THURROCK LOCAL SAFEGUARDING CHILDREN PARTNERSHIP

Independent Review of Thurrock's Local Safeguarding Children Partnership

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Independent review of the Thurrock Local Safeguarding Children Partnership (LSCP)

1. Context

The Children and Social Work Act 2017 and Working Together 2018 dissolved the requirement for Local Safeguarding Children's Boards (LSCB).

The three Strategic Partners, determined under the Children and Social Work Act 2017, comprise Thurrock Council, Essex Police and Thurrock Clinical Commissioning Group (CCG).

A Strategic Group of the three Partners was set up in November 2017 and worked on developing the new arrangements during 2018. The new arrangements are referred to as Thurrock Local Safeguarding Childrens Partnership (LSCP). Thurrock's new arrangements as the LSCP came into effect on the 7th May 2019.

The agreement of the LSCP is to have a rotating Chair from the three statutory partners, initially with Health, children's social care have taken on the Chair role from April 2020. In order to provide independence and external oversight to the LSCP arrangements, the governance document set out the requirement to have an annual peer review or independent review of the partnership arrangements.

2. Purpose of the Review

The LCSP has been operational for a year and requires an independent review to provide assurance in judging the effectiveness of the multi-agency arrangements to safeguard and promote the welfare of children, including arrangements to identify and review in a timely way serious child safeguarding cases.

This independent review will act as a constructive critical friend and will promote reflection to drive continuous improvement within the Partnership.

The independent review will consider how effectively the LSCP arrangements are working for children and families as well as for practitioners, and how well the safeguarding partners are providing strong leadership across the Partnership. The review will also identify any gaps in the Partnership working and recommend actions to be taken to ensure the Partnership is working as effectively as possible.

Scope and timescales for the Review

- To review the current structure of the LSCP; is it fit for purpose any suggested improvements?
- To review the work on Managed Reviews and Learning Practice Reviews; how effective are they? Are they timely and if not, suggestions to bring them back in line

with 6 months required in Working Together (2018). Are lessons learned from the Reviews, do they enhance practice in the Partnership?

- How to secure independent overview of the partnership; to propose options for independent scrutiny of the LSCP
- Review of the current working groups for effectiveness and outcomes
- To review the current funding arrangements of the LSCP and to propose alternative funding models
- In reviewing the partnership are any gaps identified in partnership working. To suggest ways that the partnership can close any identified gaps
- To highlight any good examples of performance of the LSCP
- How will we know we are being effective

The report will be presented to the Strategic Group of the LSCP and to the Management Executive Board of the LSCP.

3. Assurance

Working Together 2018 requires there to be independent scrutiny in order to provide assurance in judging the effectiveness of multi-agency arrangements to safeguard and promote the welfare of all children in a local area, including arrangements to identify and review serious child safeguarding cases. I can confirm that the Multi-agency Safeguarding Arrangements for Thurrock Safeguarding Children Partnership are compliant with Working Together 2018. The arrangements ensure children in Thurrock are safeguarded and their welfare promoted.

4. Process/methodology of review

The review methodology was developed and undertaken as a tool for understanding strengths and areas for improvement in the way the Thurrock Local Safeguarding Children Partnership works together to safeguard and promote the welfare of children in their area. To undertake this review a list of documents and policies from the Partnership was provided. I also have had the opportunity to meet with a range of partners /practitioners, individually and in focus group, to ascertain a range of views from partner agencies on the impact of the new Partnership arrangements (see appendix 1)

The focus of the review and questioning in the meetings was based on some key areas:

- The three core partner leads are actively involved in strategic planning and implementation
- The wider safeguarding partners (including relevant agencies) are actively involved in safeguarding children
- Children, young people, and families are aware of and involved with plans for safeguarding children
- Appropriate quality assurance procedures are in place for data collection, audit and information sharing

- There is a process for identifying and investigating learning from local and national case reviews
- There is an active program of multiagency safeguarding children training

(*Six Steps for Independent Scrutiny: Safeguarding children arrangements. Institute of Applied Social Research, University of Bedfordshire')*

I would like to thank the LSCP Business Unit and in particular Toni Archer for supplying the documents requested and setting up the meetings with key individuals. I would also like to thank all the staff who have taken part, for their thoughtful and frank evaluation of the current partnership, ideas and suggestions for improvements.

5. Strategic planning /implementation/ agency engagement

The three key Partners, determined under the Children and Social Work Act 2017 and Working Together 2018, comprise Thurrock Council, Essex Police and Thurrock Clinical Commissioning Group (CCG). After consultation, following the legislative changes, a Partnership Plan was developed and Thurrock's Local Safeguarding Children Partnership (LSCP) went live with their new arrangements on 7th May 2019. The Plan was comprehensive and is underpinned by a constitution which clarifies the working of the new Partnership arrangements. The three key partners are committed, engaged, and understand their responsibilities under the new arrangements. All three safeguarding Partners have equal and joint responsibility for the local safeguarding arrangements. In situations that require a clear, single point of leadership, all three safeguarding partners have agreed under their local arrangements who will take the lead on issues that arise. It was agreed initially that the partnership would not appoint an independent chair or scrutineer but review the arrangements through peer and independent review / scrutiny. The partners agreed to have a rolling chairing arrangement, the first year being undertaken by the health representative and subsequently by the DCS representing the Council.

The current Strategic group is made up of the three key partners at a senior strategic level, without deputise or any operational or designate level attendance. This group makes some key decisions which impact on the wider Partnership and may be assisted with a slightly wider membership, which with some major agency changes likely in future, may assist with continuity and informed decision making.

6. Subgroups

The subgroups of the previous Board arrangements were reviewed as part of the development of the new Partnership and a new structure of subgroups was put in place. In reality partners felt this had not reduced the number of meetings radically. It introduced a structure whereby the Learning and Practice Review group would oversee the work of the Individual Practice Review Groups(coordinating individual case practice reviews) the Audit Group and any Task and Finish work groups set up for specific issues. I am not aware of any of the latter being held. This created a high workload for this particular group and meant in reality receiving 'reports back' rather than being able to challenge and provide a quality assurance function. I have not seen a copy of the revised Learning and Practice Framework which should underpin these new arrangements.

It was reported by agencies that the MACE group was still in development but had made significant recent progress to track and monitor exploited young people at both tactical and strategic level. It had good links with the pan Essex – SET arrangements. It is noted that this was an area of development from the latest OFSTED inspection.

I noted that there was a separate multi agency MASH steering group. In many areas this would have its governance through the LSCP.

There was a strong sense of partnerships between agencies, good co-operation and working relationships at strategic and operation level noted throughout the review, however there had been historical tensions between agencies. There was good engagement of relevant agencies including schools and of note CRC, which is not universal. Subgroups were well attended with the right representation at the right level. Schools and agencies spoke highly of the support and information available through the LSCP Business team and use that practitioners made of the LSCP website, which was felt to have accessible and relevant information. However, there is no formal structure about involving and ensuring that frontline practitioners/schools know and understand the work of the partnership and can offer a feedback loop between the strategic and operational levels (see below). There has been considerable positive work undertaken during the COVID-19 pandemic which has put all services under significant pressure, but the strength of the partnership and working together has supported these new ways of working and the coordinated responses to children and families in Thurrock . The virtual nature of meetings and training has shown great participation and engagement.

7. Threshold document

There has been a recently revised Threshold document shared with agencies through the Partnership. This document had only been launched in July 2020, so I was not able to ascertain agencies view on its implementation and their understanding of threshold. Therefore, I was not able to review the effectiveness of information sharing or evidence how the partnership are monitoring multi-agency decision-making. I was however informed that the MASH steering group would monitor this and would regularly audit cases to test this. Agencies cited examples of being able to challenge and escalate concerns within MASH if they had concerns about cases. However, it was unclear whether the LSCP regularly receive information on this and what the Governance arrangements were for this group.

8. Wider partnership

There was positive wider engagement with the Southend, Essex and Thurrock (SET) arrangements which pulled together a number of functions across the pan Essex footprint, including developing Safeguarding procedures, CSE and Child Death arrangements. The SET Strategic Partners have met fortnightly during COVID to coordinate approached and progress joint working across borders and learn from each other. This has worked particularly well.

There are probably more opportunities that could be afforded with these arrangements , which could also have a positive financial impact , as well as helping those agencies covering more than one authority area e.g. joint training , shared learning from case practice reviews and joint campaigns/ development of policies/ strategies.

9. Priority areas

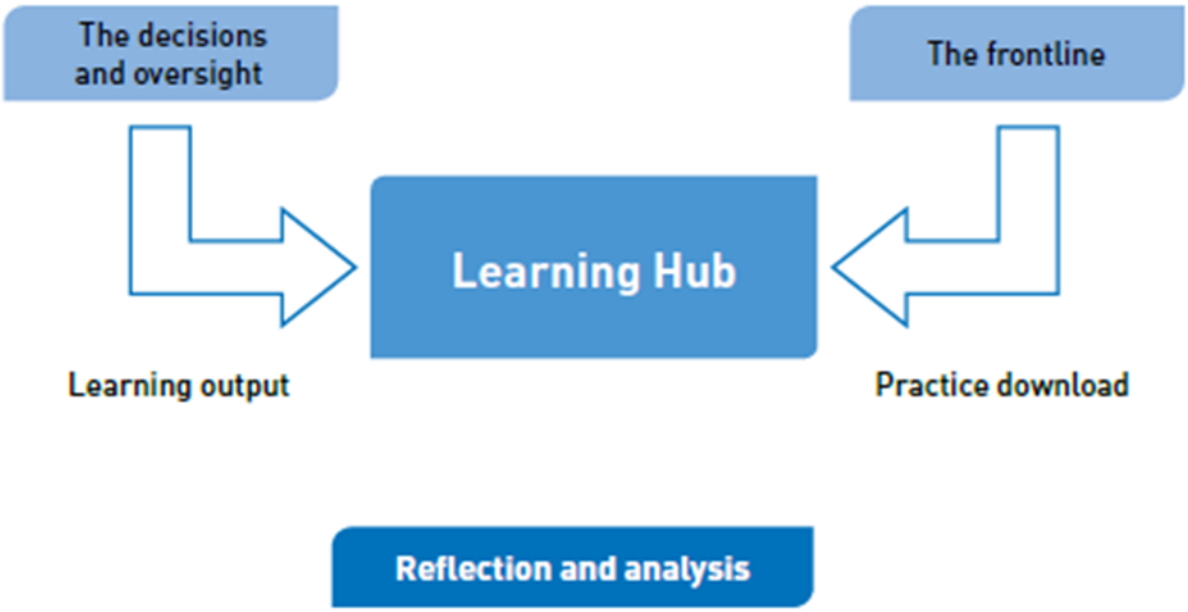
'Safeguarding *partners should put in place arrangements to monitor and challenge the quality of agencies' work in relation to children's safety and welfare. These arrangements should enable partners to identify and understand the reasons for and root causes of systemic strengths and weaknesses of local practice. Strategic decisions about local system changes should be driven by this intelligence. It is for single agencies and the safeguarding partners to decide which areas of practice should have a priority focus and why*. '(*Working Together 2018)*

Has the Partnership identified clear improvement priorities and are these incorporated into a plan to improve outcomes? How well are these understood and measured by the Partnership, practitioners and understood by the community? There is a delivery plan put together by the Business unit, but it was unclear how actions were agreed. The Partnership needs to strengthen its communication of the priorities. There is a mechanism within the Sub-Groups to agree actions within the Delivery Plan, however, there was a delay in progressing these exacerbated by COVID and the due to the absence of a core member of the Team, which has delayed the communication of the priorities to the across the wider partnership . Recruitment to this role has now been successfully completed. Additionally, COVID has delayed the communication of the priorities.

Another area for consideration was how effectively the LSCP worked alongside other partnerships, for example the Safeguarding Adults Board, Community Safety Partnership and the Health and Wellbeing Board? Were there shared prioritise for Thurrock across these partnerships and how well do the Partnerships work together to deliver these priority areas and avoid duplication. It was reported that these Partnerships generally work well together but this was based on personality and professional relationships, not on any written agreement or necessarily shared prioritise. In the LSCP constitution it does mention developing a protocol between Partnerships, but I was not able to see an example of this. It would also help to reduce duplication around decision making for case reviews when there is overlap e.g. SARs/ LCSPR/DHRs.

10. Learning hubs

There are no reported formal mechanisms to ensure a feedback loop with frontline staff. As part of the Early Adopter work, several authorities developed Learning hubs which were designed as an important two-way feedback loop between front line practitioners and the Strategic Board to ensuring learning on priority local safeguarding issues. These were shared and acted on at all levels in a timely way, as outlined in the diagram below. This has proved an effective method of involving and getting feedback from frontline staff across agencies on thematic issues - a similar model has been used to engage schools through 'twilight sessions.'



11. Recommendations (1)

- **Consider deputies on Strategic Group to bring strategic /operational leads together**
- **MASH steering group subgroup - governance through LSCP**
- **Shared and agreed priorities across Partnerships for Thurrock**
- **Protocol to reduce duplication and streamline processes across partnership groups e.g. SARs/ LCSPR/DHRs**
- **Develop wider role of SET**
- **Consider different models to involve frontline staff /schools eg learning hubs**

12. Quality assurance/ data and audit

'Thurrock LSCP has a unique statutory role & a clear responsibility to undertake a scrutiny, quality assurance & challenge role in respect of how agencies individually and collectively promote the welfare & safety of children living in Thurrock.'

'The Safeguarding Partners are accountable & responsible for ensuring the new Thurrock LSCP safeguarding arrangements are effective.'

How can the Partnership know how effective the partners are working together to safeguard children and how do you measure the impact of the Partnership?

The Partnership needs to be clear on its priority areas and set clear delivery targets that can be measured. There are also some clear safeguarding proxy measures/ performance indicators that could be supplied by agencies, which allows the Partnership to both challenge practice but can also provide assurance. Children's services have this information, as do

Public Health who collect safeguarding data across the health economy. Police may not be able to break down their data to be Thurrock specific, but it is important that this information is provided with analysis, otherwise how do you know how effectively the Partnership is working but also if there is improvement or deterioration?

Work has been undertaken to strengthen the multi-agency audit process, but it still remains weak and based on auditing a small number of cases on a regular basis. I appreciate the capacity of agencies to undertake this important role is limited, but it is essential to understanding how effectively agencies work together to safeguard children. It was not clear where the learning from these audits are presented/cascaded or how this learning was embedded in frontline practice.

Consideration needs to be given to the Audit Group receiving single agency audits from Partner agencies, which have been undertaken on safeguarding areas of work. Some suggestions for improvements in this area - consider developing different types of audit mechanisms, quality conversations etc. For example – how do you know frontline practitioners know and understand a newly implemented policy or strategy – consideration should be given to using questionnaires of staff using Survey Monkey to ascertain their knowledge and confidence in using. Consider deep dives on specific subjects similar to that undertaken by Public health, this could be incorporated in the work of the scrutineer to undertake these reviews on particular topics agreed by the Partnership. Finally, the Partnership could consider a more interactive process for s11/ S175 which could be run alternating with the current strategic process. This would give greater insight of frontline staff's understanding of their safeguarding responsibilities and whether these are understood.

There also needs to be a mechanism in place to ensure that the learning and the recommendations from SCRs and case practice reviews have been fully implemented and embedded into practice, without robust audits you cannot evidence that this is the case. There should also be an agreed audit schedule which should regularly include re-audits of priority areas or to evidence improvements, if audit has found particular areas of concern.

Where possible children and young people and their families should be involved in multi-agency audits to ensure that there is feedback from service users. Audits should also involve frontline practitioner to improve their learning.

As there is no independent scrutineer role within the partnership, there needs to effective , respectful challenge from partners of each other's performance, but there needs to be the mechanisms and processes in place so that the three key Partners have the necessary evidence to inform this challenge.

13. Recommendations (2)

- **Revise Learning and Improvement Framework**
- **Agree a multiagency dataset based on priority areas, plus regular reporting on safeguarding proxy indicators with analysis**
- **Develop different audit models– consider different types e.g. questionnaires following implementation of new policies/ processes, deep dives, quality conversations, single agency safeguarding audits, scrutiny topics**
- **Review process S11/ s175 – online , strategic and operational /alternating**

- **Agree an Audit schedule -re-audit some areas on annual basis for evidence of impact on priority areas**
- **Ensure children and young people, families and practitioners involved in audit**

14. Budget

'The safeguarding partners should agree the level of funding secured from each partner, which should be equitable and proportionate, and with each relevant agency, to support the local arrangements to safeguard and promote the welfare of children in their area. The funding should be transparent to children and families in the area and sufficient to cover all elements of the arrangements.' (Working Together 2018)

According to the Annual report (2018/19) the whole of the budget for the Board was spent last year, allowing no contingency fund for following years. I attach below the breakdown of the budget for this year.

2020/21 LSCP Contributions	
Local Authority	177,444.00
Police	17,777.00
CAFCASS	550.00
NPS	1,206.21
CRC	4,750.00
Thurrock CCG	17,777.00
NELFT	5,000.00
BTUH	5,000.00
EPUT	5,000.00
	234,504.21

Work was completed by the Association of Independent chairs in 2016 and in Eastern Region in 2018 looking at comparator Partnership contributions, commissioned Independent Chair's time and remuneration, income generation, and size and function of Business units supporting Partnerships. It also looked at population size. This is now several years out of date but acts as a comparison for size and variance. It also shows differences in the three key agencies contribution and other relevant agencies. This exercise is currently being repeated across the Eastern region. You will note from the graphs that Thurrock's Children's services contribution is above average for the region and health's below average. However, you need to take into account that Trusts, and other health agencies also contribute to the budget, which is not always the case in other Partnerships.

Thurrock has started to charge a standard rate for training, which generated an income of £14,868.75 last year, against expenditure of £15,000, which was not reported in this exercise.

There is no contribution from schools apart from charging for the Walk online production.

Total funding	Statutory partner (health, police & LA only)	other agencies (probation, CRC, Cafcass, DCs)	total income from Board partners	training income	Other income	grand totals
Bedfordshire	£189,203	£2,228	**£191,431**		£9,000	**£200,431**
Cambridgeshire	£203,456	£1,762	**£205,218**	£6,000		**£211,218**
Central Bedfordshire	£156,858	£2,229	**£159,088**		£22,210	**£181,298**
Essex	£346,018	£22,567	**£368,585**	£11,208		**£379,793**
Hertfordshire	£319,794	£7,450	**£327,244**	£9,000		**£336,244**
Luton	£252,971	£3,868	**£256,839**	£0	£6,900	**£263,739**
Norfolk	£250,340	£39,550	**£289,890**	£95,000	£10,000	**£394,890**
Peterborough	£156,215	£1,762	**£157,977**	£3,000		**£160,977**
Southend	£80,040	£4,888	**£84,928**	£5,000	£14,000	**£103,928**
Suffolk	£171,365	£40,150	**£211,515**	£0	£0	**£211,515**
Thurrock	£148,000	£10,050	**£158,050**	£0	£0	**£158,050**
AVERAGES	**£206,751**	**£12,409**	**£219,160**	**£14,356**	**£8,873**	**£236,553**

Local Authority	Population MYE-2016 [ONS]	LSCB budget 2016/17	LSCB budget per head of population £
Bedford	168,751	225,056	1.33
Cambridgeshire	651,940	255,374	0.39
Central Bedfordshire	278,937	241,765	0.87
Essex	1,455,340	389,443	0.27
Hertfordshire	1,176,720	331,724	0.28
Luton	216,791	237,220	1.09
Norfolk	892,870	363,635	0.41
Peterborough	197,095	172,710	0.88
Southend-on-Sea	179,799	108,449	0.60
Suffolk	745,274	205,821	0.28
Thurrock	167,025	120,641	0.72

ALL PARTNER CONTRIBUTIONS	Local Authority		Health		Police		other agencies (probation, CRC, Cafcass, DCs)		TOTALS
Bedford Borough	£108,240	56.5%	£62,663	32.7%	£18,300	9.6%	£2,228	1.2%	**£191,431**
Cambridgeshire	£111,530	54.3%	£43,458	21.2%	£48,468	23.6%	£1,762	0.9%	**£205,218**
Central Bedfordshire	£82,037	51.6%	£54,830	34.5%	£19,992	12.6%	£2,229	1.4%	**£159,088**
Essex	£213,166	57.8%	£66,426	18.0%	£66,426	18.0%	£22,567	6.1%	**£368,585**
Hertfordshire	£198,694	60.7%	£104,300	31.9%	£16,800	5.1%	£7,450	2.3%	**£327,244**
Luton	£141,544	55.1%	£87,068	33.9%	£24,359	9.5%	£3,868	1.5%	**£256,839**
Norfolk	£121,108	41.8%	£80,621	27.8%	£48,611	16.8%	£39,550	13.6%	**£289,890**
Peterborough	£74,911	47.4%	£45,420	28.8%	£35,884	22.7%	£1,762	1.1%	**£157,977**
Southend	£43,065	50.7%	£22,620	26.6%	£14,355	16.9%	£4,888	5.8%	**£84,928**
Suffolk	£100,865	47.7%	£47,000	22.2%	£23,500	11.1%	£40,150	19.0%	**£211,515**
Thurrock	£108,000	68.3%	£25,000	15.8%	£15,000	9.5%	£10,050	6.4%	**£158,050**
AVERAGES	**£118,469**	**54.1%**	**£58,128**	**26.7%**	**£30,154**	**14.1%**	**£12,409**	**5.4%**	£219,160

UNITARY LOCAL AUTHORITIES - ALL PARTNER CONTRIBUTIONS	Local Authority		Health		Police		other agencies (probation, CRC, Cafcass, DCs)		TOTALS
Bedford Borough	£108,240	56.5%	£62,663	32.7%	£18,300	9.6%	£2,228	1.2%	**£191,431**
Central Bedfordshire	£82,037	51.6%	£54,830	34.5%	£19,992	12.6%	£2,229	1.4%	**£159,088**
Luton	£141,544	55.1%	£87,068	33.9%	£24,359	9.5%	£3,868	1.5%	**£256,839**
Peterborough	£74,911	47.4%	£45,420	28.8%	£35,884	22.7%	£1,762	1.1%	**£157,977**
Southend	£43,065	50.7%	£22,620	26.6%	£14,355	16.9%	£4,888	5.8%	**£84,928**
Thurrock	£108,000	68.3%	£25,000	15.8%	£15,000	9.5%	£10,050	6.4%	**£158,050**
AVERAGES	**£92,966**	**54.9%**	**£49,600**	**28.7%**	**£21,315**	**13.5%**	**£4,171**	**2.9%**	£168,052

The major costs of the Partnership last year were staffing costs. The current unit costs were £120,835.00, with a further £20,000 for the Independent Chair and contributions to the Child Death review (CDR) process of 11,102.48. This function is the responsibility of health and the Local Authority and no longer sits with the LSCP. Clearly there will be some savings this year as there has not been any costs for an Independent Chair and delay in recruiting to the Business manager post. The size of the Business unit is relatively large compared to other Partnership Business units, when you also include the CDR post. There are five members of staff, LSCP Business Team Manager, LSCP Project Officer, Learning and Practice Review Co-Ordinator, LSCP Business Support Office and a part time (22.5) LSCP Training Co-Coordinator. Some areas have combined their Business units with the Adults Safeguarding Board in order to make efficiency savings. I would suggest a review of the functions of the team as it seems relatively well staffed compared to other similar sized areas. I understand this was due to be undertaken during 2019 but has not been progressed.

Nearly £20,000 was spent on SCRs last year. A contingency budget does need to be set aside to cover costs of any future LSCPR, but alternative, cheaper models may be able to be progressed when appropriate.

15. Recommendations (3)

- **Agree budget needed including contingency for LCSPR**
- **Consider bid to the Schools' Forum for contribution towards partnership**
- **Health and police gradually increase their contribution over next two years to ensure equity of funding**
- **Review functions of business unit**
- **Training – consider developing across SET sharing costs**

16. Scrutiny

The Children and Social Work Act, 2017, and the DfE guidance Working Together to Safeguard Children: A guide to interagency working to safeguard and promote the welfare of children, 2018 requires the multi-agency arrangements to be independently scrutinized. The guidance commits five paragraphs to explaining how scrutiny could take place (DfE, 2018: Paragraphs 31 to 35 condensed below). It notes that:

'*The role of independent scrutiny is to provide assurance in judging the effectiveness of multi-agency arrangements to safeguard and promote the welfare of all children in a local area, including arrangements to identify and review serious child safeguarding cases*. *This independent scrutiny will be part of a wider system which includes the independent inspectorates' single assessment of the individual safeguarding partners and the Joint Targeted Area Inspections. Whilst the decision on how best to implement a robust system of independent scrutiny is to be made locally, safeguarding partners should ensure that the scrutiny is objective, acts as a constructive critical friend and promotes reflection to drive continuous improvement*. *The independent scrutineer should consider how effectively the arrangements are working for children and families as well as for practitioners, and how well the safeguarding partners are providing strong leadership and agree with the safeguarding partners how this will be reported*. *The published arrangements should set out the plans for independent scrutiny; how the arrangements will be reviewed; and how any recommendations will be taken forward. This might include, for example, the process and timescales for ongoing review of the arrangements. Safeguarding partners should also agree arrangements for independent scrutiny of the report they must publish at least once a year.*

The National Childrens Bureau (NCB) have published lessons from Early Adopters which showed wide variation in how scrutiny is taking place, with some areas:

- employing one independent scrutineer for their local area safeguarding children partnership
- planning to appoint more than one scrutineer, with responsibility for different aspects of the multi-agency partnership arrangements
- sharing one independent scrutineer with other local area safeguarding partnerships
- creating service-user informed approach to independent scrutiny, with family led multi-agency auditing and local reviews

- instigating peer review processes with neighbouring partnerships: peers scrutinizing each other
- creating a system of internal peer reviews within the area covered by the partnership arrangements
- buying in 'national experts' to scrutinize particular aspects of the partnership arrangements, safeguarding plan and implementation
- combining scrutiny of children and adult safeguarding through a governance and assurance model that provides a whole family response, combining a strategic approach to safeguarding partnership arrangements across children and adult safeguarding agendas
- focusing independent scrutiny on partnership priorities
- giving scrutineers specifically targeted responsibility to resolve conflict as the final arbiter of the escalation processes and for dispute resolution (should it be necessary) between the safeguarding leads. *(See Bennett et al, 2018:)*

From a review of all published Partnership Plans, 58% had retained an independent chair, 42% had other chairing arrangements usually with the Chairing rotating between 3 statutory partners; 65% of Partnerships had some form of Independent scrutineer role , some were externally recruited, many were former LSCB chairs, with the Independent chair's role to include the scrutiny role; 33% had mixed scrutiny arrangements including external reviewers, peer review, LGA, multi-agency audit and young scrutineers; 2% intended using a pool of scrutineers.

In Thurrock I understand that there was a plan for a multi systems approach to be taken for the independent scrutiny of the effectiveness of the new arrangements. It was suggested that this would comprise of a number of functions which would include independent scrutiny through *'peer reviews, audits, individual scrutineers and ensuring the voice of children, young people and families is heard throughout the process'*. The feedback from the review indicated that some individuals felt the previous Independent Chair was not 'independent enough' as he was a previous DCS in Thurrock. Some staff had used the previous Business Manager as the 'independent 'link. The role of the Business unit located, and line managed within the LA, but paid for out of partnership funds needs to be cleared defined. It is a partnership resource not a Children's services one and should serve all partners equally.

Most partners spoken to felt that there should be an Independent person within the Partnership arrangements. This was clearly articulated by the Lead member, who felt that while the Partnership was currently chaired by the DCS it could blur responsibility. He was not held to account for the delivery of safeguarding in the council, as had occurred with previous Independent Chairs. This had been felt most keenly when a recent SCR was published as there was no-one who could speak independently of the Council as the previous LSCB Chair did. The role of the Independent person is also crucial as the final arbiter of a dispute resolution and for escalation of concerns.

17. Recommendation (4)

Though there was evidence of respectful challenge between the three key partners and holding each other to account, this would be further strengthened by the recruitment of an independent chair and/ or an independent scrutineer. The role of the Independent

Chair/Scrutineer would provide independent scrutiny of any partner. Thurrock LSCP to consider adding additional independence into their multi-agency safeguarding arrangements by the appointment of an Independent Chair and Scrutineer.

18. Child Practice Reviews

'Safeguarding partners are responsible for overseeing the review of serious child safeguarding cases which, in their view, raise issues of importance in relation to their area.'

'Safeguarding partners must make arrangements to:

- *identify serious child safeguarding cases which raise issues of importance in relation to the area*
- *commission and oversee the review of those cases, where they consider it appropriate for a review to be undertaken*

The purpose of a local child safeguarding practice review is to identify any improvements that should be made locally to safeguard and promote the welfare of children (both collectively and individually). This means that learning must be at the heart of all reviews and should seek to prevent or reduce the risk of recurrence of similar incidents.' (Working Together 2018)

Under the new processes for undertaking learning in relation to safeguarding incidents in Working Together 2018, currently there is no agreed Notification process to the National Panel which articulated multi agency involvement and information sharing. Not all cases which need notification will necessarily be known to the Local Authority, therefore all agencies should be aware of the process and need to inform of relevant cases that meet the criteria. It is good practice for all three partner agencies to be part of the decision making around notification. Once a case has been notified, there is a requirement to hold a Rapid Review. All agencies reported timely Rapid Reviews with good notice given by the Business unit to pull together information. This was an important to note as agencies highlighted that this was not universal across Essex. As LSCPs are no longer undertaking SCRs but local child safeguarding practice review (LCSPR) there continues to be flexibility in the types of reviews that are undertaken. The National Panel is clear in its guidance that all learning reviews should be 'timely and proportionate', the important aspect is extracting the learning and acting on this to address change in the system. It is important to develop more speedy forms of learning review, following an appreciative enquiry model, where more immediate learning can be drawn, and recommendations developed.

I understood that learning events were held for staff after SCRs were published to promote learning, however this may only reach a limited amount of staff. How is learning embedded and organisational memory best achieved? Some suggestions to do this would be to use a short video with key learning points which can be presented at every team meeting across all agencies, shared learning from LCSPRs across SET and adding short infographics on LCSPR into all induction packs of new staff .

All recommendations and agencies actions arising from SCRs and LSCPR should be tracked to completion by the LSCP and regularly subjected to multi agency audit to ensure that changes to practice /guidance and any training etc has made the necessary impact.

19. Recommendations (5)

- **Develop more immediate models of practice review/ appreciative enquiry**
- **Embedded in system/ video / induction packs**
- **Explore learning across SET**
- **Monitoring recommendations and agencies actions /audit outcomes and actions local child safeguarding practice review**

20. Multi agency training / engagement

The review briefly touched on engagement with the community as this was not specifically covered in the Terms of Reference. I understood that the LSCP Business unit attended community events such as fetes/shows and promoted the Partnership through use of goody bags with promotional material. The Partnership had tried unsuccessfully in the past to recruit lay members as currently there are no lay members on the LSCP. There are several Partnerships who have positively used Lay members to promote the voice of the community within their arrangements. I was also not aware of any representation from Faith groups. I understood that there has been successful outreach to increase the representation/voice of BAME community from the LSCP in the past and suggest this is repeated to promote understanding of safeguarding.

I understand the Walk on line training rolled out to schools and engaging with children and young people on online exploitation and widened to include wider contextualised safeguarding awareness, has been very successful, but the child's voice was not evident in other areas of the LSCP's work. This needs to be strengthen by using existing participation events, school questionnaires and ensuring children are involved in areas of work of the Partnership such as audit. Feedback to children also needs to be part of this process.

Multi agency training was viewed as a strength by partners – it was reported to be responsive and of good quality. Following the review of the Board arrangements by OFSTED in 2016, one of the recommendations was monitoring of training and there is now evidence of good evaluation of the training. I understand that a minimal charge has been made for this training which helps delivery – maybe more could be done to join up virtual training across the SET or developing more in-house trainers to further reduce cost and make this sustainable.

21. Recommendations (6)

- **Use existing structures – schools' group, young people's council to promote engagement with C&YP**
- **Questionnaires – 'you said, we did'**
- **Recruit community voice as lay member**
- **Specific work on faith groups/ community outreach**

22. Composite recommendations

1	Consider deputies on Strategic Group to bring strategic/operation leads together
2	MASH steering group subgroup - governance through LSCP
3	Shared and agreed priorities across Partnerships for Thurrock
4	Protocol to reduce duplication and streamline processes across partnership groups e.g. SARs/ LCSPR/DHRs
5	Develop wider role of SET
6	Consider different models to involve frontline staff /schools eg learning hubs
7	Revise Learning and Improvement Framework
8	Agree a multiagency dataset based on priority areas, plus regular reporting on safeguarding proxy indicators with analysis
9	Develop different audit models– consider different types e.g. Questionnaires following implementation of new policies/ processes, deep dives, quality conversations, single agency safeguarding audits, scrutiny topics
10	Review process S11/ s175 – online, strategic and operational /alternating
11	Agree an Audit schedule -re-audit some areas on annual basis for evidence of impact on priority areas
12	Ensure children and young people, families and practitioners involved in audit
13	Agree budget needed including contingency for LCSPR
14	Consider bid to schools forum for contribution towards partnership
15	Health and police gradually increase their contribution over next two years to ensure equity of funding
16	Review functions of business unit
17	Training – consider developing across SET sharing costs
18	Thurrock LSCP to consider the appointment of an Independent Chair and Scrutineer
19	Develop more immediate models of practice review
20	Embedded in system/ video / induction packs
21	Monitoring recommendations and agencies actions /audit outcomes and actions

22	Explore learning across SET
23	Use existing structures – schools group, young people's council to promote engagement with C&YP
24	Questionnaires – 'you said, we did'
25	Recruit community voice as lay member
26	Specific work on faith groups/ community outreach

23. Appendix 1

Thurrock Independent Scrutiny Review

- Meetings
    - Strategic Partners
    - Meeting with the Portfolio Holder
    - Chairs of the Sub-Groups
    - Focus Group
    - Meeting with members of the LSCP Business Team
- List of documents requested for review

	Documentation Required
1	Previous minutes of meetings of Partnership
2	Structure Chart of new safeguarding arrangements including sub-groups
3	Copy of Partnership plan
4	Last Annual Report
5	Business/Delivery Plan
6	Thurrock's LSCP constitution
7	Published SCR/practice learning reviews.
8	Action plans addressing recommendations from above
9	Last two quarters multi-agency performance data received by Partnership – not received
10	Multi-agency audits undertaken including recommendations and action plans (last 12 months)
11	Evidence of S11/157/175 audits, separate recommendations of engagement recommendations and actions arising
12.	Evidence of challenge/areas of scrutiny
13.	Evidence of partnership's engagement with service users
14.	Details of Safeguarding Partnership threshold criteria
15.	Evaluation of multi-agency safeguarding training and the partnership training strategy (
16.	Budget / partner contributions
17.	Business unit
18.	Learning and improvement framework – not supplied