Safeguarding Children in Stockport

Safeguarding Adults in Stockport

LEARNING AND IMPROVEMENT FRAMEWORK

July 2019

Contents

1. Introduction

1.1 The Stockport Safeguarding Children Partnership (SSCP) and the Stockport Safeguarding Adult Board (SSAB) are committed to developing a shared Learning and Improvement Framework locally across both children and adult safeguarding, which will support a consistent approach across the borough.

1.2 For clarity and consistency throughout this document, the Safeguarding Executives of these two partnerships are referred to as the (Stockport Safeguarding Executives).

1.3 This approach relies upon local statutory and non-statutory agencies engaging with a continuous cycle of learning and improvement, under the new established Local Safeguarding arrangements. This document describes the Learning and Improvement Framework adopted by the Stockport Safeguarding Executives and its member agencies.

1.4 The responsibility of the Stockport Safeguarding Executives is to seek assurance of effectiveness of the inter-agency arrangements to keep children and adults safe and strive to develop effective collaborative working.

1.5 This Framework describes the processes by which the Stockport Safeguarding Executives will review the effectiveness of our local safeguarding partnerships and individual agencies by using a comprehensive range of local information to evaluate the quality of local activity and outcomes against agreed practice standards. The Safeguarding Executives oversee any areas where single or multi-agency improvement has been identified within safeguarding reviews, audit or safeguarding performance review activity.

1.6 The Learning and Improvement Framework consists of four quadrants:

- Embedding learning from review processes
- Performance Framework
- Using audits to improve practice and outcomes
- Safeguarding Executives effectiveness

1.7 No one quadrant in isolation can represent, or drive, the learning and improvements in local safeguarding practice. Effective partnership working underpins all areas of activity.

1.8 Stockport Safeguarding Executives have their own structure of groups that manage reviews and other learning and improvement processes.

1.9 In Stockport, the Safeguarding Adults Board subgroup is called the Safeguarding Adult Review consideration panel (SARCP) and the Children's Safeguarding Partnership group is called the Rapid Review Panel (RRP).

1.10 For clarity and consistency throughout this document, the SARCP and RRP are referred to as the Review Group.

1.11 Our Safeguarding Executives are committed to ensuring that learning arising from reviews and audit processes are shared with staff working across local agencies and that, locally, we demonstrate continual improvement across our safeguarding activities, which improves the safety and outcomes for children, families and adults at risk.

1.12 The Safeguarding Executives have in place clear guidance on Information Sharing , which supports all kinds of review processes, and audit work. The documents detail when information can be shared lawfully by agencies for the purposes of safeguarding children and adults at risk and to support the statutory functions of each partnership.

1.13 The Stockport Safeguarding Adult Board Information Sharing Agreement (ISA) can be found on: http://www.safeguardingadultsinstockport.org.uk/wp-content/uploads/2018/01/Information-sharing-protocol.pdf

1.14 The Stockport Safeguarding Children Partnership Information Sharing and Retention Guidance can be found on: (TBC once finalised)

2. Our Learning and Improvement Principles

2.1 This Learning and Improvement Framework has been developed to reflect the changes borne out of The Children and Social Work Act 2017 and Working Together (2018) which, whilst it does not (as in previous versions) make specific reference to a learning an Improvement Framework, it does state that safeguarding partners should ensure that: The Safeguarding Executives agree to the following:

- The child, vulnerable person and their family are at the centre of the process.
- There is a culture of continuous learning and improvement.
- Reviews of serious cases should be led by individuals who are **independent**
- **Practitioners and managers** are fully involved in Case Reviews or learning reviews
- Families, including surviving children and adults, should be invited to contribute to reviews. This is important for ensuring that the child's voice and lived experience is at the centre of the process.
- Case reviews should be **proportionate**
- **Improvements must be sustained, monitored and reviewed** so findings make a real impact
- Learning must contribute **to improved services and outcomes for children, young people, and adults at risk.**
- **Local partnerships** are clear about where services and practice needs improvement and how resulting action plans will lead to sustainable improvements
- Partners are effective at challenging each other and holding each other to account
- We are honest and transparent in our appraisal of practice
- We will learn from experience, both good and problematic

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

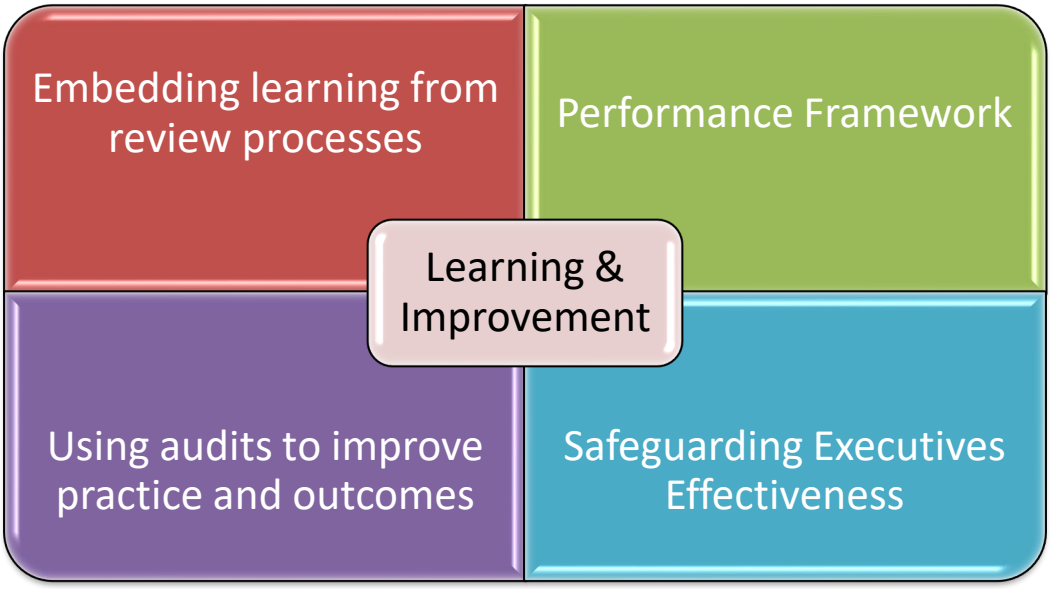
- **IDENTIFIED**
- **DISSEMINATED**
- **EMBEDDED**; and
- **EVALUATED** for direct **IMPACT** on outcomes for children and young people and adults at risk.

3. Identifying Learning

3.1 *"learning is promoted and embedded in a way that local services for children and families can become more reflective and implement changes to practice" Working Together 2018*

3.2 This learning and improvement framework has been developed on the understanding that learning about multi-agency safeguarding does not only happen in the context of a formal review process, but from a much broader set of complex systems and processes across a range of agencies.

3.3 The Safeguarding Executives foster a learning culture across all of its work; an effective learning and improvement framework will bring together in a joined up way performance data, assurance activity and the various views and experiences of children, young people, adults at risk and their families and that of frontline practitioners as illustrated below. The aim is to use the sources of information to look at what is working well, what is not and what needs to happen to improve practice.



3.4 At the forefront of all of these mechanisms will be a focus on ensuring the **child's and adult's experience** is captured (including views of parents and family members) and this informing what could be improved from their perspective to influence better practice and service delivery in the future.

3.5 Single and multi-agency reviews play an important part in the Learning and Improvement framework for the Safeguarding Executives and well-functioning Partnership/Boards are able to evidence that all staff are aware of the outcomes of local reviews and take account of these in their practice. In those circumstances where more formal review is required; there is a suite of review options that can be tailored to the individual case. (Please refer to section 4 for more details)

4. Reviews of Practice

4.1 Reviews are undertaken to learn from past events. The Safeguarding Executives will use this learning to improve practice and services for vulnerable children, adults and their families.

4.2 Reviews consolidate learning about what is working well and what presents challenges to organisations (both child and adult facing) within Stockport. Paramount to all review processes will be a focus on trying to understand events from a child/adult's perspective.

4.3 National & Local Child Safeguarding Practice Reviews (CSPRs)

4.3.1 Stockport Safeguarding Children Partnership (SSCP) and partner agencies are required under Chapter 4 of *Working Together to Safeguard Children*[1] (HM, 2018) to undertake a Rapid Review to ascertain if a local or national child safeguarding practice review is required. The purpose of these reviews is to ascertain any local or national learning to improve the way we safeguard or promote the welfare of children. In undertaking rapid and local reviews the partners are expected to apply the following principles:

- Reviews should seek to prevent or reduce the risk of recurrence of similar incidents. They are not conducted to hold individuals, organisations or agencies to account, as there are other processes for that purpose, including through employment law and disciplinary procedures, professional regulation and, in exceptional cases, criminal proceedings.

- The review should be proportionate to the circumstances of the case, focus on potential learning, and establish and explain the reasons why the events occurred as they did. Partners and the reviewer will take into account the principles of systems methodology recommended by the Munro review[2]

- The Safeguarding partners should ensure a reviewer is identified with the relevant professional knowledge, ability to understand complex circumstances of practice, an ability to understand the viewpoint of individuals and organisations alongside an ability to identify and communicate findings. Reviewers should also be transparent in relation to any perceived conflict of interest.

- Practitioners should be fully involved in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith.

- All reviews should reflect the child's perspective and the family context. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.

4.4 Safeguarding Adult Reviews (SARs)

[1] Principles are taken from page 88 point 30 onwards in Working Together 2018.
[2] The Munro Review of Child Protection: Final Report: A Child Centred System (May 2011).

4.4.1 The Care Act 2014 requires **Safeguarding Adults Boards (SABs)** to undertake Safeguarding Adults Reviews (SARs) for cases in its area where an adult, with needs for care and support, has died or experienced serious abuse or neglect and there is reasonable cause for concern about how the SAB, member agencies or other persons worked together to safeguard the adult.

4.4.2 The Care Act does not introduce a specific method that has to be used to undertake SARs giving SABs freedom to conduct them in the most appropriate manner.

4.4.3 The Stockport Learning and Improvement Framework provides an overview of the different types of proportionate enquiry used locally to support learning that will be disseminated and embedded to improve safeguarding practice across local agencies.

5. How do we review Practice?

By undertaking statutory and non-statutory reviews of serious incidents!
See appendix (a) and (b)
Detailed below is a snapshot of the type of **single and multi-agency reviews** undertaken.

- Child Rapid Review
- Child – Safeguarding Practice Reviews
- Child Death Review Panel
- Safeguarding Adults Reviews (SARs)
- Domestic Homicide Reviews
- Multi-agency Public Protection Arrangements Serious Case Review Non-Statutory Reviews
- Multi-Agency Learning Reviews
- Single Agency Learning Reviews/Serious Incident Investigations
- Peer Reviews
- Complaints, compliments, professional disputes and whistleblowing

5.1 Child Rapid Reviews

Rapid reviews must be conducted in serious child safeguarding cases which the partners believe raise issues of importance for their local area. In these cases they must conduct a Rapid Review within 15 working days to ascertain if the case highlights the need for either a national or local review. They must then share these findings via a concise report to the National Child Safeguarding Practice Review Panel. These reviews must be conducted in line with the practice guidance[3] issued by the National panel and any additions to this.

5.2 Children's Safeguarding Practice Reviews (CSPRs)

These can be conducted by the National Panel and draw on cases presented across the UK to ascertain themes from similar child death or harm cases. However, where these cases are more relevant to the local area then the review will be taken forward by the Safeguarding partners. These statutory practice reviews are described within *Working Together to Safeguard Children* (HM, 2018) and required for cases where abuse or neglect is known or suspected and either:

- A child dies; or
- A child is *seriously harmed*

5.2.1 Under the new Working Together Guidance these cases may include cases where the child is the perpetrator, where the incident occurs outside of England and where there are concerns in institutional settings[4]..

[3] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/793253/Practice_guidance_v_2.1.pdf

[4] Working Together 2018 (p85) notes that institutional settings includes children's homes (including secure children's homes) and other settings with residential provision for children; custodial settings where a child is

5.2.2 Working Together 2015 introduced for the first time a definition of "Seriously harmed"; it is further echoed in Working Together to Safeguard Children (HM, 2018) to include, but is not limited to, cases where the child has sustained, as a result of abuse or neglect, any or all of the following:

5.2.3 serious and/or long term impairment of a child's mental health or intellectual, emotional, social or behavioural development.
It should also cover impairment of physical health.

5.2.4 This definition is not exhaustive. In addition, even if a child recovers, this does not mean that serious harm cannot have occurred. SSCP should ensure that their considerations on whether serious harm has occurred are informed by available research evidence.

5.2.5 There are varieties of methodologies that can now be utilised to support the review process – see Appendix C for an overview of these.

5.2.6 Stockport Safeguarding Children Partnership has a separate framework for the Process for the Management of Notifications of Serious Child Safeguarding Cases and Rapid Review Panels.

5.3 Child Death Reviews

5.3.1 Chapter 5 of *Working Together to Safeguard Children* (HM, 2018) sets out the procedures to be followed when a child dies and this is further elaborated on in the Child Death Review: Statutory and Operational Guidance[5] which now outlines the statutory responsibilities of the Child Death Review partners. Child Death Overview Panels (CDOPs) are responsible for reviewing information on all child deaths in an area to identify and address modifiable factors in local child deaths. The details of how this is undertaken is outlined in the operational guidance which is adhered to by all statutory agencies.. The Local Safeguarding Partners may be requested by the Local Child Death Review Partners to consider a child death for a local Child Safeguarding Practice Review. The Child Death partners may also undertake thematic reviews of child deaths to conduct a deeper dive into cases of local relevance. These thematic reviews will be determined by the Child Death Overview Panel based on trends and themes identified within their data. The focus of these reviews will be on understanding modifiable factors within these cases and making recommendations to local safeguarding partners in relation to changes to practice to address these. Click the link for further details regarding Child Death Reviews

5.3.2 The SSCP works in partnership with CDOP and ensures that learning is shared across both partnerships to support improvements in local practice. This can include dissemination of information from the CDOP processes and the taking forward of relevant CSPRs.

held, including police custody, young offender institutions and secure training centres; and all settings where detention of a child takes place, including under the Mental Health Act 1983 or the Mental Capacity Act 2005

[5] Child Death Review Statutory Guidance 2018

5.4 Safeguarding Adult Reviews (SARs)

5.4.1 The Care Act 2014 introduced mandatory Safeguarding Adult Reviews for the first time. It states a Safeguarding Adults Board (SAB) must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if:

5.4.2 There is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and condition 1 or 2 is met.

Condition 1 is met if —

a) The adult has died, and
b) The SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

Condition 2 is met if —

a) The adult is still alive, and
b) The SAB knows or suspects that the adult has experienced serious abuse or neglect.

5.4.3 A SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

5.4.4 The Care Act 2014 goes onto say that each member of the SAB must co-operate and contribute to the carrying out of a review under this section with a view to identifying the lessons to be learnt from the adult's case, and applying those lessons to future cases

5.4.5 No one model is prescribed, SAB must determine locally the process for undertaking a SAR. There are varieties of methodologies that can now be utilised to support the investigation process – see section 4 for an overview of these methods.

5.4.6 Further details can be found on the link regarding the **Safeguarding Adult Review**

5.5 Domestic Homicide Reviews (DHRs)

Domestic Homicide Reviews (DHRs) are statutory reviews under section 9 of the Domestic Violence, Crime and Victims Act (2004), which came into force in April 2011. These reviews enquire if agencies locally are responding appropriately to victims of domestic violence by offering and/or putting in place suitable support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and violence.

5.5.1 The DHR will also assess whether agencies have sufficient procedures and protocols in place, which were understood and followed by their staff and where there may be a need to improve these procedures.

5.5.2 Potential DHR cases are discussed within the Review Groups and commissioned on behalf of the Community Safety Partnerships who maintain statutory responsibility to:

a) establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

b) identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

d) prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

e) contribute to a better understanding of the nature of domestic violence and abuse; and

f) highlight good practice.

5.5.3 Learning from the DHR is fed back to staff within safeguarding briefings or workshop events.

5.5.4 Click on the link for further details regarding **Domestic Homicide Reviews**.

5.6 Multi-Agency Public Protection Arrangements (MAPPA) – Serious Case Reviews

5.6.1 The work of the Multi-Agency Public Protection Arrangements (MAPPA) is overseen and managed by the Strategic Management Board (SMB). A case may be considered for a statutory MAPPA Serious Case Review where there are concerns about multi-agency failures to manage a serious offender in the community, or a further serious offence takes place. The Review Group will support scoping across agencies. A panel is established and terms of reference (ToR) agreed. An Independent Author produces an overview report and identifies learning from the case. The MAPPA who oversees the progression of the actions receives the Report. Relevant multi-agency learning is shared with the Practice Improvement Partnership Group.

5.6.2 Click on the link for further details regarding **MAPPA and SCRs**.

5.7 Non-statutory Reviews

5.7.1 Local Safeguarding Executives should also (where appropriate) conduct reviews of cases which do not meet the criteria for a statutory review, but which can provide valuable lessons about how organisations/agencies are working together to

safeguard and promote the welfare of children and adults. Although not required by statute these reviews are important for highlighting good practice as well as identifying improvements, which need to be made to local services. Such reviews may be conducted either by single organisation/agencies or by a number of organisations/agencies working together.

5.7.2 Reviews are not ends in themselves. The purpose of reviews is to identify improvements, which are needed, and to consolidate good practice. Local Safeguarding Executives and their partner agencies should translate the findings from reviews into programmes of action, which lead to sustainable improvements, and the prevention of deaths, serious injury or harm to children and vulnerable adults.

5.7.3 Partner agencies should consider notifying the Local Safeguarding Executives of cases, which may not meet the criterion for a statutory review, but there remains particular concern about inter-agency safeguarding practices. If in doubt, discuss the circumstances with the safeguarding business manager who will take advice from the Review Group

5.8 Multi-Agency Learning Reviews

5.8.1 This is a meeting of key professionals or managers across agencies to discuss a single or a cluster of cases where there are concerns about: the multi-agency management of the case, and where it is recognised there was a “near miss” or the events could have led to more serious outcomes that do not meet statutory review criteria. The Review Group will agree the terms of reference for this type of reflective review, which is chaired independently by a Senior Manager from an agency not involved in the case. The aim of the multi-agency case discussion is to take remedial action across agencies to prevent the likelihood of this happening again. This type of review is particularly useful where a system/process needs a timely review to prevent further risk. A summary report and recommendations/actions are received back to the commissioning Review Group.

5.8.2 It is recommended this approach be only used on cases where there is a single episode or cluster of similar key practice episode that took place over a brief period.

5.8.3 A brief summary of the key practice episode would be written up (anonymised) with agreed recommendations/actions agreed. The Review group agree and formulate the action plan, and the Practice Improvement Partnership will oversee the delivery of the action plan.

5.8.4 The Safeguarding Executives Business Manager will organise a moderation day when action plan is ready for sign off. Twelve months later, the Quality Assurance Partnership will provide assurance to the Safeguarding Executives on the learning embedded from audit.

5.9 Single Agency Learning Reviews

5.9.1 A Single Agency identifies a Serious Incident requiring investigation/review that meets the agency’s threshold to conduct a review.

5.9.2 The incident clearly only involves this agency, but safeguarding is a significant feature

of the review and learning would benefit learning to be shared with member agencies. Agencies need to determine that, if other agencies are involved, they ensure their contribution is built into the review process.

5.9.3 Even where there is no other agency feature in a single agency learning review if the finding suggest there are implications for the inter-agency response to safeguarding children or adult then the findings must be shared with the Local Safeguarding Executives and their partners.

5.9.4 The Review Group receives a brief summary of learning and the action plan being taken forward by the agency for information.

5.10 Peer Reviews

5.10.1 An appropriate "peer" undertakes a peer review: for example, one Board or Partnership may undertake a review of another Board's or Partnerships effectiveness, or a provider agency may review another provider. Peer Review methods are also employed across agencies to enable comparisons on performance across a range of standards, or used to focus on particular activity. An analytical report using qualitative data or quantitative data would be received drawing comparisons and conclusions.

5.10.2 There are various methodologies that can be used to support a learning review process; some of these are shown at **appendix (a)** however, this is not an exhaustive list. What has become common practice is the use of elements from a number of approaches to create a bespoke model to ensure each review is managed proportionately.

5.11 Complaints, Compliments, Professional Disputes and Whistleblowing

5.11.1 The SSCP inter-agency procedures provide that key messages from complaints, compliments, professional disputes, escalations and whistleblowing should be used to inform learning and improvement activity including development of procedures. Any learning and improvement activity required will be addressed through the relevant Executive Group and delivered by the appropriate Sub group under the auspices of their delivery plan.

6 Why audit?

6.1 Systematic Process

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

6.1.2 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 adults, child, young person's voice has been heard through intervention.
- Whether multi-agency practice is making a difference for children, young people adults 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

In addition to review processes, the **Safeguarding Executives have a programme of audits** to review single and multi-agency practice. They include:

- Single-agency case file audits
- Multi-agency case file audits (including SSAB/SSCP Joint audits)
- Section 11 audits
- Safeguarding Adults Quality Assurance Statement

6.2 Single Agency Case File Audits

The Chair of the Quality Assurance Partnership makes a formal request to colleagues in partner agencies for a schedule of reporting of their own agency/ organisation's safeguarding case file audits, where these exist.

6.3 Multi-Agency Case File Audits (MACFAs)

The purpose of MACFAs is to provide regular and effective monitoring and evaluation of frontline practice and the quality of management oversight. However, it is not enough merely to gather the findings; these must be used to improve practice.

6.3.1 The theme of a particular MACFA can be determined by:

- A recommendation by a statutory inspectorate that audit activity should inform practice and judgements about effectiveness

- A recommendation arising from a review process conducted by the Board
- Practice to support a particular priority group of service users, such as Looked After Children (LAC)
- Trends in data and performance monitoring that require further investigation.

6.3.2 Guidance for participants in the MACFA process is made available to practitioners prior to the event.

6.3.3 The safeguarding performance and assurance groups receive reports on the findings of each MACFA and monitors progress on an action plan arising from each of the various audits.

6.4 Section 11 Audits

A Section 11 Audit enables the relevant Safeguarding Children Partnership to assess whether statutory partners are fulfilling their statutory responsibilities to help, protect and care for children and young people. Stockport Safeguarding Children Partnership works with colleagues to conduct a joint biennial Section 11 audit of partner agencies. This Audit is based on expectation outlined in Section 11 of the Children's Act 2006 which sets out basic provisions all agencies must make to meet their safeguarding responsibilities.

6.4.1 The findings from the audit are reported to the Quality Assurance Partnership on a regular basis.

6.5 Audits under 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 arrange 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.

6.5.1 The SSCP 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.

6.6 Safeguarding Adults Quality Assurance Statement

The Safeguarding Adults Quality Assurance Statement is the Adults Safeguarding Boards equivalent of the Section 11 audit. It is managed in the same way and the results are regularly reported to the Quality Assurance Partnership in the same way.

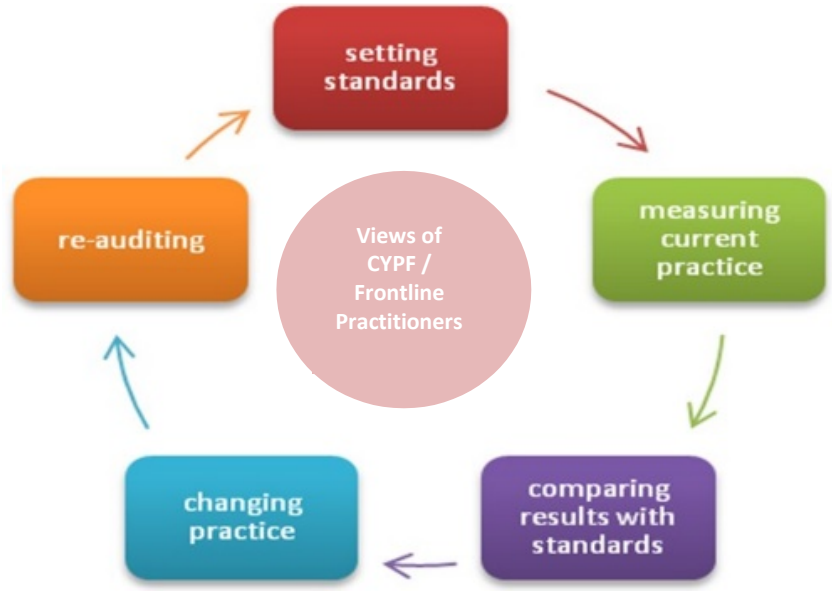
6.7 External Lessons

Opportunities for learning from national reviews, feedback from corporate structures and other forums external to the Safeguarding Executives are equally relevant to how our safeguarding systems improve. The Safeguarding Executives will take account of such learning and ensure it is appropriately disseminated or included in related action plans targeting service improvement. For example by sharing Executive Summaries of the learning for dissemination across Stockport.

7. The Local Safeguarding Board/Executive Performance and Assurance Cycle

7.1 Outside of learning reviews, the local Safeguarding Executives have other methods of seeking assurance on compliance with multi-agency safeguarding procedures and quality of practice. These include a range of activity detailed below.

7.2 The Local Safeguarding Executives performance and assurance cycle is shown in diagram form below:



7.3 Performance Management Information – Safeguarding Executives Datasets
The Quality Assurance and Scrutiny Partnership manages the collection and analysis of performance data information in relation to defined aspects of safeguarding practice in accordance with the Safeguarding Executives business plan and core datasets.

7.4 The datasets are designed to provide quantitative information to monitor key points in the child/adults journey through safeguarding systems in order to provide evidence for the support or challenge to partners of their individual and multiagency response to the new Stockport safeguarding arrangements.

7.5 The Safeguarding Executives respective sub-groups will oversee and agree the dataset and regularly review the merit of the indicators for their relevance. The dataset is scrutinised alongside qualitative information (reviews, audits and specific assurance questionnaires) as part of the quality assurance and performance management framework and in turn for learning and improvement.

8 Single and Multi-agency Front-line Practitioner Intelligence

8.1 Engagement with front-line staff, first-line managers, Child Protection Chairs and Independent Reviewing Officers to understand their experiences of what is working well and what is not, is key to the Safeguarding Executives in gaining a transparent understanding of the realities of front-line child and adult protection and safeguarding work. Critically the examination of practitioner feedback in respect of the knowledge, skills, experience and opportunities they have for direct work and engagement with children, young people and adults at risk.

9 Engagement of families and service users

9.1 The Safeguarding Executives are committed to approaches to strengthen family and service user engagement and participation in safeguarding processes. This will also improve feedback on experiences following a safeguarding process. The information gathered by all agencies from adults/carers/families who interface with services (plaudits, complaints) provides organisations with a valuable insight into service delivery.

10 The Boards' Risk Register

10.1 The risk register is an important element in the business of the Safeguarding Executives as it identifies risks to the delivery of safeguarding practice across the partnership and its impact on children, adults at risk and their families. The risk register is managed by the Safeguarding Executives.

11 Annual Reports

11.1 The requirement for the Annual Report is to "provide a rigorous and transparent assessment of the performance and effectiveness of local services" and should be informed by evidence gathered from agencies. The Report should therefore be a reflection of the assurances (or concerns) raised by the Safeguarding Executives over the course of the preceding financial year.

12 Sharing the Learning

12.1 An important part of supporting a culture of continuous learning and improvement is to disseminate and embed good practice from what information tells us about what works well; and learning from when things go wrong. Integral to the success of this framework will be the sharing of learning across organisations to ensure transparency, accountability and consistent improvement to practice.

12.2 Senior Officers 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 and volunteers.

How the Safeguarding Executives **share their lessons**

- Safeguarding Executives Training Programme and Strategy
- Large scale multiagency safeguarding conferences
- Single Agency Training
- Multi-agency thematic briefing notes
- Single Agency Briefings
- Campaigns and promotional material
- Communications through Safeguarding Executives and partner agency web / Social Media.
- Publication of Rapid Reviews and Case Reviews
- Annual Reports
- Website

12.3 For any review undertaken by the Board, the dissemination of the learning is achieved by a number of means:

- The key messages are shared with partners at Board meetings, with the expectation that Safeguarding Leads will then disseminate these messages within their own agencies/organisations. Briefing presentations are made available to Safeguarding Leads to assist in the sharing of key messages.

- Learning from reviews is incorporated to inform the development and content of single and multi-agency training and learning content. A formal system of reporting learning outcomes is fed into commissioning group.

- Workshops for multi-agency groups take place as soon as possible after the Safeguarding Executives has been briefed on the review outcomes (timing is subject to legal and publication considerations).

- Key learning is featured in the Joint Safeguarding newsletters of the safeguarding messages that are most relevant to the range of disciplines covered by the Safeguarding Executives.

- The learning is shared with other Board colleagues at a range of joint business meetings (SCR Media Planning meetings, LLR Procedures and Development Subgroup, the Joint City and County Executive Groups, etc.)

- The learning is shared with colleagues in Children's and Adult Services via the mutual attendance on each other's Partnership Groups and Safeguarding Executive meetings.

- The Safeguarding Executives website features any published review.

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

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

13 Monitoring and Evaluating the Effectiveness of Safeguarding Training

13.1 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 and adults in Stockport.

13.2 Our most frequent question will be **"**what difference have we made to adult/children's safety and wellbeing as a result of identifying learning, disseminating lessons and embedding those lessons in day to day practice."

13.3 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/adults and being clear about the difference that any learning would have made if applied at the time of intervention.

13.4 One main conceptual framework for assessing the effectiveness of training is "McKendrick's Four Stage Model". This is issued as the basis on which to gather evidence to support a judgement on effectiveness. It is intended that the evidence gathered under this framework will identify areas of weakness, the causes of those weaknesses and enable the partnership training strategy to adapt and address these.

13.5 The system has two elements:

a) Workforce leads in statutory partner agencies will provide evidence on the amount, quality and effectiveness of single agency safeguarding training.

b) Evidence on the amount and effectiveness of safeguarding training provided as part of the Section 11 and the Safeguarding Adults Quality Assurance Statement performance framework, Provider Annual Safeguarding Reports and audit processes.

Appendix (A): Summary - Types of statutory review processes

TYPE	REVIEW PROCESS
RAPID REVIEW	• Meets Working Together 2018 Statutory Guidance • Notifiable Incident with suspected Serious Harm • Process outlined within the Stockport Safeguarding Children Partnership Review Guidance • Identifies whether Child Safeguarding Practice Review is required and if so the relevant key lines of enquiry • Rapid Review report is submitted to National Child Safeguarding Practice Review Panel with proposal of next steps. • National panel endorse proposals and / or propose a National review
CHILD Safeguarding Practice REVIEW	• Meets Working Together 2018 statutory guidance • Significant harm abuse or neglect & omissions in management case across agencies identified in initial scoping • Independent Chair agrees with recommendation • Independent Author / Panel established / Terms of Reference agreed • Methodology for conducting review is agreed – this may include the requirement for a single agency review • Overview report identifies key practice episodes, learning and actions
CHILD DEATH REVIEW	• Unexpected Child Death – meets definition Working Together 2018 and Child Death Operational Guidance for statutory review within CDOP process • Abuse or neglect of child not suspected • Likely public health learning – prevention focused • CDOP panel established, investigation progressed to agreed TOR • Overview Report identifies key learning and actions • Learning from CDOP reported into Serious Case Review (SCR) Group & Annual Report

TYPE	REVIEW PROCESS
SAFEGUARDING ADULT REVIEW	• Care Act 2014 criteria for adult Serious Case Review met • Independent Chair agrees with recommendation • Independent Author / Panel established / Terms of Reference agreed • Methodology agreed for conducting review • Overview report identifies learning and improvement • Actions progressed and overseen by SCR Group
DOMESTIC HOMICIDE REVIEWS	• Commissioned by Community Safety Partnerships • Coordinated through Review Group of relevant Safeguarding Executives area • Independent Author Commissioned and DHR panel established • Terms of Reference for the review agreed. Individual Management Review (IMR)reports requested from involved agencies • Overview report agreed by panel and actions • Actions progressed
MAPPA SERIOUS CASE REVIEWS	• Case meets criteria for statutory Multi Agency Public Protection Arrangements (MAPPA) Serious Case Review • Management of serious offender has failed around public protection and number of agencies are involved • Review Group assists scoping of case across Board agencies • MAPPA panel agree Terms of Reference. • Report identifies findings and agreed actions, MAPPA will oversee progress.
MENTAL HEALTH HOMICIDE REVIEWS	• In April 2013 NHS England became responsible for commissioning independent investigations into homicides (sometimes referred to as mental health homicide reviews) that are committed by patients being treated for mental illness. The purpose of an independent investigation is to review thoroughly the care and treatment received by the patient so that the NHS can: ○ Be clear about what – if anything – went wrong with the care of the patient ○ Minimise the possibility of a reoccurrence of similar events ○ Make recommendations for the delivery of health services in the future • An independent investigation is carried out separately from any police, legal and Coroner's proceedings. It is done by an independent, expert organisation, which is given access to all the

TYPE	REVIEW PROCESS
	information and reports about the individual patient's care and treatment (within the usual patient confidentiality rules), and who can also request interviews with any NHS staff involved.
SERIOUS FURTHER OFFENCES	• Serious Further Offences (SFOs) were introduced in December 2008. The SFO Notification and Review procedure is intended to ensure rigorous scrutiny of those cases where specified offenders under the supervision of the Probation Provision have been charged with a violent or sexual offence. • The review process for all eligible offenders charged with a SFO who have been assessed as low risk of serious harm and are subject to either a community order or a suspended sentence order, even where the qualifying offence attracts a mandatory review. In these cases, the SFO Review will focus chiefly, but not exclusively, on the area of risk assessment.

Appendix (B): Summary -Types of non-statutory review processes

PEER REVIEW	• SSCP / SSAB / agency initiated. Peer review process within safeguarding where data is compared across key performance areas • Findings reported to Review Group. • Analytical report looking at national, regional and local best practice areas and comparisons made. • Report formulates conclusions and any recommendations.
MULTI- AGENCY CASE REVIEW	• Initial scoping of the case identifies number of agencies involved in an "assessment / procedures / process" system management of case • Terms of Reference agreed for the Multi-Agency Case Review (MACR) • Timeframe for the review is short; agencies asked to review records, identify key practice episodes against Terms of Reference (ToR) prior to meeting • Managers of services meet to review case management • Brief summary report identifies learning and recommendations / actions
SINGLE AGENCY CASE REVIEW	• Safeguarding is a significant feature of the investigation • Independent Investigator appointed by agency and leads review • Safeguarding Investigation report provides summary of findings and learning arising from review • Brief summary of incident and learning reported into the ReviewGroup • Learning shared with other agencies when learning could improve practice

Appendix (C): Types of Review methodologies

METHOD	FEATURES OF THIS METHODOLOGY
MULTI-AGENCY SYSTEMS APPROACH WITHIN CASE REVIEWS	• The 'systems' model helps identify which factors in the work environment support good practice, and which create unsafe conditions in which poor safeguarding practice is more likely. • It provides a way of thinking about frontline practice and a method for conducting case reviews. • It produces organisational learning that is vital to improving the quality of work with families and the ability of services to keep children safe. • It supports an analysis that goes beyond identifying what happened to explain why it did so – recognising that actions or decisions will usually have seemed sensible at the time they were taken. • It involves moving beyond the basic facts of a case and appreciating the views of people from different agencies and professions. • It is a collaborative model for case reviews – those directly involved in the case are centrally and actively involved in the analysis and development of recommendations. • Examples of this approach include the SCIE model http://www.scie.org.uk/publications/guides/guide24/index.asp and SILPs http://www.reviewconsulting.co.uk/ however, there are other suppliers and models for this type of review.
SINGLE AGENCY ASSURANCE REPORT	• Can be provided by agencies or requested by the SCR Groups • The focus of the report is identifying gaps or strengths in practice and providing assurance as to how practice has improved, what we need to do more of and any control measures now in place or further actions required. • Reports are presented at SCR Group meetings

ROOT CAUSE ANALYSIS	• Looks at causation / is a systematic enquiry
	• Can use a variety of different methods to identify root cause:
	  • 5 "why" techniques
	  • Cause and effect (fishbone)
	  • Brainstorming
	  • Timelines and chronologies
	• Cause of the incident identifies the actions to be taken forward
	• Provides learning at a number of levels from individual to agency

METHOD	FEATURES OF THIS METHODOLOGY
ACTION LEARNING METHOD	• Action Learning involves working on real problems, focusing on learning and actually implementing solutions. It is a form of learning by doing. • The process integrates: research (into what is obscure); learning (about what is unknown); and action (to resolve a problem) into a single activity and develops an attitude of questioning and reflection to help individuals and organisations change themselves • Embedded within the SILP review process as a key methodology for learning
INDEPENDENT MANAGEMENT REVIEW	• Based loosely on the guidance for reviews as issued by the 2010 version of Working Together • Information gathering through IMRs • Systems review process is added by format of IMR template • No need for a separate chair and author
APPECIATIVE INQUIRY	• Appreciative Inquiry (AI) is a change management approach that focuses on identifying what is working well, analysing why it is working well and then doing more of it. • The basic tenet of AI is that an organisation will grow in whichever direction that people in the organisation focus their attention. • If all the attention is focused on problems, then identifying problems and dealing with them is what the organisation will do best. • If all the attention is focused on strengths, however, then identifying strengths and building on those strengths is what the organisation will do best. • It is designed to provide safe environment for staff to come together to examine a case and look at what went well and what didn't go so well in safeguarding • Best used in non-critical reviews.
CASE MAPPING EXERCISE	• Case mapping is useful in bringing practitioners and managers together to consider a case(s) to identify and understanding similar features or factors in cases particularly where outcomes for children have not been met and the case does not meet the criteria for a statutory review.