Safeguarding ENFIELD

Enfield Children Safeguarding Partnership:
Learning and Improvement Framework

1. Introduction and purpose

The purpose of this framework is to support the partnership in delivering its quality assurance and learning functions and meet all statutory obligations. It is underpinned by the journey of the child, and the evaluation criteria of the Inspection of Local Authority Children's Services (ILACS) framework, evaluation criteria of the Joint Targeted Inspection (JTAI) framework, Working Together 2018 and Keeping Children Safe in Education (2022)

It describes what the ESCP partners do to understand the effectiveness of the local multi-agency arrangements for safeguarding children and identifies how the learning from these activities is used to support practice development. All the activities described here seek to ensure that:

- The Partnership is ensuring quality across the safeguarding system
- The Partnership sets the right priorities to meet these needs
- The Partnership is holding partners to account for providing effective safeguarding services to children, young people, and families in Enfield
- The Partnership supports the Local Authority in fulfilling its statutory responsibilities in relation to the notification of serious incidents and will commission independent or Local Child Safeguarding Practice Reviews (LSCPR) where required.

This framework supports a culture of continuous improvement and learning, with a focus on the lived experience of children and young people in the borough. It seeks to guide the partnership to follow the 'golden thread' from improvement and change in the delivery of safeguarding services to the impact on outcomes for children and young people. Each year we will publish the details of learning and outcomes in our Annual Report

It supports identifying priority areas for scrutiny and improvement activity through targeted activity and should complement the activity in individual agencies which measures their performance in key areas of practice including the application of the Enfield Threshold document; effective assessments for children, robust planning to keep children and young people safe and the impact of interventions upon the child's lived experience.

Below, in Part One, a range of activities are described that help us understand and identify learning. We use an Outcomes-based accountability' approach, asking three questions of all of the information we gather:

- How much did we do? *Quantitative indicators - data*
- How well did we do it? *Qualitative data themed audits; case reviews*
- Did it make a difference? *Impact measures for all action plans*

The next step is then to identify and agree what the partners will do to continue improvements to practice (action planning and prioritisation)?

At Part Two, this framework sets out the process from identifying the learning, **extracting and agreeing** the learning; activities for dissemination and embedding the learning. We then seek to review what has been done in order to ensure there is an impact upon the lives of children and young people in the borough.

PART A Identifying Learning - Our key learning activities (*4 headings below)*

1. Learning from performance data

The Business Unit collates targeted, child level data from across the Partnership about safeguarding activity and our priorities. It is responsible for developing horizon scanning intelligence to identify current and future risks to the effectiveness of the Safeguarding Children Partnership arrangements. We use this to tell us what is going on; to show us gaps; to show us patterns and themes, and areas for further scrutiny through our audit and review programme.

A fuller picture of vulnerability from Adult safeguarding, Children Social Care, Housing etc. as well as Health partners, and Police teams such as Safeguarding Hubs, Local intelligence Team and neighborhood teams will result in a more directed and tailored intervention, thus avoiding duplication and greater management of risk by the most appropriate team / teams within the partnership.

2. Learning from practice

The partnership has several ways of understanding what is happening in practice in the borough. Across all of these activities we will seek to identify where any challenges lie and will work with those in practice to identify and implement solutions. We will involve children,

families, and front-line workers in audits as appropriate to the activity. These are our learning activities:

i. Single agency audits

Single-agency case audits occur in most organisations as part of the assurance of their duties (set out in section 11, Children Act 2004. We hold an annual meeting of the Practice Improvement Group at the end of each year (March), where the key agency partners share learning and impact on outcomes of their single-agency audits. There may be a spotlight on particular areas of practice which have been identified in other activities *e.g. the nature of supervision and reflective opportunities across the safeguarding system.*

ii. multi-agency themed audit programme

Safeguarding Children Partnerships are expected to undertake multi-agency audits to evaluate practice and gain assurance of good systems in place to safeguard children and young people (as per Working Together 2018). The multi-agency audit process enables identification of areas of practice that are working well and those that need improvement across the partnership. Audits also promote service development through the identification of key practice issues which are addressed in action plans that are implemented and monitored by the Practice Improvement Group. Learning from the audits will be disseminated and embedded.

Our annual programme of multi-agency audits is linked with the Business Plan priorities as a response and in identifying emerging future priorities. However, the programme is flexible enough to respond to new priorities that may arise. We will prioritise audits that provide opportunities to focus on front-line practice and encourage professional multi-agency challenge.

The primary focus is to establish the effectiveness of front-line practice, what has worked well and where improvements, both single-agency and multi-agency, are needed. The plan is to complete 3-4 per year and oversight sits with the Practice Improvement Group. There is an agreed methodology and Terms of Reference for each audit, and we seek the most appropriate methodology to extract the learning.

iii. Rapid Reviews and Local Child Safeguarding Practice Reviews

As set out in Chapter Four of Working Together to Safeguarding Children 2018, the partnership works together to improve children protection and safeguarding practice in cases by learning from cases where a child suffers a serious injury or death as a result of child abuse or neglect. *Understanding not only what happened but also why things happened as they did can help to improve our response in the future. Understanding the impact that the actions of different organisations and agencies had on the child's life, and on the lives of his or her family, and whether or not different approaches or actions may have resulted in a different outcome, is essential to improve our collective knowledge. (Chap 4, para 2).* To fulfil the responsibility, the partners will:

- Support the Local Authority in fulfilling its duty to notify the National Panel of cases where a child is seriously harmed or neglected, and in some cases die as a result. (16C (1) of the Children Act 2004 (as amended by the Children and Social Work Act 2017). This should be done within 5 days of becoming aware of the child's case. The partnership will contribute information and resource.
- Conduct Rapid Reviews as per the guidance from the National Panel and build upon the learning that arises from the process each time. The partnership also links closely with the National Panel's engagement activities to ensure best practice in this area. How potential learning is relevant locally will be a governing factor in our decision making at the end of a Rapid Review, and we acknowledge that some learning has a wider importance for all practitioners working with children and families and for the government and policy-makers. *Understanding whether there are systemic issues, and whether and how policy and practice need to change, is critical to the system being dynamic and self-improving.* Working Together to Safeguard Children July 2018 Guide All rapid review reports are sent to the National Panel and the feedback regarding their content and quality and the appropriateness of our decision making is noted.
- Follow the response and suggested actions after a Rapid Review of a case and either embed the learning from the rapid reviews, conduct a LSCPR or working with the National Panel to complete a National Child Safeguarding Practice Review.
- If requested, we will also implement assurance activity if learning from any national case reviews is relevant for the local context in Enfield
- Our learning from our reviewing activity and arising recommendations are tracked and the outcome and impact from each review is reported. When we have conducted a LSCPR, we will feedback outcomes back to the National Panel.

iv CDOP processes

The process of expertly reviewing all children's deaths is grounded in deep respect for the rights of children and their families, with the intention of preventing future child deaths. The child death review process covers children; a child is defined in the Act as a person under 18 years of age. A child death review must be carried out for all children regardless of the cause of death. This includes the death of any live-born baby where a death certificate has been issued.

A Joint Agency Response (JAR) coordinated multi-agency meeting (on-call health professional, police investigator, duty social worker), should be triggered if a child's death:

- is or could be due to external causes;
- is sudden and there is no immediately apparent cause (including SUDI/C);
- occurs in custody, or where the child was detained under the Mental Health Act;
- where the initial circumstances raise any suspicions that the death may not have been natural; or
- in the case of a stillbirth where no healthcare professional was in attendance.

The child death review process is completed via the eCDOP system which creates a record to co-ordinate all information on an individual case -

- Notification Form (previously "Form A") for initial notification of a death within 24 hours
- Reporting Form (previously "Form B") for gathering information from agencies or professionals who have information relevant to the case.
- Analysis Form (previously "Form C") initially drafted at the CDRM and completed at CDOP for evaluating information and identifying lessons to be learned.

The Analysis Form is the final output of the child death review process. From 2020 this information has shared with the National Child Mortality Database directly who produce a national learning from deaths annual report.

Immediate learning following a JAR meeting is escalated to the Safeguarding Children Partnership either via the Practice Improvement Group or directly via the Local Authority lead who co-ordinates the notification to the National Panel. Local learning is included in the annual report with cases raised by exception to the Practice Improvement panel following

presentation at the NCL Child Death Overview Panel. NCL CDOP is represented on the Practice Improvement Group.

v. S 11 reporting

Section 11 of the Children Act 2004 places a duty on local authorities to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children.

The Section 11 audit forms part of the independent scrutiny arrangements and feeds into the reporting requirements as set out in Chapter 3 of Working Together to Safeguard Children 2018. All Safeguarding Children's Partnerships have a statutory duty to assess whether agencies in their areas are fulfilling their statutory obligation to safeguard and promote the welfare of children, as described in Section 11 of the Children's Act 2004.

vi. Other reviewing processes

As a safeguarding partnership we are aware that an individual case may potentially be subject to other multi-agency statutory reviewing processes. These may include:

- **Domestic Homicide Review (DHR)** – where the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse, or neglect by a relative, household member or someone he or she has been in an intimate relationship with.
- **Safeguarding Adult Review (SAR)** – when an adult in Solihull with needs for care and support dies, and the Safeguarding Adult Board (SAB) knows or suspects that the death resulted from abuse or neglect, or the adult is still alive and the SAB knows or suspects that the adult has experienced serious abuse or neglect, and there is concern about how SAB members worked together to safeguard the adult.
- In addition to these there may be other processes within health trusts under the Serious Incident Framework; Youth Justice Board activity around youth deaths in custody; as well as criminal investigations and proceedings; and Coroner's Inquests.

As a partnership we are committed to ensuring that all reviewing activity meets any statutory guidance but are mindful of the need to avoid duplication and unnecessary activity and will work with colleagues in Community Safety, Adult Safeguarding, and other local authority areas to identify the best way to work together in each case.

vii Activity arising from Independent Scrutiny of the Partnership

The Independent Scrutiny arrangements are set out in our Local Arrangements document. Learning from this activity will be reported on in our Annual Report however feedback will be received more regularly by an independent scrutineer. We will also be scrutinised by young people within the borough who form our Safeguarding Ambassadors programme on a regular basis.

3. Front-Line Intelligence – feedback from practitioners and service users

We will work to understand the experience of those receiving services and those responding to need and risk and offering intervention to keep children and young people safe from harm. To do so we will:

- Regularly canvas the views of the partners that participate in our learning activities and Practice Improvement Group to 'take the temperature' of the system
- Engage practitioner and families in our learning activities wherever possible
- Run surveys on specific issues for practitioners to support engaging them in our work and to hear their experience of practice
- Hold engagement events if required. These can be responsive events set-up to explore emerging safeguarding themes and risks or triangulate some of the analysis from our learning activities.
- Receive and analyse training evaluation information
- Ensure we work closely with our Safeguarding Ambassadors to receive their feedback as well as measure the impact of what we do.

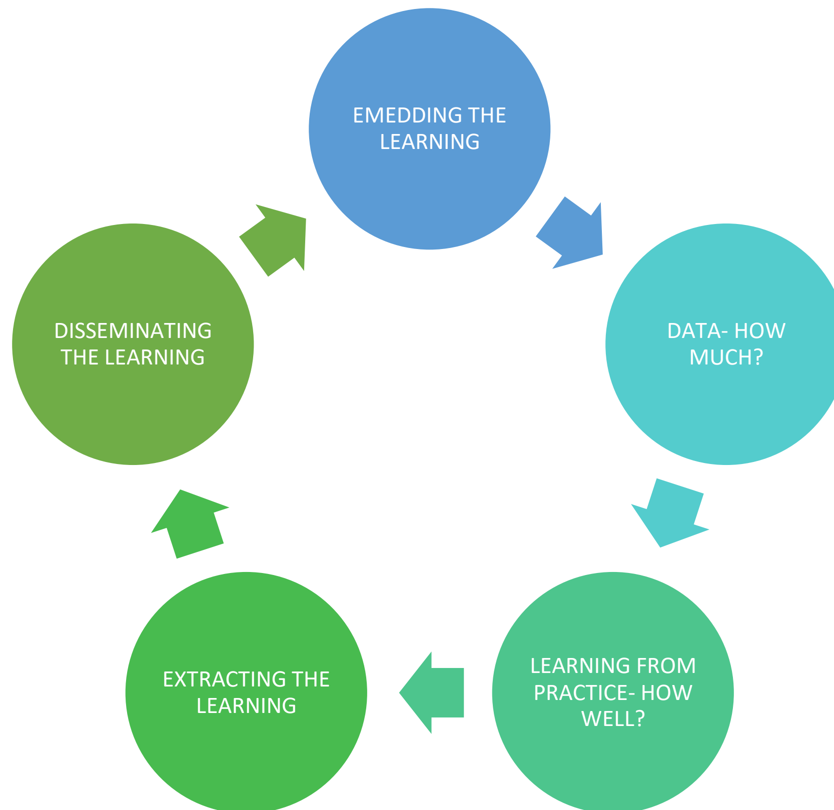
4. External learning

- National Panel themed reports and annual reports
  Child Safeguarding Practice Review Panel - GOV.UK (www.gov.uk)
- NSPCC case review summaries and reports Case reviews | NSPCC Learning
- JTAI reports
- Key inspectorate reports eg HMIP; HMIC etc

PART B Extracting lessons, Disseminating and Embedding the Learning

Cycle of learning

Impact- How have we made a difference to children and young people?



Practice Improvement Group- Terms of Reference

a. Extracting the learning

The Practice Improvement group has oversight of all our activities and through regularly reflecting on practice and the emerging information from audits and review, the group identifies the key learning, and works together to recognise where change improvement is needed. The group will negotiate and plan for practice improvement through the action plans.

The Practice Improvement group will work together to produce Learning from Practice Updates twice a year (March and September) which will be disseminated and embedding in practice. This will summarise local learning, from reviews, audits and surveys as well as national learning.

The Practice Improvement group will aim to prioritise 'Three Themes' per year throughout the year to focus on. *Examples of this might be professional curiosity in practice; good information sharing; confident escalation practice; culturally competent practice.*

b. Dissemination of learning

This requires good and established methods of communication by all partners and their representatives on the Practice Improvement Group, supported by the Partnership's business group. Methods might include

- ensuring that required policy changes are made and implemented
- sharing summaries new practice guides, 7 minutes briefings and possible videos arising from training
- disseminate learning from practice updates.
- disseminate information regarding changes in their agencies
- Information around training opportunities arising from learning
- briefings, newsletters, and communications to partner agencies and relevant organisations, using the ECSP website

c. Embedding the learning from our activities

We recognise that for a very busy workforce, simply receiving information may not be enough to assimilate the learning into their practice and to make any changes that were identified. Therefore, the partnership will offer workshops, partnership events and reflective opportunities to consider the learning arising and reflect upon what some of Three Themes learning might mean for their practice. As well as this, advice can be given as to how partners might use the Learning materials in their own agencies and spaces.

PI members should ensure that single agency training reflects current practice and reflect learning outcomes from case reviews and audit. Members of the Practice Improvement group are expected to feedback the outcomes and implications of the audit findings within their own agency, ensure that progress is made on any actions which they are responsible for and provide updates to the PI group

The PI group will also ensure that findings, recommendations, and outcomes resulting from multi-agency audit feed into ESCP policy and practice guidance, training and development activity and strategy and commissioning processes.

d. Evidencing impact

The partnership is committed to ensure that what it does makes a difference to the lives of children and young people. Therefore, impact measures will be written into our action plans as required and the methods for evidencing impact agreed at the outset. Regular action plan reviewing is a key regular task for the Practice Improvement group – during challenge and support conversations, asking *“what did we do to make a difference?* These will take place twice a year to support our Learning from Practice updates.

When evidencing impact, we will ensure that we do this collaboratively with service users and with a wide range of partners, including ECYPS, representing the third sector organisations working in Enfield.