to all relevant agencies within 2 working days of receiving the referral, along with an accompanying letter that briefly outlines the referral and explains the purpose of this initial scoping.

Agencies should prioritise completion of the form and return it within 5 working days.

All agencies should also be asked to secure all records/files in relation to the case, ensuring they are removed to a secure place where they are not accessible to agency personnel other than through a nominated representative. This request is included in the template letter.

Setting the Date of the Rapid Review Meeting

Some areas in the wider West Midlands will have a standing Group which meets regularly to oversee learning from serious incidents and this Group will be well placed to undertake the Rapid Review of new referrals. Other areas may have to convene an extraordinary meeting to undertake the Rapid Review.

The date of the Rapid Review meeting[1] should be set as soon as the templates for Initial Scoping and Information Sharing have been sent out. The Rapid Review meeting should be scheduled between 7 and 13 working days of receiving the referral. This will allow for analysis of the Initial Scoping and Information Sharing, to establish the key events in the child's life and inform the Rapid Review whilst also allowing sufficient time is available to prepare the necessary documents for the national Panel.

Documentation

The following documents should be shared with all those attending the Rapid Review meeting:

- the completed *Serious Incident Referral Form* that initiated the process;
- Local Authority Serious Incident Notification to Ofsted, DfE and the national panel in relation to the incident;
- Copies of the completed Initial Scoping and Information Sharing templates from relevant agencies.

[1] Where absolutely essential to meet the required timescales, extraordinary meetings may be held via tele-conference.

Wherever possible the documentation should be shared with participants in advance of the meeting. However, it is recognised that it may on occasion be necessary to share documentation at the meeting.

All information shared for the purpose of the rapid review meeting is strictly confidential and will be shared with the Rapid Review meeting attendees securely.

The Rapid Review Meeting

The meeting should include representatives from each of the safeguarding partners and any other relevant individuals. It will only be quorate if at least one representative is present from each of the safeguarding partners (the CCG, Police and Local Authority).

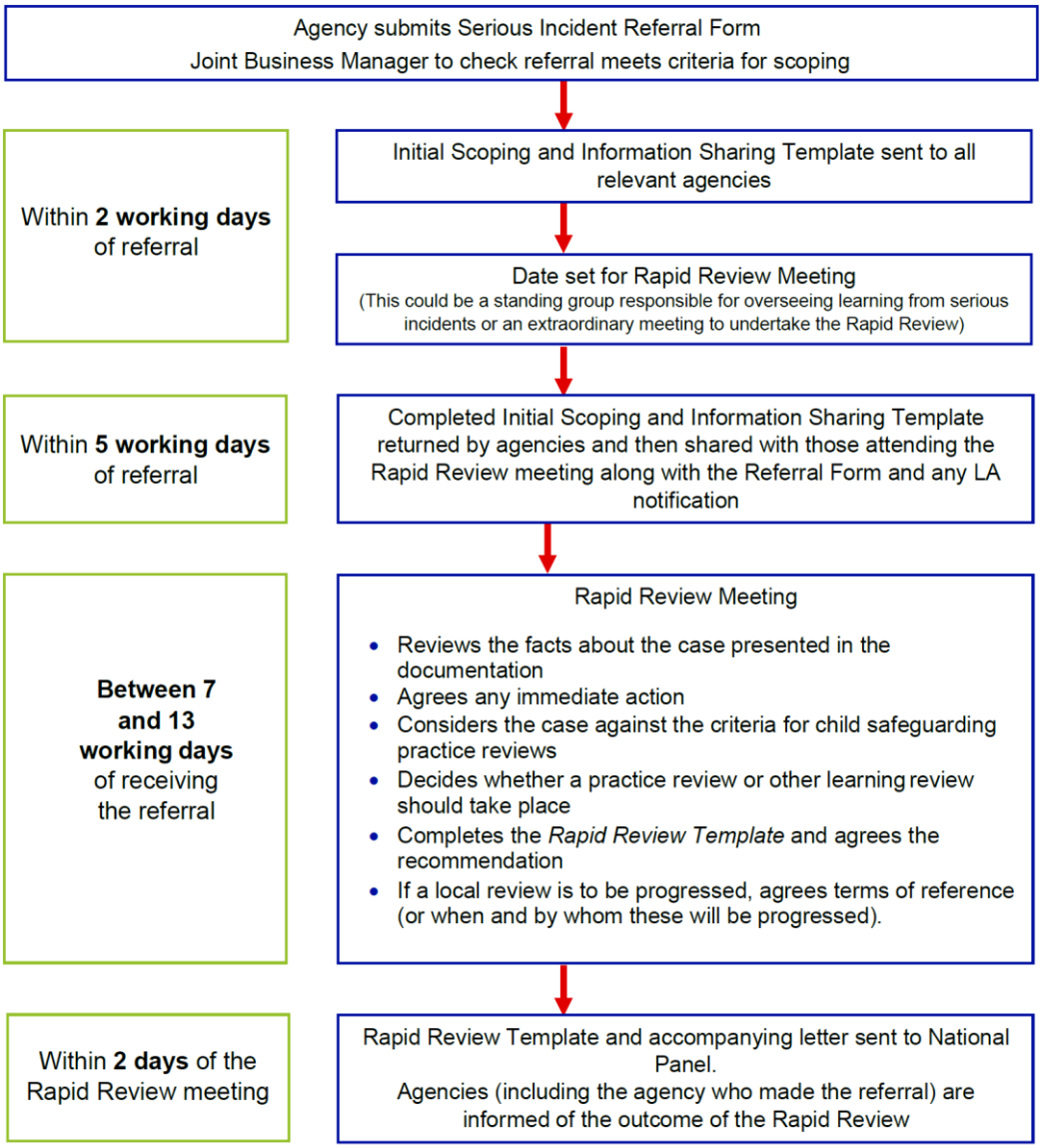
The Rapid Review meeting should:

- Review the facts about the case as presented in the documentation.
- Discuss whether there is any immediate action needed to ensure children's safety and share any learning appropriately.
- Consider the potential for identifying improvements to safeguard and promote the welfare of children.
- Decide whether or not to undertake a child safeguarding practice review. If the decision is not to proceed with a formal child safeguarding practice review, the Group will consider whether an alternative form of learning review is appropriate, for example a table top review. The Rapid Review Template should be completed and agreed at this meeting. Some areas who have decided to retain Independent Chairs, they should be asked to endorse the outcome of the Rapid Review.

Sharing the Outcome of the Rapid Review

Within 2 working days of the Rapid Review meeting, the safeguarding partners should send the completed Rapid Review template to the National Panel at Mailbox.NationalReviewPanel@education.gov.uk together with a covering letter. Other agencies (including the agency who made the referral) should also be informed of the outcome of the Rapid Review. In some cases, the rapid review may identify all themes, lessons and any learning and would therefore be accepted by the National Panel as a completed review.

Overview of the process to decide whether to convene a child safeguarding practice review or alternative learning review and the associated timescales.



Available at https://safeguarding.dudley.gov.uk/safeguarding/partnership/reviews/csprs-and-scrs/

Child Safeguarding Practice Reviews (CSPRs)

1. The Rapid Review panel will decide if the case reaches the threshold for a Child Safeguarding Practice Review (CSPR), if an alternative review/audit is appropriate or if no review is required. They will then inform the National Child Safeguarding Practice Review Panel of their decision and await their endorsement. Following agreement to undertake a Local CSPR (or not), the safeguarding partners are responsible for commissioning and supervising reviewers for local reviews.

2. The safeguarding partners should agree with the reviewer(s) the methodology by which the review should be conducted.

3. Working Together 2018 states that as part of their duty to ensure that the review is of satisfactory quality, the safeguarding partners should seek to ensure that:

    - Practitioners are fully involved in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith.
    - Families, including surviving children, are invited to contribute to reviews. This is important for ensuring that the child is at the centre of the process. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.

4. Following consensus to undertake a CSPR, the Business Unit will contact all partner agencies in order to collate further information about the child and family if required. Information from the initial Rapid Review will inform the terms of reference for the CSPR.

5. A standardised report template will be used in all cases. This can be adapted to use in both multi and single agency reviews.

6. All information shared for the purpose of the review is strictly confidential and will be shared securely. Any draft reports shared with partners for comment will be unpublished draft's and marked accordingly. Unpublished drafts should be treated as strictly confidential and not shared with practitioners or the public.

Children and Adult MACFAs (Multi Agency Case File Audits)

All multi-agency audits will be underpinned by the following approach:

- The audits will have a clear scope, timescale and a deadline for completion.
- The audit tool used for children's MACFAs will be consistent with key elements of the Ofsted Inspection Audit Framework and will be used by all partners of the DSPP.
- The same questions will be sent out to each agency that will focus on the named child, young person or adult at risk as the subject.
- The responses will be based on each agency's perspective, using only that agencies records of the case.
- Questions should not be simply responded with a 'yes' or 'no' where the audit tool asks an open question.
- Where agencies do not hold any information or have access to that information, the agency should state clearly **no information available** on the form as opposed to leaving any section blank.
- When completing the audit tool each agency should provide evidence of impact of interventions on improving outcomes for children, young people and adults at risk.
- Safeguarding is everyone's business and it is imperative that all agencies contribute to the multi-agency audits and attendance at learning events is required.

In the process of completing the audit, any immediate safeguarding concerns identified by the auditor should be shared promptly (dependent on urgency and procedure) and be clearly recorded on the multi-agency audit form.

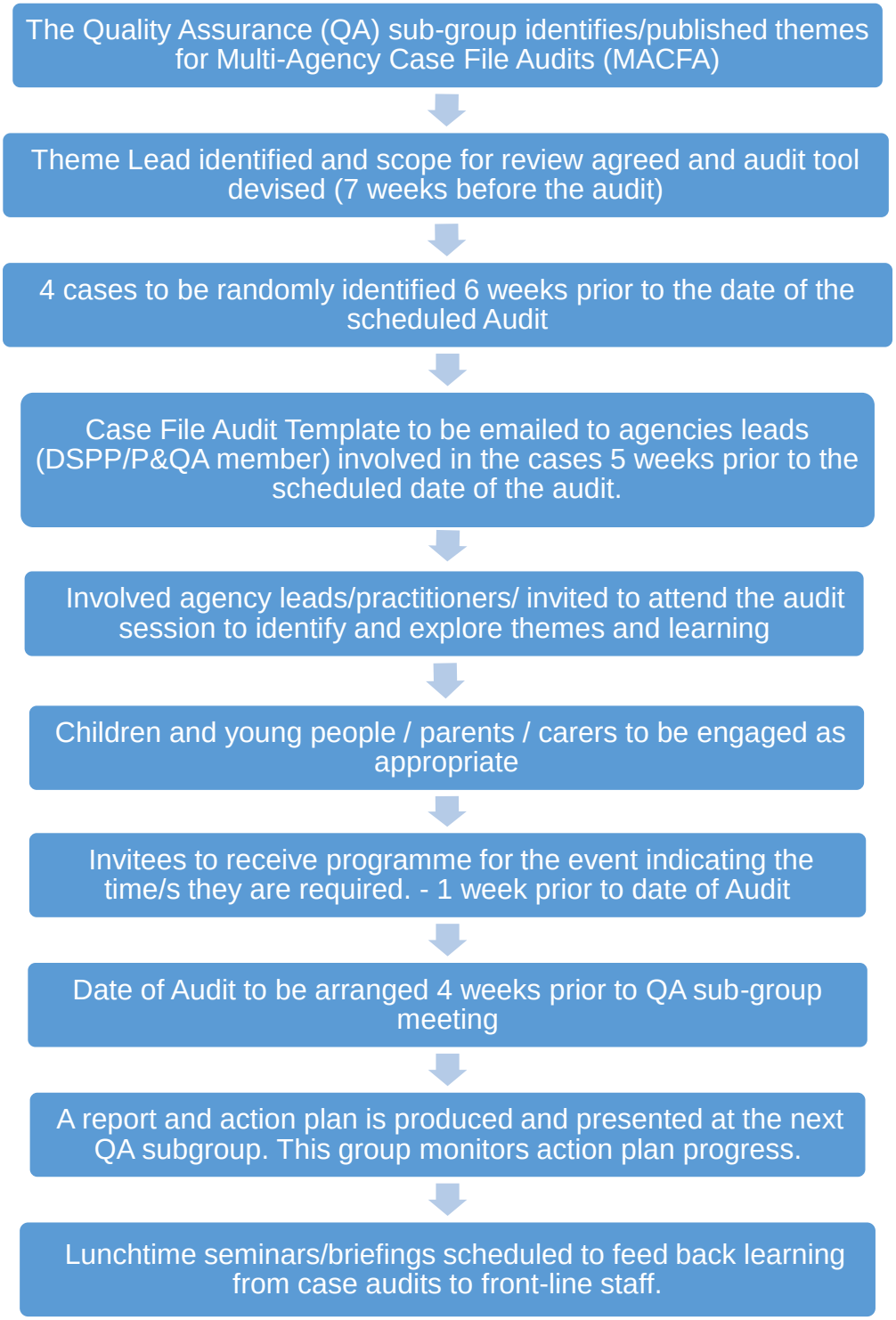
Learning Event

Partner agencies invited to the learning event will be required to attend. Each agency should identify the most appropriate person to attend. This could include a manager, auditor or lead practitioner. The purpose of the learning event is to consider the findings of the audit and to maximize multi- agency learning. The findings will be ratified by the Dudley Safeguarding Children's Partnership Group (DSCPG) for children MACFAs and the Dudley Safeguarding Adult Board (SAB) for adult MACFAs before being shared with the DSPP Executive. Representatives will take responsibility for disseminating the findings and learning within their own organisation.

Feedback and Reporting

- The audit report, including findings, recommendations and proposed action plans will be fed back to the Quality Assurance and Performance Sub Group, contributing agencies and DSPP.
- Action plans to address learning points will be agreed by the Quality Assurance and Performance Sub Group and relevant Sub Group leads will be responsible for monitoring, implementation and reporting back to the Chair of Quality Assurance and Performance Sub Group.

- The DSCPG or DSAB will receive final audit reports and will monitor progress against the action plan within the overall performance framework.
- Where good or excellent practice has been identified through audit, DSPP will note this and acknowledge achievement via the Senior Management Team.
- Learning from each multi-agency audit will be added to the DSPP website for information.



Adult Learning Reviews

Safeguarding Adult Reviews (SAR)

A SAR will not blame any organisation or person for something that has not worked well. It is not an alternative to a complaint. The SAR process looks at whether any lessons can be learned about the way organisations worked together to support and protect the person who died or suffered harm.

Referrals

The SAR Panel considers referrals for Safeguarding Adult Reviews and makes recommendations to the DSPP Independent Chair on whether a SAR should be held or if other steps can be taken to respond to the issues that a case has raised.

- A member of the public that wishes to make a referral should contact the worker involved with the person's care to discuss the circumstances. The worker will then assess whether there is sufficient evidence to make a referral on their behalf.
- Any professional can make a referral. If you know of a case that meets the SAR criteria then you should first discuss a possible referral with the safeguarding lead for your organisation.
- Cases that have the potential for a SAR and notification of any single agency reviews should be referred immediately.
- Referrals should be quality assured and authorised by your agencies Safeguarding Lead or a Senior Manager prior to submission.
- Please note: referrals received will be screened by the Business Manager and chair of the SAR Panel and signed off by the Independent Chair to agree for scoping. Any incomplete referrals will be returned to the sender.
- All referrals must be submitted securely. Please contact the DSPPB Business Unit to discuss as required.
- Scoping for referrals will be carried out via a SAR rapid review process, requiring all agencies with involvement to provide information for review.
- Referrals will be considered for a review by the rapid review panel, the outcome will then be reviewed by the Independent Chair. The referrer will be informed of the outcome.

Process

The SAR Referral Flow Chart can be viewed here

Terms of Reference will be drafted following learning identified from the SAR Rapid Review. Each agency involved in the case, including any independent providers involved, arranges for an Individual Management Review (IMR) to be carried out by a manager independent of the case. The IMR reviews the agencies involvement and actions in the case. It has to address relevant aspects of the terms of reference and be based on a set format including a chronology, a review of recorded information and interviews with the key people involved.

The overview report and draft summary report is presented to the SAR Panel. The

panel reviews the report and recommended actions. These are then presented to the SAB for the senior representatives from each agency on the board to consider and agree the proposed actions needed before presenting to the DSPP for oversight. The SAB then monitors the implementation of these actions with the help of the SAR Panel. The summary report is published and made available to the public.

Timescales

The timescale from the decision to conduct a SAR to completion is six months**.** In the event that the SAR is likely to take longer for example, because of potential prejudice to related court proceedings, the adult/advocate and others should be advised in writing the reasons for the delay and kept updated on progress.

Task	**Planned Date**
Sub group meets to make decision to convene a SAR	Within six to eight weeks of receipt of request (including deadline of 20 working days for receiving scoping from all partners)
SAR Agreed by Independent Chair	Within 10 working days of Scoping Review
Independent Chair or a nominated senior professional from the Statutory Partner Agencies to notify family that a SAR is being commissioned	Once SAR agreed
Reviewers commissioned	Within three weeks of the commission of the SAR
Initial Scoping Meeting with reviewers and SAR Panel	Within four weeks of commissioning reviewers
IMRs requested and interviews/meetings with key people	Following first meeting of reviewer and SAR Panel
SAR Panel meetings	Monthly throughout the process
Presentations of draft final report to SAR Panel	Five months from date of commission
Presentation to SAR Committee	Five and a half months from date of commission
Presentation of completed report to the SAB for sign off	Six months from date of commission
Decision by SAB whether to publish full SAR or a Summary Report	At point of sign off
Sharing of the report with family members	Within two weeks of sign off
Publication	Seven months from date of commission
Learning Event	Nine months from date of commission

The SAR Panel will meet to:

- Review progress of the SAR.

- Identify immediate risks and address these.
- Identify learning that can be shared.
- Provide guidance to the SAR Independent Reviewer.
- Review draft reports.
- Agree and recommend the final draft report to the SAR committee and then the SAB.
- Review communications and media in light of emerging issues.

Learning

The focus of Safeguarding Adult Reviews, in line with both multi-agency policy and national guidance is to:

- Learn from past experiences and the specific event examined.
- Improve future practice and outcomes by acting on learning identified by the review.
- Improve multi-agency working and compliance with any other multi-agency or single agency procedures, including regulated care services.

Findings from any SARs should be published in the DSPP's annual report and what actions it has taken or intends to take in relation to those findings.

SAR reports should:

- Provide a sound analysis of what happened, why and what action needs to be taken to prevent a reoccurrence, if possible
- Be written in plain English
- Contain findings of practical value to organisations and professionals

Completed SAR reports will be published on the local authority's website with the agreement of the multi-agency partnership. In addition, partners may also choose to publish the report on their own organisation's website.

Disseminating and Embedding Learning

DSPP recognises the importance of developing a culture and shared understanding of working together. It provides the ability to embed lessons learned through multi-agency practice reviews and audits ensuring training fosters communication within the safeguarding network. This in turn enhances knowledge, skill and understanding of safeguarding requirements among professionals.

The DSPP has arrangements in place to monitor and evaluate the multi-agency training programme. The programme includes formal training and briefings which is regularly quality assured. An assessment of the impact of the DSPP's core safeguarding training forms a part of this improvement and performance framework.

The impact of the core training programme will be systematically evaluated through follow-up surveys three months after completion of the training.

This will enable some exploration of the impact of training on professional's practice as reported by them. A further survey to managers will be undertaken to establish if an impact for the team or service is noticed.

Measuring Impact and Outcomes

The aim of the activity outlined in this framework is to have a positive impact on frontline practice and in turn improve outcomes for the residents of Dudley.

The DSPP as part of its learning and improvement activity evaluates the impact of the lessons learnt from review of practice. This evaluation includes:

How	Who	Reporting
Single/Multi-Agency case audits	All agencies	Quality Assurance and Performance Sub Group
Case reviews	All agencies	Learning and Improvement Sub Group
Action Plans	All agencies	Learning and Improvement or Quality Assurance and Performance Sub Group
Evaluation of training	All agencies	DSPP Learning and Development co-ordinator

This evaluation process identifies whether or not lessons have been learnt and will help to identify any new issues. This process allows us to complete a 360 review to support embedding and direction of travel of the learning and improvement framework.