Oldham Safeguarding Children Partnership Learning Hub Framework

> “The complexity of the multi-agency child protection system heightens the need for continual and reliable feedback about how the system is performing. This is in order that organisations can learn about what is working well and identify emerging problems and so adapt accordingly. Such a learning culture is needed both within and between agencies. It needs to include people at all levels in organisations, from the frontline workers engaging with families, to the most senior managers in hierarchies.” (Eileen Munro)

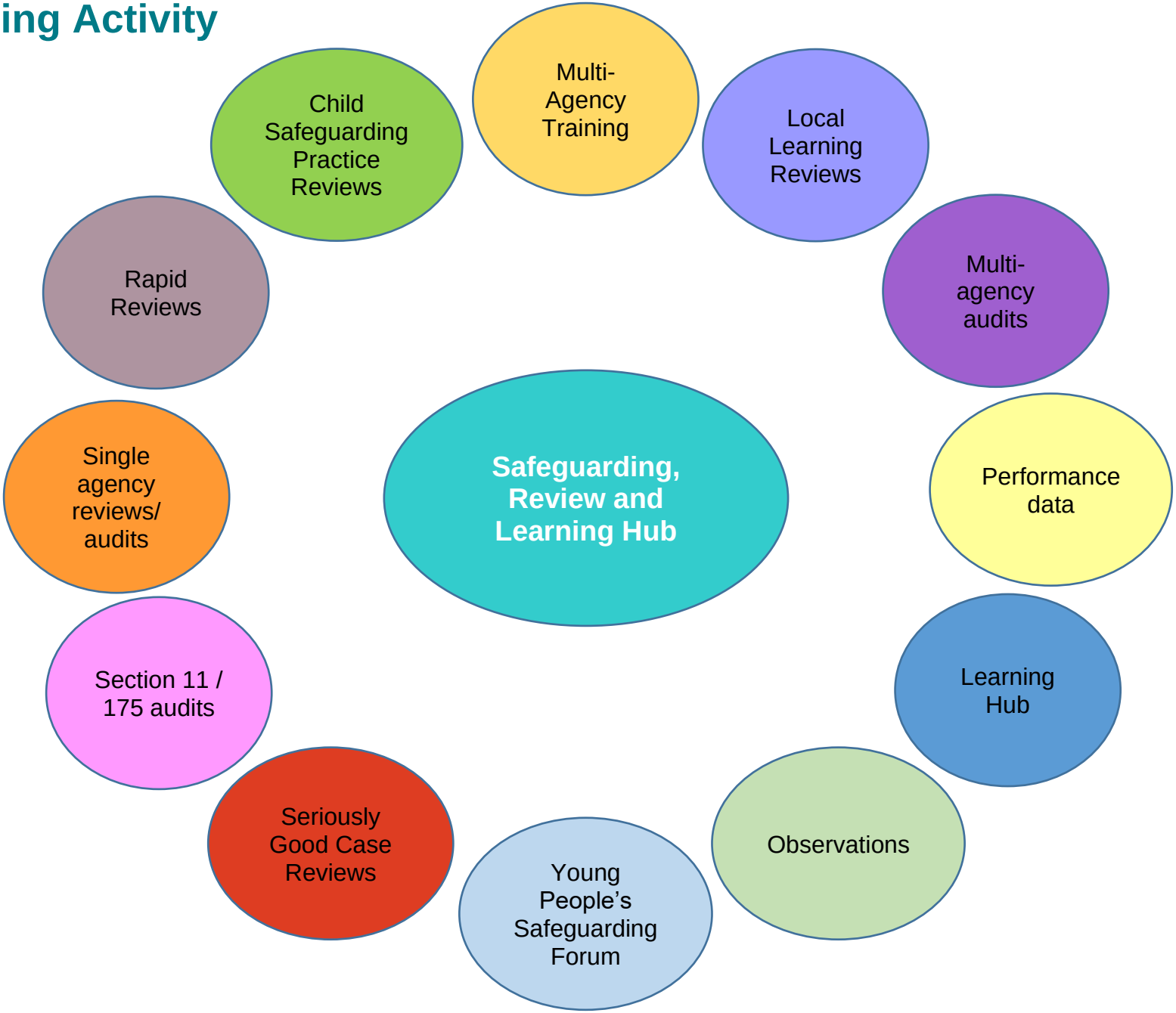
Working Together 2018 requires local safeguarding arrangements to:

- Use data and intelligence to assess the effectiveness of the help being provided to children and families, including early help
- Commission and deliver multi-agency training and monitor the impact
- Undertake multi-agency and inter-agency audits
- Undertake local child safeguarding practice reviews and embed learning across organisations and agencies
- Include the voice of children, young people, and families

Oldham Safeguarding Children Partnership is committed to the continuous improvement of local organisations working with children and families. This framework details the methods by which safeguarding partners will review their individual and collective response to practice and determine whether it resulted and/or continues to result in the best outcomes for children and families in Oldham.

The framework is designed to complement the Partnership’s Multi- Agency Practice Standards (insert link), Partner’s single agency quality assurance processes as well as other statutory review processes such as Domestic Homicide Reviews and Safeguarding Adult Reviews. The learning from these processes will be presented to the Learning Hub to ensure a coherent and consistent approach to learning and improvement.

1. Learning Activity

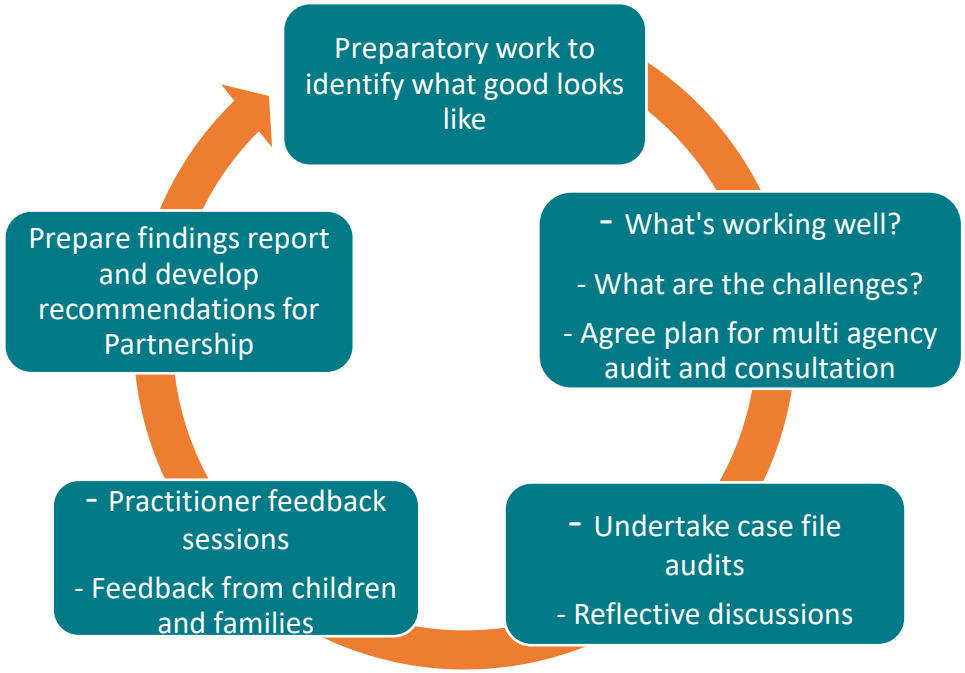


2. Learning Hub

The learning hub is a “back to practice” approach which creates a space for professionals from different agencies to have different types of conversations about improving and changing partnership practice.

The model works on cyclic approach to engaging partners at both a strategic and operational level in developing effective multi-agency collaboration. Leading with the establishment of “what good looks like” the model promotes a strength- based approach to improving practice.

The Partnership intends to undertake 2-3 thematic learning hubs per year.



3. Young People's Safeguarding Forum

The Youth Service will support the facilitation of thematic workshops every 2-3 months focussing upon areas such as mental health, trauma, bullying and wellbeing.

The aim of the workshops is to allow a wider cross section of children and young people to attend. Inclusion won't be based on young people having to be part of a pre-existing group and participants will include:

- Members of the Oldham Youth Voice Family
- Children and Young People from schools
- Children and Young People engaged with youth organisations across Oldham
- Young people known to social care who are Child in Need/Child Protection/Children Looked After or Care Leavers.

Once a year the young people and the Safeguarding Partnership will have a joint development day to review the years' activity and plan ahead.

4. Rapid Reviews

Working Together 2018 identifies that where a case is a "serious child safeguarding case" then partners must make arrangements to identify, commission and oversee arrangements for that review process.

A Serious Child Safeguarding Case in one in which a child has died or been seriously harmed, **and** abuse or neglect is known or suspected

Serious harm" This term is defined as:

"… 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…judgment should be exercised in cases where impairment is likely to be long-term, even if this is not immediately certain. Even if a child recovers, including from a one-off incident, serious harm may still have occurred."

These cases are clearly identified within the statutory guidance as distinct from our day-to-day practice. If local partners identify a case where serious harm has occurred and abuse and or neglect is suspected, then this case must be notified to the National Panel and consideration given to whether a local review is required.

Therefore, not every case referred to the OSCP will lead to a Rapid Review as these are held only for those cases meeting these distinct criteria. A Virtual Panel, consisting of the three statutory partners, will consider these referrals and determine if a Rapid Review will be triggered. In these cases, a Rapid Review Report will be returned to the National Panel within 15 working days of the referral being received.

The Rapid Review should aim to:

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- Gather the facts about the case as far as they can be readily established at the time.
- Discuss whether there is any immediate action needed to ensure children's safety and share learning appropriately.
- Consider the potential for identifying improvements to safeguard and promote the welfare of children.
- Decide what steps they should take next, including whether to undertake a Child Safeguarding Practice Review.

All partners/agencies who had knowledge of the child will be required to contribute to a Rapid Review.

See Appendix A for Practice guidance.

5. Child Safeguarding Practice Reviews

Following a Rapid Review, a Local Child Safeguarding Practice Review (LCSPR) may be appropriate where:

- highlights or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified
- highlights or may highlight recurrent themes in the safeguarding and promotion of the welfare of children
- highlights or may highlight concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children
- the National Panel have considered and concluded a local review may be more appropriate
- the safeguarding partners have cause for concern about the actions of a single agency
- there has been no agency involvement, and this gives safeguarding partners cause for concern
- more than one LA, police area or CCG is involved, including where families have moved around
- the case may raise issues relating to safeguarding or promoting the welfare of children in institutional settings.

Working Together 2018 is clear that, where the potential for further learning is identified, then this should be through the commissioning of a proportionate LCSPR. When a further review is warranted, that should always be labelled as an LCSPR regardless of the approach taken to complete it.

Any LCSPR should:

- Recognise the complex circumstances in which professionals work together to safeguard children.
- Seek to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did.
- Seek to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight.
- Identify recurrent and/or thematic learning
- Be transparent about the way data is collected and analysed.
- Make use of relevant research and case evidence to inform the findings.

The purpose of reviews of serious child safeguarding cases, at both local and national level, is to identify improvements to be made to safeguard and promote the welfare of children. Therefore, the focus will be on understanding practice and not to hold individuals or organisations to account. There are other processes that exist to undertake that role, such as employment law and disciplinary procedures, and these should be used when that is sought. These processes can be run in parallel or subsequent to one another and decisions regarding the appropriate timetabling will be made on a case-by-case basis.

For many of these cases an Independent Reviewer will be commissioned to lead the review and write the report with recommendations.

6. Single Agency Reviews (SAR)

Where a case is considered for a serious child safeguarding case but does not meet the criteria, as practice requiring further analysis and learning is limited to a single agency, the Virtual Panel may recommend a Single Agency Review.

If a Single Agency Review is agreed by the Statutory Safeguarding Partners, a letter will be sent to the OSCP representative from the relevant agency requesting that the review is undertaken, with lines of enquiry provided by the Panel.

The review should be completed within three weeks of receipt of the letter from the Independent Chair of the OSCP.

7. Seriously Good Case Reviews

Learning from what has worked well is just as important as learning from serious child safeguarding cases. The OSCP is committed to delivering regular briefing sessions on cases where there has been strong multi-agency working and/ or positive outcomes for children and families.

This is a standing agenda item at our monthly Safeguarding Review and Learning Hub meetings providing an opportunity for all agencies to share good practice examples that can then be disseminated via a multi-agency briefing session.

8. Performance Data

Partnership data is collected and analysed by the OSCP Performance group on a quarterly basis, before being reported by exception, to the Strategic Safeguarding Partnership.

Data is collated from Children's Social Care, Targeted Early Help, Police, LADO, 0-19 Service, Pennine Care NHS Foundation Trust, Northern Care Alliance, Positive Steps (Youth Justice Service), Education and OSCP Business Unit.

Covering safeguarding themes such as referrals to MASH and Early Help, Child Protection conferences and planning, domestic abuse, children missing from home/care, youth justice, mental health, 0–2-year-olds and hospital admissions the data is scrutinise by a multi-agency group and is used to direct further analytical work and/or multi-agency audits in order to assure the Partnership of effective multi-agency practice.

9. Section 11/175 Audits

The OSCP has a statutory responsibility to ensure that agencies are fulfilling their duties under Section 11 of the Children's Act 2004. In order to do this the Partnership undertakes a cycle of section 11 audits every two years.

Agencies are asked to self-assess their organisation against the following standards, providing evidence to support their assessment:

1. Leadership and Accountability
2. Policies and Procedures
3. Recruitment and Selection
4. Staff Induction, Training and Development
5. Complaints, Allegations and Whistleblowing
6. Information Sharing, Communication and Confidentiality
7. Listening to Children and Young People
8. Equality of Opportunity

Schools and Education (S175)

OSCP has a review audit tool for schools and education establishments which is based on Keeping Children Safe in Education guidance. Completed every two years. the audit tool comprises of 13 areas which include:

1. Designated Safeguarding Lead
2. Staff
3. Pupils
4. Risk Assessments
5. Record Keeping
6. Parents
7. Curriculum
8. Multi-Agency Safeguarding Standards and Links with Key Agencies
9. Governors
10. Recruitment and Selection
11. Allegations against staff
12. Other audits in school
13. Single Central Record

An overview report for all of the audits will be prepared by the OSCP Business Manager and presented to the Safeguarding, Review and Learning Hub. Three agencies and three schools will be invited to attend a peer review "challenge panel" which will be made of members of the Hub, and a representative from the Young People's Safeguarding Forum. A separate checklist is available for the Voluntary and Community Sector. The Section 11 Template and VCSO checklist can be found at: Safeguarding Review and Learning Hub (olscb.org)

10. Multi-Agency Audits & Observations

A calendar of multi-agency audits is developed by the Safeguarding, Review and Learning Hub based on key areas of focus identified through case reviews and performance data. Observations of key Partnership meetings such as strategy meetings, core groups and child protection conferences are also included.

Members of the Hub undertake this activity and, using a template developed based on the theme and feed their findings back to the Hub and/or Performance group.

The calendar for 2022-2023 can be found at Appendix B.

11. Learning and Improving Practice

To ensure that learning from the variety of review activities undertaken by the OSCP are effectively disseminated we will:

- Provide a calendar of Multi-Agency Safeguarding Training courses which are aligned to key areas of learning and undertake surveys with attendees and managers in order to assess impact on practice.
- Develop a 7-minute briefing following each learning activity and disseminate across the Partnership for use within team meetings etc.
- Deliver an Information Highway Friday session to share the findings of any learning activity with multi-agency professionals
- Undertake regular snap surveys to gather professionals' views

It is the responsibility of safeguarding partners to ensure and evidence that learning is embedded within their agency's practice and to evaluate the impact of learning on their agency's safeguarding practice.

The Learning Hub will produce an annual report detailing the activity undertaken and the evidencing the impact of learning and improvement in practice.

Appendix A – Case Review Practice Guidance

Practice Review Guidance Oldham -

Appendix B – Multi-Agency Audit and Observations calendar

Partnership audit plan (2022-23).docx