Our Safeguarding Partnership

*This document sets out the **Safeguarding Partnership Arrangements** for Gloucestershire under their Published Arrangements and Working Together to Safeguard Children Statutory Guidance There are 10 key statutory areas relating to the work of the Safeguarding Partnership. Click on the Hyperlinks to access further detail.*

1. *The Gloucestershire Safeguarding Children Partnership has a statutory Function to ensure the three safeguarding partners can **work together to safeguard children** – The Purpose, Membership, Function and structure can be found by clicking on the links.*

2. ***Undertaking Serious Safeguarding Reviews** to understand and improve multi agency practice arrangements.*

3. *The GSCP seeks assurances regards **Partners Safeguarding Efficacy** under the Section 11 and Keeping Children Safe in Education audit arrangements.*

4. ***Multi Agency Audits** allows the Partnership to test multi agency practice arrangements looking for good practice, areas for improvement and the landing of learning from safeguarding reviews. The range of Audits undertaken can be viewed here.*

5. *The collation and analysis of **multi-agency data** is a vital aspect of the partnerships function to facilitate a good understanding of the local safeguarding arrangements and to assist in priority setting.*

6. *The safeguarding partnership has a well-defined **Multi agency Training and Practice Development** curriculum that is available to all practitioners across the partnership. The curriculum is influenced by local and national safeguarding learning reviews.*

7. ***The Child Death Review Arrangements** for Gloucestershire are overseen by the GSCP as part of the partnership's responsibilities.*

8. *The GSCP holds and manages a **Multi-Agency Policy and Procedure Manual** defining and directing how the partners, and their relevant agencies will work together to safeguard children.*

9. *The GSCP ensures there is a **Dispute Resolution** process to ensure that partners can escalate concerns relating to how the partnership is working together.*

10. *Ensuring that local arrangements are **Appropriately Funded** is a key collective task of the three Safeguarding Partners.*

Gloucestershire Safeguarding Children Partnership

Our Safeguarding Partnership

Purpose: *The Gloucestershire NHS Integrated Care Board, Constabulary and Local Authority have a shared and equal duty, under Working Together to Safeguard Children Statutory Guidance (WT), to ensure that collectively their own organisations as a whole and any agency with a function relating to children, referred to as Relevant Agencies, operating in the county work together effectively to keep children safe.*

Structure & Membership: There is no defacto body or legally defined organisation called the GSCP, the GSCP is a partnership of all agencies with a function relating to children. Led by the three partners operating collectively under WT legislative guidance and within the GSCP structure (opposite) enabling joint working between agencies. Agencies nominate lead safeguarding representatives who populate the GSCP Structure to undertake the work of the partnership.

Function: *The Published Arrangements sets out how the Partnership will fulfil both its WT statutory functions and its own identified priorities. These functions include:*

1. Arrangements for the partnership to Identify and respond to children's needs

2. Undertaking Local Child Safeguarding Practice Reviews (LCSPR's)

3. Undertaking Multi Agency Audits, Section 11, KCSiE, Early Years Foundation Audits

4. Arrangements for the sharing of learning from reviews and audits

5. Arrangements for the effective sharing of information to safeguard children

6. Multi Agency Policy and procedural arrangements to facilitate Multi agency working, including escalation arrangements

7. Commissioning and delivery of Multi Agency safeguarding training

8. Seeking assurances on the effectiveness of legal processes such as the Child Death Review Arrangements, Allegations Management, Private Fostering, and other arrangements

GSCP Executive

GSCP Management Group

GSCP Sub-Groups

Education Sub-Group

Quality & Improvement in Practice (QiiP) Sub-Group

MASH Sub-Group

Policy & Procedures Sub-Group

Child Death Overview Panel (CDOP)

Child Exploitation & Missing Sub-Group

Districts Safeguarding Sub-Group

Local Child Safeguarding Practice Review Process (LCSPR)
Child Death/Acute Life-Threatening Event (ALTE) Reviews

Task and Finish and Specific Working Groups

The GSCP Produce a yearly report on the activity of the partnership. This can be found on the GSCP Website

Our Safeguarding Partnership

Reviewing Multi Agency Practice: Safeguarding Practice Reviews

Under Working Together guidance the local Safeguarding Partners must have a process in place to identify, review and respond to serious safeguarding incidents that are referred to the partners for consideration of a Local Child Safeguarding Practice Review (LCSPR).

Where a local authority in England knows or suspects that a child has been abused or neglected, the local authority must notify the Child Safeguarding Practice Review Panel (National Panel) if –

a) The child dies or is seriously harmed in the local authority's area, or

b) While normally resident in the local authority's area, the child dies or is seriously harmed outside England. (This includes Wales)

Serious Incident Notifications *(SIN) (Statutory Function)*
Safeguarding Partners notify cases which meet a SIN threshold. In some circumstances a referral from the Child Death Review process may also require consideration for a SIN

The GSCP collectively consider all serious safeguarding cases against the threshold for a SIN asking the Local Authority to report a SIN formally to the National Child Safeguarding Practice Review Panel (National Panel).

Rapid Review: (Statutory Function)
Where a safeguarding incident meets threshold for a SIN the GSCP must convene a Rapid Review. The Rapid Review assesses the case and provides a report to the GSCP. That report is submitted to the National Panel. A Rapid Review will bring together the most appropriate practitioners and professionals from the partnership on a case-by-case basis ensuring the right front line professionals are in attendance. In the main, but not always, Rapid Reviews will be chaired by an independent Rapid Review Chair, as an element of the Independent Scrutiny Function. The Chair will produce the Rapid Review Report. The Rapid Review will assess the case and consider if a LCSPR is required or if the partnership can proceed with implementing learning from the Rapid Review itself.

Reports from Rapid Reviews are not published but should be used by contributing partners to improve practice.

Local Child Safeguarding Practice Review (LCSPR): (Statutory Function)
Where a Rapid Review considers a serious safeguarding incident requires a LCSPR it will make that recommendation in its report to the National Panel. Where a Rapid Review reports that a LCSPR is needed it is expected that the report will set out why and what focus the LCSPR should take. LCSPRs will look in detail at an aspect of the incident and should not be a larger rerun of the Rapid Review. An independent Chair can be appointed to oversee and lead the LCSPR and produce a formal report as required by Working Together guidance.

LCSPR Reports are formally published on the GSCP Website along with an appropriate action plan setting out how the partnership has or will address the report's recommendations.

Our Safeguarding Partnership

Reviewing Multi Agency Practice: Multi Agency Auditing

Section 11 Children Act 2004

The section 11 process is a statutory requirement and an integral part of the self-assessment and assurance of effective safeguarding practice for each partner agency and relevant agency as set out in the Children Act 2004.

The section 11 process requires each agency to produce and submit a brief and succinct section 11 report. All agencies should address the four section 11 standards identifying evidence of compliance, through existing business processes, for example inspection reports, single agency audit and other processes and practices available.

Partners are asked to attend a S11 Panel Day, the Panel comprising of young people to discuss their submissions with a focus on the Voice of the Child.

The GSCP Independent Scrutineer Reviews the submissions and chairs the panel day, producing a report to the executive on compliance against the S11 standards.

Keeping Children Safe in Education (KCSiE) – Safeguarding Declaration for all Education Settings

The KCSiE Declaration Procedure is a requirement of the GSCP covering educational settings legal obligations under Working Together to Safeguard Children 2018, Keeping Children Safe in Education 2022 (KCSiE), Section 175/157 of the Education Act 2002.

The process is not to make a judgement on the settings safeguarding arrangements but to seek assurances from the setting on their understanding of their safeguarding duties and responsibilities. OFSTED have the duty to make a judgement on settings safeguarding arrangements, those judgements will form part of the GSCP assurance process.

This process requires each setting to have an up-to-date declaration at any given time utilising the provided proforma. It should not be considered as a stand-alone tool but should be a live document and activity routinely reviewed by the Governing Body, Board of Trustees, Management Committee and/or Proprietor and therefore should feature in all settings reporting and internal self-assessment and governance processes.

The GSCP Independently check compliance, details contained in submissions and hold a Focus Group for selected settings, producing a compliance report to the GSCP Executive annually.

Our Safeguarding Partnership

Multi Agency Auditing

The GSCP undertake Multi-Agency Audits which can take the form of either a Multi-Agency Case Audit (MACA) or a Multi-Agency Thematic Audit (MATA).

All Multi-Agency Audit Activity that is undertaken, is overseen by the Quality and Improvement In Practice Subgroup of the GSCP.

Multi-Agency Case Audits (MACAs): *involve a range of key agencies taking a forensic look at the effectiveness of multi-agency working at a case-based level.*

Once audit activity is completed, involved professionals/agencies come together at a MACA meeting to share observations drawn from their related audit activity and to hear the reflections of their partner agencies.

Multi-Agency Thematic Audits (MATAs): *Involve a range of quality assurance activities such as focus or working groups, policy & procedural reviews, and bespoke area or process audits to form a view about the effectiveness of multi-agency working where there is common practice feature to draw out cross cutting practice themes which agencies can learn from.*

Learning is shared through the partnership influencing policy, procedure, training, and other practice improvement areas.

Reviewing Multi Agency Practice: Multi Agency Auditing

Audit Activity:

Third MATA Audit on Strategy Discussions planned for February 2024 – ***Outcome:*** *Progress assurance.* ***MATA Child Sexual Abuse Audit May 2023*** – *Review of all Serious Safeguarding reviews with a presenting theme of CSA, Cross matched to the IICSA Findings and Historic Abuse report.* ***Outcome:*** Understanding on a *thematic basis recommendations and findings from CSA reviews to identify practice themes to be addressed.*

MACA Audit Criminal Exploitation March 2023 – *Three children identified for CE Audit of practice.* ***Outcome****: : Change in practice, understanding multi agency practice arrangements*

MATA Fortnightly MASH Audit Jan 2023 Ongoing – *Testing application of thresholds across the partnership through contact with the Front Door* ***Outcome:*** *Change in practice, understanding thresholds, website consolidation of MASH arrangements.*

MATA Complex Abuse Audit March 2023 – *As part of Complex Strategy process mapping* ***Outcome****: Understanding Process gaps and areas for improvement, Revised Guidance.*

MATA Audit of findings from Safeguarding Reviews March 2023 – *Auditing of Adult Reviews, Serious Case Reviews, Local Child Safeguarding Practice Reviews, Rapid Reviews and Domestic Homicide Reviews.* ***Outcome:*** *Thematic understanding of recommendations and findings from across child and adult safeguarding reviews to identify practice themes to be addressed.*

Our Safeguarding Partnership

Reviewing Multi Agency Practice: Multi Agency Auditing

Audit Activity:

MATA MSM Audit March 2023. *– Review of new My Safety Meeting approach to safeguarding young people* ***Outcome:*** *Developing ways to work with families and children when risk exists outside of the family home.*

MACA Audit Family R Learning Review Feb 2023 - *The audit used the experiences of the family to identify learning and to continually improve the way that agencies work together to safeguard children and young people.* ***Outcome****: Change in practice, understanding thresholds for legal proceedings, arrangements for Strategy Discussions.*

MATA Audit Strategy Discussions Audit Feb 2023 – *Measuring improvement in practice standards.* ***Outcome:*** *Improved timeliness of Strategy Discussions, improved Threshold Application.*

MATA Audit of 'Accidental' Injuries to Non-Mobile Babies Jan 2023 *– part of the GSCP 'vulnerable babies' oversight and follow up on the NAI MATA Audit 2020 and 2019 –* ***Outcome****: Revision of Pre-Birth and Bruising in Non-Mobile Children Policies.*

MATA Audit Strategy Discussions October 2022 *– OFSTED and PEEL Report findings including National Reviews into Star and Arthur prompted GSCP Activity. Process Mapping and Audit exercise undertaken October 2022.* ***Outcome:*** *Creation of GSCP Strategy Discussion Working Group, Revision of GSCP Guidance, Increases partnership resource allocation to timeliness of Strategy Discussions.*

Multi Agency Data – *The GSCP accesses and analyses a range of data from across the partnership using that data and intelligence through its subgroups and working groups to assess the effectiveness of the help being provided to children and families, including early help. Data will be drawn from across all areas of the partnership and benchmarked against national and statistical neighbor data. The use of data is a valuable tool for the GSCP to understand the effectiveness of safeguarding arrangements.*

Our Safeguarding Partnership

Practice Development:

Under 'Working Together to Safeguard Children Statutory Guidance' the local Safeguarding Partnership and their designated relevant agencies, must ensure that effective arrangements are in place to disseminate and learn from safeguarding reviews and other activity locally and nationally.

The multi-agency curriculum on offer through the GSCP Business Unit offers a range of learning opportunities in the form of virtual and face to face training modules and bespoke eLearning courses, allowing participants to build a comprehensive portfolio of continual professional development. All aspects of the curriculum are influenced by local and national learning.

Gloucestershire schools have access to Safeguarding Support through the Safeguarding in Education Team as a Traded Service, managed by the GSCP Business Unit. During 2022, 87% of Gloucestershire Schools bought into this service. Its remit is to support all settings in ensuring they are compliant with Keeping Children Safe in Education legislation.

GSCP Safeguarding Curriculum

Delivers more than 100 virtual and face to face training sessions through a range of curriculum offers every year. Training on average 8,000 to 10,000 practitioners from across the partnership, including education settings and the VCS.

Gloucestershire Schools training saw approximately 100 settings accessing whole school training and other bespoke packages offered through the GSCP Business Unit

Safeguarding Practice Development:

Practice Development Activity

Throughout the year the GSCP offers a variety of practice events and resources linked to current safeguarding priorities.

Webinars/Learning Lunches/eLearning

Thematic Practice briefing sessions.

- *Child Exploitation – NRM Awareness March 2023*
- *Perplexing Presentations and Fabricated or induced Illness Feb 2023*
- *Domestic Homicide Timeline Jan 2023*
- *Domestic Abuse Suicide Timeline Nov 2022*

Education Designated Safeguarding Lead Hubs *– Providing support and guidance on themed safeguarding topics linked to emerging local and national themes.*

Practice (Coffee Break) Briefings *- Developed against findings from Safeguarding Reviews and Audit activity, shared through the GSCP Newsletter as well as saved to the GSCP Website for open access.*

GSCP Newsletters *- Monthly GSCP Newsletter: Disseminates a wide range of information on both local and National theme's; promotes new resources, training courses, webinars, policies and procedural updates, learning from Reviews and local and National campaigns.*

Practice Resources *– Child Protection Handbook, guidance documents and safeguarding toolkits developed as a mechanism to improve practice across the partnership.*

Quality Assurance of inter-agency and single agency training and practice learning *- The GSCP training curriculum requires on-going quality assurance, monitoring of course topics and measurement of impact.*

Our Safeguarding Partnership

Gloucestershire Child Death Review Arrangements

The Child Death review Partners, Gloucestershire Integrated Care Board (ICB) and Gloucestershire County Council must make arrangements to review all deaths of children normally resident in the local area, and if they consider it appropriate, for any non-resident child who has died in their area. The Child Death Overview Panel (CDOP) oversees the local arrangements under the Child death review: statutory and operational guidance (England) and Working Together to Safeguard Children Statutory Guidance through the Child Death Review (CDR) team. The CDR Team are responsible for conducting and coordinating such reviews. The CDR Team comprises of the Named Nurse for Child Death employed through GHC and the Designated Doctor for Child Death employed by Gloucestershire Hospitals Trust supported by the GSCP Business Unit Statutory Review Coordinator and by the GSCP Executive Business Manager.

The Child Death Overview Panel produce an Annual Report which can be found on the GSCP Website

Gloucestershire has a well-established Child Death Overview Panel (CDOP) that facilitates comprehensive multi-agency reviews of child deaths to better understand how and why children die. All child deaths are considered through a safeguarding lens and consideration of local safeguarding arrangements.

- *There was a total of 43 child deaths in Gloucestershire between 1st April 2022 and 31st March 2023.*
- *The vast majority of child deaths in county are not safeguarding relatable with only one child death proceeding to a Rapid Review under the Safeguarding Practice Review Arrangements in 2022/2023 which was conducted as a joint Initial Child Death Review and Rapid Review.*

Our Safeguarding Partnership

Multi Agency Safeguarding Policies and Procedures

Gloucestershire Child Protection Procedures *– The GSCP has a core procedural manual as a foundation that provides effective multi agency working arrangements in Gloucestershire, ensuring that the Multi Agency Safeguarding Arrangements can meet the legislative requirements of the partnership.*

GSCP Local Arrangements - *Working Together to Safeguard Children Statutory Guidance requires the GSCP to have a set of published arrangements setting out how it intends to meet its obligations, alongside of these published arrangements the GSCP holds a range of local Policies, procedures, protocols and guidelines that set out its partnership commitment and approach to safeguarding children. These policies and procedures clearly define how agencies down to practitioner level should be working together to safeguard children.*
All local policies and procedures can be sourced in the GSCP Procedural Manual

Dispute Resolution *- Safeguarding partners and relevant agencies must act in accordance with the published arrangements for their area and will be expected to work together to resolve any disputes locally. The GSCP has a defined dispute or Escalation policy that should be referred to in all cases where two or more agencies disagree in the joint application of any of the partnerships arrangements and always with the interest of the child or children at the heart.*

GSCP Finance Arrangements

"Ensuring that local arrangements are appropriately funded is one of the key tasks of the three Safeguarding Partners. Central government should reaffirm advice to statutory partners that funding has to be agreed by them and not be left in limbo with their delegates and then commit the funding agreed". Allan Wood Review May 2021

The GSCP Executive maintained the previously agreed funding model. The Local Authority, who have historically been the largest contributor, have retained that position but with increased contributions from both the Clinical Commissioning Group and the Constabulary providing growth in the Partnerships ability to meet its statutory duties. This has allowed the GSCP Executive to focus on their statutory duties confident that funding is available and at the appropriate level.