Children's Annual Report 2020/21

Worried about a child or an adult?

What do I need to do?

Know how to report your concerns– if you are worried about a child, young person or adult you may wish to talk to them, listen calmly and reassure them that it's not their fault and encourage them to tell you what's happened. If you can't speak to the directly that's ok but its important that you tell someone about your concerns.

If they are at immediate harm or in need of emergency medical attention call the emergency services on 999

Otherwise if you are worried about a child or young person call Wigan Children's Social Care Team on 01942 828300

If you are worried about an adult at risk then call Wigan Adults Social Care Team on 01942 828777

Abuse, harassment and harm can happen to anyone. It's not always visible and often not spoken about.

Children and adults may be abused in any setting and they may be abused by another adult/ adults or another child or children.

Whistleblowing

If you are concerned about the behaviour of a staff member at an organisation that cares for children or adult, this may include a hospital, care home, school or nursery, you should try and report your concerns to the manager or head teacher or you can call the NSPCC whistleblowing helpline on 0800 028 0285 or email help@nspcc.org.uk

Foreword

Our Vision

'that residents of the Wigan Borough can live safely, free from harm and abuse or the fear of abuse in communities which:

- *Have a culture that does not tolerate abuse*
- *Work together to prevent abuse*
- *Know what to do when abuse happens'*

Colette Dutton, Director of Children's Services, Wigan Council
Alison McKenzie-Folen, Chief Executive, Wigan Council
Craig Harris, Managing Director, Wigan Borough Clinical Commissioning Group
Stuart Ellison, GMP Divisional Commander, Wigan

There has been a real focus across the Safeguarding Children's Partnership over the last 12 months to strengthen our collective arrangements. This has included a complete change in our Multi Agency Safeguarding Arrangements (MASA) in separating from Adult Services. This has ensured a more rigorous focus on issues concerning the safeguarding arrangements for Children within Wigan which were necessary to ensure improvements were made. Through these revisions we have seen the significant benefit of having an Independent Scrutineer who has directed challenge into the system and brought about change.

An important part of making that change happen is how we harness the power and resources of the partnership to drive forward new ways of working together that listen to our children and improve their outcomes within Wigan. This year has brought with it significant challenges, undertaking improvements to services whilst managing a Pandemic has been difficult and it has been the strength of the partnership in understanding what has been necessary and then delivering that has ensured success. We are honest and open across the partnership, about the challenges that we face to improve the services we deliver and are working at pace to make the improvements that we recognise are required. There many strengths to celebrate too, not least the commitment of our staff over the last 12 months, working through an unprecedented time has required us all to adapt and our staff have risen to this

challenge. They remain our greatest asset, and the work done to support and develop our respective workforce, is one of the things that we are the most proud of.

We have the highest ambitions for children, we know ourselves well and have an accurate self-assessment of services, developed through both internal and external scrutiny of our work. With a refreshed senior leadership team within the council and across the partnership we have set a bold and fast paced agenda to drive forward the improvements necessary to strengthen the quality of services we all deliver. Responding to feedback from the regulator Ofsted, a renewed vigour since August 2020 has been in place to drive developments to ensure that good outcomes are consistently achieved for our children and young people in Wigan. Priorities for improvement are based around the 4P's, (Practice, Partners, People and Permanence) and it is progress against these priorities that we have been measuring our success and impact. The establishment of The Deal for Children and Young People Board in November 2020; a multi-agency improvement board chaired by an Independent Chair with membership including the Chief Exec, Lead Member, LGA improvement advisor and strategic Partnership Leads, has been key in holding the local authority and the partnership to account in ensuring that we deliver against the Improvement Plan.

The work across the system throughout the pandemic, ensuring that our most vulnerable residents were protected and supported is detailed in this report. This has not been an easy year, but success in ensuring that we now have the building blocks in place for a successful partnership to deliver effective safeguarding services to children and support to their families, we are confident that we enter into 2021/2022 from a position of strength.

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Section 1: Board Governance

The responsibilities, values and ambitions of Wigan Safeguarding Children Partnership:

1. The Children's Safeguarding Partnership was formed pursuant to the arrangements described in Working Together to Safeguard Children (2018). Wigan Safeguarding Children Partnership has key responsibilities, some defined statutorily and others at a local level:

2. Overseeing the production and delivery of the local safeguarding strategies and plans and ensure that partner agencies have clear and effective strategic and operational responses to safeguarding the people of Wigan and that they discharge their responsibilities effectively.
3. Ensuring that safeguarding plans and processes actively contribute to the Wigan Deal 2030 objectives and outcomes.
4. Ensuring that robust systems and processes are in place to hold partner agencies to account in relation to safeguarding policy and practice and to ensure that serious incidents and/or breaches in policy and practice are fully investigated and lessons learned.
5. Delivering and ensure the provision of guidance, support, and workforce development to partner agencies to enable them to discharge their safeguarding responsibilities effectively.
6. Producing annual business plans and strategic planning documents in line with statutory requirements.
7. Ensuring compliance with all statutory requirements for monitoring and reporting safeguarding activity at strategic level (e.g., reporting of performance management information, compliance with inspections)
8. Ensuring that an appropriate and effective infrastructure is in place to support the Board in delivering the local safeguarding strategy and business plans.
9. Overseeing the commitment of resources to support safeguarding in Wigan including income generation and financial support to the partnership.
10. **Our values** illustrate the approach the partnership will take in delivering its vision
11. Children have the right to live their lives free from violence, abuse, and neglect and to feel safe in their homes and communities.

12. All children and young people should have the opportunity to grow up safely and be protected from abuse and neglect, crime and anti-social behaviour

13. Safeguarding children is a shared responsibility of all agencies and agencies commit to holding each to account.

14. The individual, family and community should be at the heart of safeguarding practice, and we should value and actively seek their views and experiences to shape future practice and policy.

15. High quality multi-agency working based on consensus, equality, respect, and collaboration is essential to good safeguarding outcomes.

16. There is a commitment to continuous improvement and learning across the partnership.
17. **Our Ambition** is that in achieving this we will:
18. Champion the interests and rights of children, young people, and adults at risk of abuse and neglect

19. Ensure there is an emphasis on outcomes for children, young people, families, and adults at risk of abuse and neglect.

20. Provide independent and objective challenge and leadership that is essential to ensure the best outcomes for those in need of protection and safeguarding amidst competing priorities.

21. Involve all partners, not just police, health, and the local authority, with a clear platform and duty to co-operate.

22. Scrutinise and improve practice - using a range of new practice and individual user led approaches and meaningful measures to provide accountable oversight and feedback on performance and outcomes, with a focus on before crisis and that incorporates early help across the life course.

23. Learn from experience and evidence of what works well – creating workable strategic and operational arrangements that fit form to function and are proportionate, efficient, effective, and adequately resourced.

24. Meet the leadership challenge of connecting multiple partners together and collaborate to achieve common goals and within new ways of working.

25. Ensure that every child and young person becomes a confident, resilient adult.

How do we independently scrutinise the effectiveness of the arrangements?

26. Working Together 2018 states that the purpose of the 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. WSCP has chosen to develop the role of an Independent Scrutineer with the aim of providing independent rigour and scrutiny of arrangements in Wigan. This role was appointed to in October 2020.

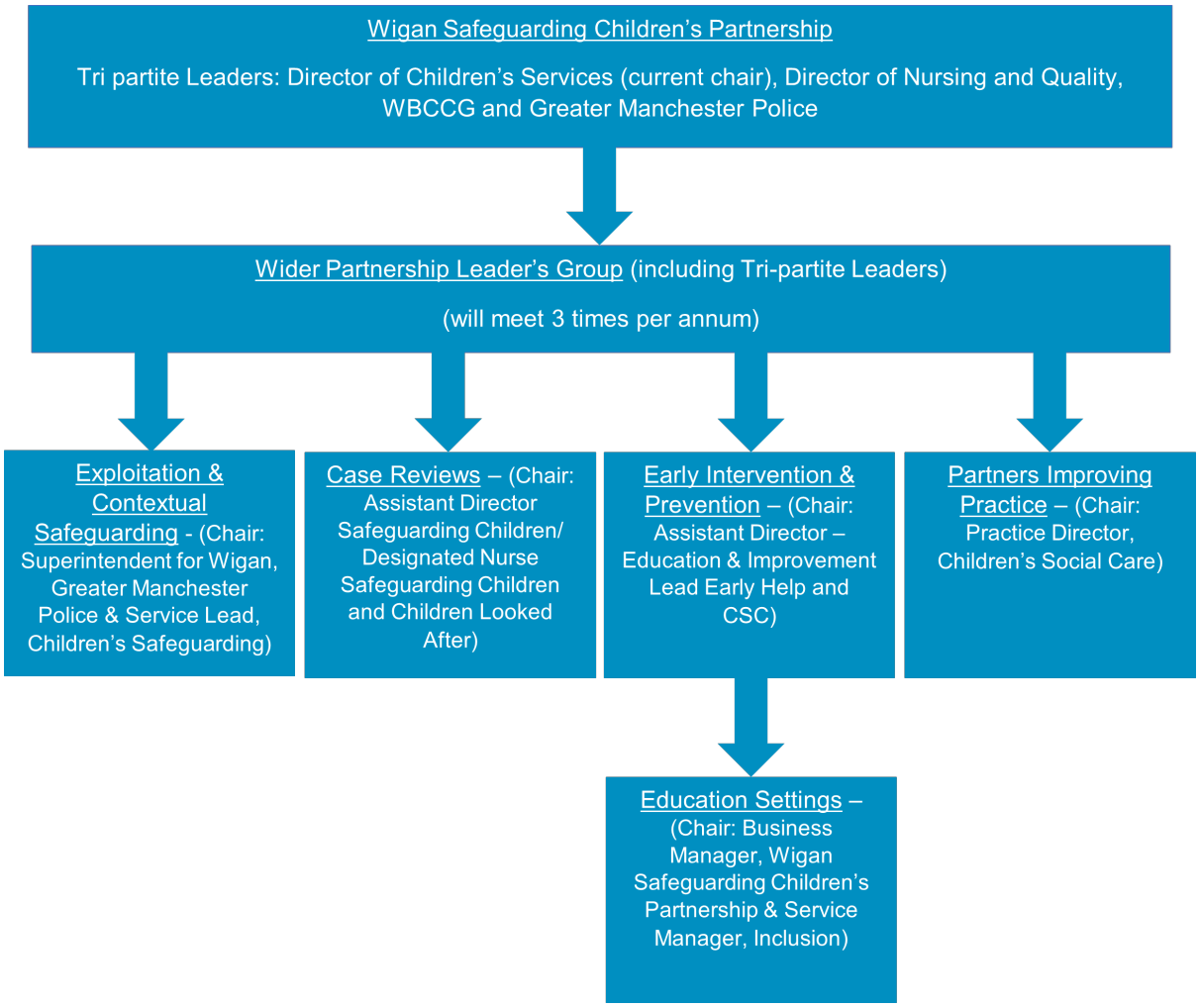
27. This independent scrutiny is part of a wider system which includes the independent inspectorates of the individual safeguarding partners and the joint targeted area inspections.

28. Robust and objective scrutiny cannot rest with one individual or a single exercise, rather it requires a range of mechanisms to achieve two aims:

- To ensure Wigan has robust and effective safeguarding children arrangements in place that are owned and delivered by key partners and all relevant bodies
- To ensure that the plan is subject to regular constructive challenge throughout the year and that the three key partners address identified weaknesses

29. The Independent Scrutineer produced her first report in January 2020 and will routinely scrutinise areas of business in over the calendar year including a published response to the WSCP's Annual Reports.

30. **Wigan Safeguarding Children Partnership Structure:**



Subgroup Reports 2020 -21:

Exploitation Subgroup – Chair Report 2020-21 (Mark Kenny, Superintendent, Wigan, Greater Manchester Police & Glynis Williams Service Lead Children's Social Care)

31. We have a dedicated Complex Safeguarding team which covers both Child Sexual Exploitation and also wider Criminal Exploitation- such as county lines activity.
32. We have a dedicated Exploitation group sitting under the WSCB/CSP - Joint chaired by Police and Social Care with a bespoke action plans with key priority areas namely:
33. **Priority 1:** Ensure single and multi-agency processes and procedures deliver effective protection, support and guidance for victims and potential victims of exploitation and their families
34. **Priority 2:** Develop and embed a whole system (early age / stage) model of assessment and intervention rooted in Contextual Safeguarding policy and practice. Ensuring that our approach incorporates current learning from key areas of work (youth justice etc.)
35. **Priority 3:** Deliver an effective and co-ordinated workforce development and awareness raising plan across organisations and within communities, schools and the wider Service Delivery Footprint
36. **Priority 4:** Measure our effectiveness of the support and interventions we provide and analyse the risk factors of people at risk of exploitation so that this influences future delivery of services.
37. **Priority 5:** Proactively identify and disrupt exploitation activity
38. **Priority 6:** Ensure perpetrators are brought to justice.
39. Each of these priority areas have an identified senior lead across the partnership, ensuring full strategic support is given to the operational delivery of tasks to achieve the priority areas

Education Settings Subgroup – Chair Report 2020 – 21 (Rick Bolton, Business Manager, Wigan Safeguarding Children Partnership and Rachel Clemow, Service Manager - Inclusion)

40. The Education Settings Subgroup includes representation from across the 0-19 years education sector, early years provision, Primary and Secondary schools, special schools, and colleges. The impact of the Covid pandemic has been experienced acutely by these schools and settings throughout this reporting year, with lockdowns and isolation periods running throughout and reducing children and young people's access to a full curriculum and social interactions in settings.

41. In March 2020, at the start of the first national lockdown, the group reviewed the existing 'model safeguarding policy' to include guidance around the emerging prevalence of remote learning via technology, and all safeguarding training to school staff provided as part of the Wigan Safeguarding Children Partnership buy-back offer moved online.
42. Over 2020 the group concentrated on several key workstreams:
43. Supporting schools and settings, and therefore children and families, through the Covid Pandemic.

44. Managing Training needs within the sector.

45. Embedding the new thresholds of need strategy and guidance in schools and settings.

46. Review of Wigan policy and protocols to support families who choose to Electively Home Educate their children, ensuring the decision is in the best interest of the child.

47. Redesign and creation of digital process for S.175 safeguarding assurance returns.

Partners Improving Practice Sub-Group – (Sandie Hayes , Practice Director, Wigan Children's Social Care)

48. Membership of the Sub-Group has increased over the past year and attendance is good. Priorities over the past six months has included embedding the Neglect Strategy and Graded Care Profile which has been launched and included in the Thresholds of Need update. Briefings about the Domestic Abuse Act have been delivered across the partnership and programmes for victims and perpetrators are now available.
49. The Workforce Development offer has progressed and engagement in learning across the partnership is positive including multi agency participation in 'learning circles'. The group are driving the continued embedding across the partnership of Signs of Safety developing a bespoke training offer for partners as knowledge bites.
50. The Sub-Group aims to engage with and increase membership of the third sector and community groups.

Case Review Sub-Group – (Nichola Osborne, Assistant Director Safeguarding Children/ Designated Nurse Safeguarding Children & Children Looked After)

51. The Case Review Sub-Group was created to reduce the workload of the Partnership Improving Practice Sub-Group and bring increased focus on the case review elements of partnership work. The Sub-Group is chaired by the Assistant Director of Safeguarding Children from WBCCG, and the inaugural meeting was held in Quarter 4 of 2020/21. Attendance remains variable with some agencies having not yet attended any meetings, this has been escalated to relevant system leaders. The group have developed a Terms of Reference and work plan which outlines how we intend to review and approve action plans from legacy Serious Case Reviews whilst implementing a new approach to the newer style of Local Child Safeguarding Practice Reviews (LCSPRs).

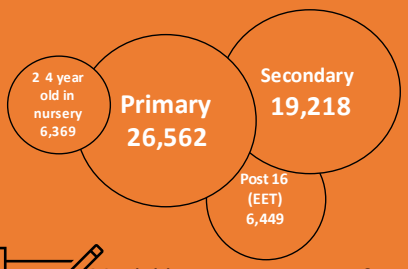
52. Our priorities going into 2021/22 are to:
53. Explore with Partners who has the necessary skills within the system to lead on LCSPRs and Brief Learning Review (BLR's).
54. Ensure a robust oversight to manage the anticipated timescales for completion of cases to ensure learning is disseminated and embedded at the earliest opportunity.
55. Ensure that workforce development, training, and quality assurance processes align with learning from case reviews and the priorities of WSCP.
56. Obtain assurance that Partners are embedding findings, recommendations and learning from WSCP case reviews into front line practice and that as a Partnership we can evidence impact of intervention.

57. Work with our Independent Scrutineer to review good practice from other Safeguarding Children Partnerships which enable us to get to the heart of key wider thematic learning, truly change culture in frontline practice and most importantly improve the outcomes for children and young people in the Borough.

58. **2.1 Section 2: About Wigan Children:**

What do we know about Children in Wigan?

Approximately there are 75,500 children aged 0- 19 that live in Wigan.



2128 children have an EHCP

6751 children receive SEN support

24% of children receive Free School Meals – an additional 2,232 since Jan 2020

91% of Wigan schools are Good or Better. 95% of all Wigan leaners in good or better Primary School, 100% of children in special schools, and 72% of children attend a good or better secondary school

30 children were missing from education (end March 2021)

229 children had a Part time timetable

337 children registered as being Electively Home Educated at end of March (+106 from 2020)

- In autumn 2020 on average 17.5 sessions were lost per child in Wigan due to COVID absence
- 13,220 children isolated between Sept – December 2020.
- 77.1% of pupils had at least 1 COVID absence during Autumn compared with 58.5% nationally

*data as at end march 2021 unless other wise stated

Safeguarding activity in 2020-2021?

5089 referrals for Children's Social Care in the last 12 months – (Police 31.4%, Education 13.7%, Health 14.9%)

We initiated 1644 Section 47 investigations, which led to 623 initial child protection conferences

At the end of March 2021 we had 2678 children and young people open to Childrens Services.

463 of these had a Child Protection Plan
596 CPP started (27.6% of these for the second or subsequent time)
509 CPP ended in the year

We completed 6841 assessments over the year

At the end of March 2021, 646 of the children open to us were looked after (21% more than last year)

174 Care Leavers,
46 aged 17-18
128 aged 19-21
We are in touch with 93.6%
91.9% in suit. Accomodation
43.5% in EET

246 children started to be looked after in 2020/21 and 129 children ceased to be looked after in the year.

95 children in our care were missing form during the year, this amounted to 691 incidents (slight reduction -1.4% on prev year)

Preliminary end of year data

Section 3: Review of the Partnership Priorities 2020 – 2021:

59. One of the Wigan Safeguarding Children Partnership's key areas to progress over 2020-21 was to accelerate the cycle between learning from review processes to establishing new, improved practice. The Partners Improving Practice Sub-Group provides governance and direction to this work whilst it is led operationally within each partner agency. What follows are updates from around the Partnership on how they have achieved this outcome:

NHS Wigan Borough Clinical Commissioning Group (WBCCG)

60. As part of their statutory responsibilities the Designated and Named Safeguarding Children Health Professionals within the WBCCG Safeguarding Team take the lead role in ensuring robust processes are in place across healthcare services to learn lessons from all safeguarding reviews such and Serious Case Reviews (SCRs), Local Child Safeguarding Practice Reviews (LCSPRs) and Brief Learning Reviews.

61. The WBCCG Safeguarding Team have oversight of NHS Provider safeguarding arrangements and progress of action plans for safeguarding reviews via WBCCG quality directorate governance arrangements. This includes bi-monthly Quality and Safeguarding Groups (QSGs) meetings with each NHS Provider to review and monitor compliance with quality standards as specified in the Acute and Community contracts. Alongside QSGs the WBCCG safeguarding Team also obtain assurance by way of assurance visits to review evidence against 'Clinical Commissioning Groups Safeguarding Children, Young People and Adults at Risk Contractual Standards' with NHS providers and through the 'General Practice Safeguarding Assurance Toolkit' in General Practice as outlined in the WBCCG section of the report.

62. The purpose of QSGs is to:
63. Provide assurance that commissioning incorporates and upholds the tenets of Clinical Governance (patient safety, clinical effectiveness; and experience).
64. Promote and assure clinical quality so that patients receive effective and safer care with a positive experience of services commissioned by WBCCG.
65. Oversee the execution of the WBCCG's duties in relation to safeguarding of children and adults.
66. Provide systematic assurance to the WBCCG Quality Sub Committee on the quality and safety of Acute and Community Healthcare Services commissioned on behalf of and for the population of the Wigan Borough.

67. In addition to the above, and to review the evidence in more detail, the WBBCG Safeguarding Team would usually undertake visits to establish Wigan NHS Providers' progress against recommendations and subsequent action plans from safeguarding reviews commissioned by WSCP. The WSCP Business Manager is invited to take part in the visits to provide an independent view from a non-NHS perspective.

68. Unfortunately, due to the pressures on the WBCCG Safeguarding Team due to the Covid 19 pandemic this activity was deferred in 2020/21. This was in line with Covid 19 guidance from NHS England and Improvement (NHSE/I) who disseminated 'Prioritisation within Community Health Services' which set out how providers of NHS Providers could release capacity to support the Covid 19 preparedness and response. In this document Designated and Named Safeguarding Health professionals were directed to reduce time spent on SCRs. Clinical Commissioning Groups (CCGs) were also directed to cease all non-essential assurance activity to allow NHS Providers to focus on the Covid 19 response.

69. In previous validation visits conducted in 2019/20 to explore how NHS Providers had embedded the learning from Serious Case Reviews WBCCG found that their Safeguarding Teams had a clear oversight of the SCR Action Plans which had been completed and supporting evidence was seen and reviewed on the day. Any outstanding actions were clearly explained and deemed to be reasonable. The reviewers were impressed with the volume and quality of the work the NHS Provider Safeguarding Teams had achieved. The process demonstrated that the Named Nurses for Safeguarding Children had robust systems and processes in place; and the NHS Provider Organisations had robust governance and oversight of the work of their Safeguarding Teams.

70. This work will be revisited in 2021/22 and the reports shared with WSCP.

Mersey Care NHS Foundation Trust (Mid-Mersey Division, formerly North West Boroughs NHS Foundation Trust).

71. Prior to April 2021 the provision of mental health services in the borough of Wigan was facilitated by North West Boroughs NHS Foundation Trust, which was then acquired by Mersey Care NHS Foundation Trust. In Wigan since April 2021 all mental health provision is commissioned from Greater Manchester Mental Health NHS Foundation Trust. For the purposes of this Annual Report which covers April 2020 – April 2021 the information was given by Mersey Care NHS Foundation Trust.

72. Over 2020 – 21 the Safeguarding team at Mersey Care committed to implementing Quarterly Learning Themes and supporting learning presentations. These were delivered, taking lessons directly from SCR to frontline practitioners and included lessons learned around Effective Use of Escalation Procedures, Understanding Thresholds of Need, Contextual Safeguarding and Adolescent Neglect. Wigan Safeguarding Children Partnership's 7 Minute Briefing documents have also been cascaded across the workforce to strengthen the quarterly themes and promote positive practice.

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

73. Throughout 2020-2021 Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation trust (The Trust), have contributed to all safeguarding reviews, including Serious Case Reviews (SCR's), Local Child Safeguarding Practice Reviews (LSCPR's). As part of their statutory responsibilities the Named Safeguarding Children along with the Named Nurse Safeguarding Adults have taken the lead roles in ensuring robust processes are in place across The Trust to learn lessons from these reviews.

74. The Safeguarding Team have progressed the associated action plans from both a single agency and multi-agency perspective. The progress of these action plans has been monitored via the Trust's Safeguarding Effectiveness Group which is chaired by the Chief Nurse. They are also monitored via the governance arrangements with Wigan Borough Clinical Commissioning Group (WBCCG). This includes bi-monthly Quality and Safeguarding Groups (QSGs) meetings between the Trust and WBCCG.

75. In addition to the above, the WBBCG Safeguarding Team undertake visits to establish the Trust's progress against recommendations and subsequent action plans from safeguarding reviews commissioned by WSCP. The WSCP Business Manager is invited to take part in the visits to provide an independent view from a non-NHS perspective. However due to the pressures on both Safeguarding Team's due to the Covid 19 pandemic this activity was deferred in 2020/21.

76. The aim of the Trust Safeguarding Team has been to embed learning into frontline practice. The Team have achieved this through various approaches. These have included:
    - Working with relevant teams within the Trust to develop and or update relevant Policies and procedures.
    - Develop our model of safeguarding supervision to frontline practitioners to consider themes emerging from case reviews.
    - To include themes and learning from reviews into safeguarding mandatory training to all Trust staff.

- To develop and deliver bespoke training packages to identified staff groups. These themes have included professional curiosity, escalation, use of tools and assessments, avoidance of victim blaming language and domestic abuse routine enquiry.
- Working with partners to embed a Signs of Safety approach.
- Developing a Think Family Safeguarding Team approach to consider all family members when working with children and families.

Greater Manchester Police:

77. The Recording of Strategy meetings/minutes and ensuring these are placed on police recording systems was highlighted as an area for improvement for Greater Manchester Police in 2020-21. As result the Greater Manchester Police central Public Protection Governance unit has developed and disseminated guidance on triage expectations (Child Protection, Domestic Abuse and Adult Safeguarding) and Strategy Meeting Guidance to GMP Vulnerability leads across Greater Manchester Police.

78. Following final sign off by Chief Officers, GMP have implemented phase one of planned changes to its investigation and safeguarding model on the 27th September 2021. The new model is a key element of the Force's 'Planning Our Future: Building a New GMP' strategy which was announced by Chief Constable Stephen Watson. It will help us to work effectively with partners to fight, prevent and reduce crime; reduce the risk to vulnerable people; and stop people becoming victims in the first place.

79. Under this model, the Force will have specialist units, officers and staff in the areas of child protection, serious and complex criminal investigation, adult safeguarding and complex safeguarding. This change will enable us to offer an enhanced service and address concerns raised by staff, partners, victims and HMICFRS.

80. With Wigan, each of the units will focus on its specialist area and also work collaboratively with other teams and partners to problem solve and deliver the policing services we know our communities deserve.

81. The new structures focus on having the right number of staff with an interest in their specialist field to meet demand and with the right training and leadership to work with partners effectively to offer the best possible service to vulnerable children and adults in Greater Manchester.

82. The new Child Protection Investigation Units will work closely with partners to identify children that are most at risk of becoming victims or offenders and find the best outcomes for them and child protection investigations will be dealt with or supervised by a specialist officer.

83. There will be a child protection triage 'front door' and single points of contact for partners. The units will investigate all child protection crimes allocated via the Children's Crime Allocation Triage (C-CAT) or Child Protection Triage and conduct joint visits and child protection medicals with partner agencies. The child protection case conference function will sit within the CPIU which will allow daily discussions around children and families who are most at risk to take place.

84. Following the force wide Investigation and Safeguarding review GMP have re-introduced specialist Child Protection teams back onto districts. For Wigan this equates to 2 detective Sgts, 10 detective constables, 6 police constables, 2 case conference leads, 1 case management officer and additional administrative staff, all overseen by a dedicated detective Insp.

85. Wigan are currently recruiting an additional dedicated Detective Superintendent, an additional vulnerability DCI, 2 additional Detective constables, a further case management lead and additional administrative support to enhance our safeguarding response

Children's Social Care

86. Over the last twelve months we have amended and strengthened many of our policies and procedures to support our safeguarding activity to improve the experience that families have with our services.

87. The supervision policy was refreshed. It was recognised that our management oversight was not always clear on case files and didn't provide enough challenge to social workers to ensure that consistently good decision was recorded for children (identified in Ofsted visits and through our internal quality assurance processes). We were previously not using supervision as a tool to raise the standards of practice. The new supervision policy makes clear the importance of personal and profession supervision and provides clear guidelines about the frequency of supervision. The purpose of supervision is to support the social worker in both their profession development but also, importantly to provide time for reflection on the impact of the work that we are doing with the family. Effective supervision is a key enabler of raising the standards of practice throughout our services.

88. Another key development for Wigans children's services has been the refreshed practice standards. These set out the expectations for practitioners working within the Signs of Safety practice model and should be used a working document to guide practitioners in their day-to-day practice. Compromising of seven standards they will be critical in ensuring that we have consistent practice across the service.

89. Children and families will be placed at the heart of everything we do

- Every child will have an assessment of their individual needs
- All children will have an assessment which reflects their strengths and assets, their family and safety networks

- All children's plans will be developed with children and the people that care for them
- Children's case records will provide a clear story about our services involvement
- Every child's journey through our service must be supported by regular, timely management oversight of the work
- Staff will use signs of safety as out practice model to resolve problems and improve children's lives; 'with' children and families as opposed to doing 'to' of 'for' them.

90. One of our key areas of develop last year was the bringing together all of the policies and procedures for safeguarding children into the Wigan Workforce Essentials site. This has made all of the policies and procedures accessible for our employees and they have reported that this has been helpful to their practice.

91. Over the last 12 months one of the biggest changes to policy has been the refresh in the threshold of needs for the partnership. We took a leading role in this and have been integral to the roll out of the new thresholds, leading a number of multiagency training sessions to partnerships, schools, voluntary sector organisations about the thresholds of need. The renewed threshold of need focusses on supporting children, young people, families, carers, and communities to help themselves wherever possible by developing a strengths-based model/ approach. It outlines that services should work to quickly identify children, young people, families, or carers who might need extra help from them. It also makes it clear that services should act quickly as soon as they know help is needed. Our developments at the Front Door and the move to an integrated front door will support this work going forward into the new reporting year.

92. Underpinning our understanding of the improvement activity that we have undertaken this year is the refreshed Quality Assurance Framework. Our approach to quality assurance focusses on the quality of practice and helps us to understand the things that we are doing well, and where we need to improve. Our ambition to create a learning culture is growing and the Principal Social Worker is key to this in her role around QA and workforce development, allowing us to identify the issues in practice and embed the learning. There has been much improvement over the last 12 months in the approach and participation of auditing, but we recognise that this needs to further mature, and this will continue to be one of the priorities for the upcoming year.

93. We have introduced 'WES' Wigan Workforce Essentials in SharePoint. This directory has over 47 practice folders, and 270 documents including various training and further learning and development materials.

94. All staff across children's social work have accessed 'Essentials' training and Managers have accessed training sessions on management standards. Our focus this year has been about being 'brilliant at the basics.' This training has

provided staff with an opportunity to reflect and learn about the core principles of our practice and how we work with children and families.

- Sixteen sessions across six were delivered to dedicated team groups, totalling 96 half days, offering 1152 training places to the staff group. 153 staff attended. The sessions took place between Jan 2021 – May 2021. Content was as follows:
- Child Care Law
- Pre-proceedings and preventing the need to issue
- The importance of permanence being at the heart of what we are aiming to achieve for children in Wigan
- Engaging with families, working in collaboration, working with strengths, and doing our best work early on
- The Public Law Outline process, including writing a Social Work Evidence Template (SWET) and care planning
- Key skills for social workers i.e., chronologies and genograms
- Specialist assessments, and the importance of getting the analysis right
- Giving evidence in Court
- Working with private proceedings

95. In terms of evaluation and impact, this is measured throughout auditing process. We identified that we needed to invest in our support to social workers working with families in court and created and recruited to a post for a court progression officer to lead on this development work.
96. We also received training from the Local Government Association (LGA) on Outcome Focused Audits in November 2020. 46 attended. Subsequent to this the trainer is holding one to one moderation sessions with the auditor pool, to enhance their development and audit skills.
97. Evaluation and impact of the audit training has shown some green shoots of improvement through ongoing moderation of audits.
98. Agreement with the overall judgement given on audits, although still some differing judgements on some sections of the audit tool.
99. There is still some inconsistency in the richness of the detail about audit findings; we do have some good practice to be learned from.
100. We can improve in the level of evidence and analysis provided about how auditors arrive at judgements, with clearer direction provided to the SW about the improvement required.
101. Actions are not always SMART; we could be clearer with dates for actions to be completed.
102. Closing the loop and using the learning from audit in case supervision is area that we need to become more mature in.

103. Quality assurance activity will continue to be a priority focus for the service in the next 12 months.

104. Another key development for us in the last years was the development of the Children's services continuous professional development booklet. This has been key to enabling our workforce to access and identify the training that

we require them to undertake as part of their role, and also to seek opportunities for further learning to improve their practice.

105. For managers, the resource is helpful in identifying opportunities to develop and enhance our learning culture within their team. We encourage the use of the toolkit in My Time and Supervision discussions with team members to help support them to develop their skills as well as more generally through team meetings and informal catch ups.

106. Our employees regularly access the learning offered through the Partnership arrangements and provide support for training for partners on the use of the graded care profile, private fostering, signs of safety, threshold of need.

107. Despite the covid pandemic our commitment to training and developing our workforce has not faltered. The use of online training has actually enabled us to make training more accessible for our workforce and ensured a wider reach.

108. We continue our improvement journey through the pandemic as an ambitious and determined leadership team with a shared vision and commitment to improvement in outcomes for children and young people in Wigan:

"We want all children in Wigan to be happy, healthy and safe; to feel listened to and to have the maximum opportunities to be ambitious. If children or their families need help and support it should be at the right time, by the right person and in the right placed for them. To achieve this, we want to be 'brilliant at the basics' in our practice and, by having creative and collaborative partnerships. We want our staff to feel supported, confident and skilled to help our children and families achieve their aspirations."

Start Well Early Help and Targeted Youth Support Service:

Early Help / Start Well:

109. For early help and start well have implemented various strategies to improve frontline practice to support learning from Serious Case Reviews, and in addition to SCR's (now Local Child Safeguarding Practice Reviews) , there is also the Brief Learning Review and Rapid Review process involvement.

110. Managers are encouraging professional curiosity and challenge with staff, and ensuring that the SOS model is embedded, alongside the new practice standards. The updated threshold document has been shared and is being used to ensure that the cases are sat with the right service area, in line with the level of risk.

111. There has been a new supervision process and format in Early Help Module (EHM) to provide clear management oversight on cases, this will bring about further challenge and reflections for all cases open to early help.

112. Regular audits are now taking place monthly and there has been increased compliance around this. This will ensure that not only quantitative

data is being obtained and used to aid practice, but also the quality of the work we do.

113. The use of Strengths and Difficulties Questionnaires in parenting input/assessment and planning has also allowed staff to remain focussed on the identified needs, and where the support is needed. The implementation of genograms, chronologies and case summaries on all cases ensures that workers are using the history of the cases to inform their practice, and also identify any risks from theses.

114. All cases now require management oversight to be added upon allocation and a case discussion with the allocated worker. This ensures staff have a good understanding of the case and the history, the work to be completed, and clear actions to follow. It also ensures consistency across the service.

115. Weekly meetings with early help and MAST managers are held to ensure cases are not being passed from each service area without planning and this builds better relationships between services to provide a better service to the children and families of Wigan.

Targeted Youth Support Service (TYSS):

116. The Brief Learning Reviews held on young people known to TYSS were attended by staff and managers involved with the cases. The reviews facilitated the sharing of information by agencies and provided the opportunity for workers to reflect on the cases and the concerns identified.

We Are With You (Substance Misuse Service):

117. At the end of Feb 2020 just before the period for this annual report the substance misuse service provider in Wigan for many years, Addaction, renamed to become We Are With You.

118. Over 2020-21 We Are With You continued to attend all case reviews that are linked to young people, service users or significant others that are in treatment (with the service or where substances have been a contributing factor to the incident.

119. All of the above cases were reviewed by We Are With You's management team and this included a deep dive into case management. This information allowed the service to reflect and explore missed opportunities, gaps in treatment and offered information to identify missed opportunities that can therefore lead to the implementation of new processes and improved ways of working and best practise.

120. Over 2020-21 the learning from these processes was shared with the team at the monthly Service Meetings and are followed up with new practice guidance, and some new internal systems like the Safeguarding Tracker were implemented.

121. The Safeguarding Tracker was a response to the management oversight, reflective practice of the team and collaborative work with Wigan Safeguarding Children Partnership's Learning and Improvement officers as part of one of the Serious Case Review's (SCRs) undertaken by WSCP in 2020. This SCR identified that information known by We Are With You regarding a positive parental drug test, had not been shared with social care. The children in the family of the SCR were subject to 'Child in Need', indicating a level of vulnerability, and as social care had no corroborative information that the parents were using substances at the time, it would have been highly relevant to share.

122. The safeguarding tracker details all cases known to social care and provides continuous process mapping, This document is then reviewed in every Supervision and the Team Leader audits the case to ensure that all information and risk is shared with social care and relevant partners.

123. During a CQC inspection of We Are With You the safeguarding tracker process was identified as good practise and this has been rolled out organisationally to all We Are With You projects across the country and is now implemented into new contracts.

124. The We Are With You Service Manager has remained a member of both the Safeguarding Adult Board and Wigan Safeguarding Children Partnership, allowing a life-course oversight of the issues as a service provider to all age groups.

125. We Are With You continues to have dedicated safeguarding leads who meet to share learning, reflect, and examine the case and identify responses and these are cascaded organisationally to ensure safe practises across the wider organisation.

126. The service is commissioned by Wigan Councils Drug and Alcohol Team and is subject to quarterly reviews of the contract and partnership with Wigan Council, at these meetings local safeguarding issues are discussed and monitored.

127. The Drug and Alcohol Commissioning Team also attend all case reviews to ensure learning is reflected into service delivery improvements and to inform our work to prevent drug and alcohol related deaths.

Education Service:

128. Over 2020-21 Education service safeguarding leads have established processes to ensure appropriate representation is available for case reviews. This involves identifying which schools and settings have been supporting the child or family and if any education services have provided specific intervention.

129. Evidence and recommendations from reviews are cascaded to local authority education services, schools and settings safeguarding leads through a number of forums including training, briefings, DSL networks, newsletters,

heads forums and a specific Governor briefing programme which runs twice yearly.

130. The Wigan Safeguarding Children Partnership training team provide a school newsletter to cascade key information for action and understanding, ensuring schools and settings understand implications for their provision. In addition to this the Early years team provide newsletters to that sector where key messages are shared and an annual conference.

131. The Wigan Safeguarding Children Partnership Education settings Subgroup has agenda setting according to key themes from learning reviews. Learning is discussed with key leaders from all education sectors and format for cascading information agreed.

Greater Manchester Fire and Rescue Service (GMFRS):

132. As part of the GMFRS Programme for Change and on-going work to improve our safeguarding supervision, the organisation has regular referral review meetings that include sharing learning outcomes from local Safeguarding Boards.

133. GMFRS have also increased the number and skill levels of our Designated Safeguarding Officers (DSOs). We will have 37 DSOs by the end of July 2021 who will have completed an FAA Level 3 Award in the Principles of Safeguarding Children, Young People and Vulnerable Adults (RQF). GMFRS DSOs provide 24/7 support to frontline staff where safeguarding may be a concern. A new Safeguarding Development Officer fixed term post has been added to the GMFRS Prevention structure, the responsibilities of this role will include taking lead on GMFRS Safeguarding, development of our internal Safeguarding Policy and Procedure and identifying training needs. All GMFRS staff are required to complete e-learning safeguarding training annually, in addition the new DSOs will complete new or refresher training every 3 years.

Domestic Abuse:

134. The response to domestic abuse, and the damaging effect it has on children in our borough remained a priority area for the Partnership over 2020-2021. Wigan remains the busiest district in Greater Manchester in terms of calls to the police regarding domestic incidents, and it is a concurrent feature either as the primary reason for multi-agency intervention or as a contributory factor in a significant proportion of work across the partnership agencies.

NHS Wigan Borough Clinical Commissioning Group (WBCCG)

135. The WBCCG Safeguarding Team hosted one virtual GP Safeguarding Lead meeting in Quarter 3 chaired by Dr Tankard Named GP Safeguarding Children and entitled 'The New Wigan Domestic Abuse Strategy and The Role of Primary Care'.

136. Presenters included the Business Manager for Domestic Abuse, Sexual Violence and Public Service Reform (PSR) Hub (Wigan Council) and the Chief Officer from 'Drop in and Share' (DIAS) and Wigan Borough Domestic Abuse Service.

137. Two sessions were offered virtually via MS Teams, and they covered the following key areas:

- The Wigan Domestic Abuse Strategy 2020-2030
- The Domestic Abuse Community Contract (DIAS)
- The new Domestic Abuse Bill 2020

138. The WBCCG Safeguarding Team developed a monthly GP safeguarding newsletter to alert GPs to safeguarding issues expected to increase during the Covid-19 lockdown such as domestic abuse, this included guidance about how to be alert to domestic abuse when conducting consultations using virtual platforms.

139. In Quarter 4 of 2020/21 the Assistant Director Safeguarding Children/Designated Nurse conducted a Multi-Agency Risk Assessment Conferences (MARAC) scoping exercise as part of the work of the Greater Manchester (GM) Designated Clinical Network for Safeguarding Children and Designated Clinical Network for Safeguarding Adults to look at current health provider contributions to the Wigan MARAC process. Subsequently we conducted a scoping exercise to benchmark NHS Providers in the Borough against numerous domestic abuse guidance and standards application to health providers (see bullet pointed list below).

140. Department of Health guidance - Responding to domestic abuse: A resource for health professionals - https://www.gov.uk/government/publications/domestic-abuse-a-resource-for-health-professionals

141. Domestic violence and abuse: multi-agency working, Public health guideline [PH50]

    a. https://www.nice.org.uk/guidance/ph50

142. University of Bristol/Pathfinder Project - https://irisi.org/pathfinder-toolkit-new-model-launched-to-transform-health-systems-response-to-domestic-abuse/

143. Adult Safeguarding: Roles and Competencies for Health Care Staff - https://www.rcn.org.uk/professional-development/publications/pub-007069

144. Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff - https://www.rcn.org.uk/professional-development/publications/pub-007366

Mersey Care NHS Foundation Trust (Mid-Mersey Division, formerly North West Boroughs NHS Foundation Trust).

145. Responding to the rise of concerns around Domestic Abuse under the pandemic lens, the Trust revisited and refreshed existing policy and procedures to reflect changes to working practices and opportunities to identifying domestic abuse. To strengthen this an interactive Domestic Abuse Toolkit was created which prompts staff in routine questioning and navigates staff towards local pathways for responding effectively to concerns about domestic abuse.

146. Domestic Abuse (DA) training has been converted to virtual delivery and a revision of contents has brought current key messages and expectations for staff and provides a practical learning around 'Asking the question' and completion of Domestic Abuse Stalking and Harassment (DASH) Risk Assessments and referrals to local Multi-Agency Risk Assessment Conference (MARAC) and DA Services.

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

147. The Trust have recently updated the Domestic Abuse Policy to combine the legacy policies from Wrightington, Wigan and Leigh and Bridgewater. This is now an overarching policy which now includes Domestic Abuse, Honour Based Violence, Human Trafficking and Female Genital Mutilation. It is now available on the Trust Intranet.

148. The Trust has a hospital IDSVA Service (Independent, Domestic and Sexual Violence Advocate). This comprises of 2 IDSVA's who are hospital based and sit within the Safeguarding Team. They accept referrals from the hospital and community staff in respect of domestic and sexual abuse. IDSVAs can be contacted to support staff or potential victims when there are concerns or disclosures regarding domestic abuse.

149. The IDSVAs Service posters are throughout hospital and community environment with tear off telephone contact numbers. This includes patient and staff toilets and in waiting areas.

150. During the pandemic DA information leaflets are given to every person attending for a Covid test and vaccine. The Trust is exploring options to add the leaflet to the Email invite for the COVID vaccination.

151. The Trust has a number of services such as Midwifery and Health Visiting where routine enquiry in relation to domestic abuse is part of standard practice. These services have Standard Operating Procedures which are audited to ensure compliance. These services are also able to accept professional support from our IDSVA's. Services such as Midwifery create opportunities to see women alone to enable exploratory conversations. Routine enquiry is part of standard practice and this is audited. Appointment letters outline that women will be seen for part of the appointment alone.

152. Domestic Abuse Training is now mandatory, therefore all Trust staff have a minimum level of awareness regarding domestic abuse. In addition Level 3 domestic abuse training includes guidance around how to enquire about domestic abuse sensitively and supportively through an explorative conversation. This is also reinforced through safeguarding supervision.

153. The Safeguarding Team attend daily Multi-Agency Risk Assessment Conference Meetings (MARAC), they share relevant health information and contribute to the multi-agency plan to protect victims and children. The action plans are shared with midwifery and the 0-19's service.

154. In Quarter 4 of 2020/21 the Assistant Director Safeguarding Children/Designated Nurse conducted and Named Nurse Safeguarding Children completed a Multi-Agency Risk Assessment Conferences (MARAC) scoping exercise to look at the Trust's contributions to the Wigan MARAC process. Subsequently we conducted a scoping exercise to benchmark NHS Providers in the Borough against numerous domestic abuse guidance and standards application to health providers. The outcome was that most actions were 'green' with only 2 ambers which are currently being progressed.

Greater Manchester Police:

155. GMP DA Policy and Procedures are currently being revised and updated to reflect the new DA enactments, general changes in Domestic Abuse, drawing on areas of best practice and support new systems

developed to improve our DA response which includes but not limited to, however over 2020-21 significant progress was achieved:

156. Our Domestic Violence Protection Notices and Orders (DVPN/O) Policy was revised to create a more robust and transparent process to support victims and manage offenders. Updates include key changes in respect of the roles and responsibilities for the Inspector rank and the Multi Agency Safeguarding Team. This generated Continuous Professional Development (CPD) Online Training Sessions for Inspectors & District Multi Agency Safeguarding Hubs

157. There is a strong partnership response to Domestic abuse, and we aim, with our partners in the Public Service Reform (PSR) Hub and other key partners, to offer a response to every person who reports domestic Abuse, which given that Wigan is the busiest district within GMP for reports of Domestic Abuse receiving over 7000 reports per year, is a significant achievement

158. Domestic Abuse Triage- GMP also strive to ensure that all incidents of domestic abuse are triaged further by a specialist team within 24 hours. This has required a significant investment in resources in order to meet this particular target, with 17 staff deployed into a triage role.

159. **Children's Social Care**

160. The Practice Director chairs the Partners Improving Practice subgroup, and the domestic abuse action plan is reported through that. We have been raising awareness of the resources available to support the families we work with who experience domestic abuse. The service lead for domestic abuse has attended all service briefings to share the toolkit and raise awareness about programmes and interventions that are available. With the inception of Domestic Abuse Bill and the increased statutory responsibilities that this Bill brings, there will be an even closer working relationship between children's services and domestic abuse services.

We Are With You (Substance Misuse Service):

161. We are With You's Wigan Operations Manager is a dedicated domestic abuse Single Point Of Contact and is available at all times to support improvements to the MARAC process as well as field any conversations around referrals that police may need to clarify before a case is heard. The relationship between Multi Agency Risk Assessment Conferences and We Are With You continues to be effective.

162. The service manager for We Are With You represents the organisation on a domestic abuse task and finish support group which is chaired by Wigan Council and attended by a range of agencies. This meeting is an information sharing to ensure knowledge and the wide range of activities and support available to perpetrators, victims and family members affected by domestic abuse.

163. We Are With You have a partnership with Intuitive Thinking Skills and this offers perpetrators and victims of domestic abuse the opportunity to attend a course with cohorts 6 times per year for 30 people. The course provides a whole family approach to addressing domestic abuse, with the 'enough is enough' programme delivered for affected others and 'this ends here' for perpetrators. This course is also extended to probation clients and those identified through the PSR and victim hubs as requiring interventions to support a reduction in domestic abuse.

164. All staff undertake the domestic abuse e-learning provided by DIAS - this is mandatory for all new and existing staff to complete.

165. The service has a Domestic Abuse Lead who is available for all staff members to discuss cases, this worker represents the service internally and externally and shares relevant learnings and best practise.

166. We Are With You offer a community approach to treatment, this offers access to treatment without having to walk through the doors of a treatment centre, work is being done to embed this model in refugees across the borough as alcohol use is often a significant factor for those who have been victims of domestic abuse.

167. The service is working on a trauma informed care package and all staff will be trained up in this area.

168. We Are With You support the scheme created by the government 'Ask for ANI' (Action Needed Immediately) this is a code word scheme to enable victims of domestic abuse to access immediate help from professionals, posters with details are up in buildings, waiting rooms, toilets and community venues across the borough.

Education Service:

169. Wigan Domestic Abuse service attended managers events last term and shared an e-learning course and contact details with managers from early years settings and childminders. All nurseries in Wigan have been added to Operation Encompass alerts and have information regarding the local Domestic abuse campaign.

170. All early year's settings are also included in the designated lead and level 2 courses run by the Early learning and childcare team and staff in Wigan Engagement Centres have attended domestic abuse training in 2021.

171. Early years and education service representatives attend the Wigan Community Safety Partnership Domestic Abuse Sub-Groups and cascade information to services and education providers.

Greater Manchester Fire and Rescue Service (GMFRS):

172. GMFRS support victims of DA by offering a Priority Safe & Well visit as part of the target hardening procedure and DA awareness is included within the current Safeguarding Policy and e-learning package.

Neglect

173. In 2020 – 2021 the Partnership continued to have the prevention of neglect as a key area, and perhaps unsurprisingly it continues to be a repeated theme in the Partnership's review and learning and improvement work whether as a primary issue or allied with other forms of abuse.

174. In spring 2021 a refresh of the Wigan Safeguarding Children Partnership Neglect Strategy was undertaken, and a new Thresholds of Need Framework redesign was rolled out across the Partnership agencies. The Neglect Strategy and Action plan was launched and over 500 people attended the briefing on the thresholds of Need where this was launched also.

175. The task and finish group for Neglect is meeting regularly to drive this work. The membership is good, with a primary school represented and health sector present. There has been an increase in graded care profiles (Neglect tool) completed with families across the partnership and staff accessing training.

NHS Wigan Borough Clinical Commissioning Group (WBCCG)

176. The Assistant Director Safeguarding Children/Designated Nurse has contributed to the development of the WSCP Neglect Strategy, attended the Neglect task and finish group to develop a workplan to implement this and contributed to the development of the self-neglect tool for adults.

177. In 2021/22 WBCCG Designated Professionals for Safeguarding Children will lead on developing guidance on the response and management of childhood obesity as part of the neglect strategy. Frontline professionals have indicated that they need direction regarding when childhood obesity becomes a safeguarding issue. We will work with our GM colleagues in developing this guidance and build on the work already completed by Salford CCG.

Mersey Care NHS Foundation Trust (Mid-Mersey Division, formerly North West Boroughs NHS Foundation Trust)

178. In 2020-2021 the Trust embraced the opportunity to access the NSPCC Train the Trainer course which allows for the delivery of licenced training for using Graded Care Profile 2. A virtual GCP2 course has been cascaded by NSPCC which has been delivered throughout the year and significantly uplifted the number of staff available and licenced to complete this specialised neglect screening and support tool.

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

179. The Named Nurse Safeguarding Children has contributed to the development of the WSCP Neglect Strategy, attended the Neglect task and finish group to develop a workplan to implement this.

180. One of the Safeguarding Specialist Nurses has completed the training the trainer to enable them to contribute to multi-agency Graded Care Profile Training. She has also delivered this as bespoke sessions to identified staff groups including the Children's Community Nursing Team and 0-19's Service. Unfortunately, due to the pandemic this training has been on hold but there are plans to recommence this training with a pool of identified trainers including our Specialist safeguarding Nurse.

181. Wrightington, Wigan and Leigh will continue to contribute to the neglect strategy and work with WBCCG to develop guidance in the management of and response to childhood obesity to help practitioners identify when this becomes a safeguarding concern.

Children's Social Care

182. The Local Authority is an active member of the Partnership task and finish group which the service lead for quality assurance and practice improvement chaired this group. Children's social care have created a community of practice where practitioners completing the graded care profile meet regularly to share practice. Social workers have attended training and Child Protection Chairs specifically focussed on conferences where neglect was a factor and ensure the use of the GCP, to understand the impact of neglect, is becoming more embedded. Repeat child protection planning is high and this causes concern as we know that neglect is present for many children, and we recognise that there is more work to do in this area to identify and work with the root causes of neglect to support families to make meaningful change and ensure that they do not experience repeat episodes of statutory intervention.

Wigan Start Well Early Help and Targeted Youth Support Service:

183. In 2020 – 21 all staff had Graded Care Profile 2 (GCP2) training and this tool helps staff to identify is there is any hidden issue of neglect.

184. The updated threshold document is also used as a tool to support staff across Start Well and partner agencies to identify the appropriate level of intervention for those children who are suffering neglect.

185. The GCP2 Community of Practice allows practitioners to explore the 'masking of neglect' by re-referrals and multiple referrals/contacts.

We Are With You (Substance Misuse Service)

186. The We Are With You team have all completed the Level 3 Safeguarding Training and are confident in identifying all areas of abuse to include neglect. The year 2020-21 saw We Are With You attend strategy meetings, Child in Need, Child Protection and Core Group Meetings lead by Wigan's Children's Social Care and work together with other partners regularly.

187. All cases reported to Social Care are reported internally via an Incident Reporting system called Ulysses and this is also reported to CQC via a notification. All incidents reported on Ulysses are reviewed weekly by the Contract Manager and Service Manager and reviewed and any learnings and themes identified are shared with the wider team through Peer Supervision and Service Meetings.

Education Service:

188. All engagement centre staff completed training on Awareness of Child Abuse and Neglect from WSCP.

189. Launch of the Thresholds of need guidance training was attended by a significant number of school leaders with positive responses shared at Wigan Safeguarding Children Partnership Education Settings subgroup.

190. Early years and education service representatives attend the WSCP Neglect subgroups and cascade information to services and education providers, and the new neglect strategy and launch of the new thresholds' documentation was rolled out across all schools in the Spring term.

Greater Manchester Fire and Rescue Service (GMFRS)

191. As GMFRS offers services on a life-course basis it is useful to view the work on a borough wide level.

192. Neglect is included as part of the current safeguarding e-learning package for the GMFRS workforce. GMFRS offer home fire safety visits as part of our Prevention strategy and refer concerns to appropriate agencies where safeguarding, including self-neglect/hoarding concerns are identified.

193. In the period April 20 – April 21, GMFRS made 44 referrals for safeguarding concerns in Wigan Borough, 4 were referrals to children services and 4 were adult referrals after attending an attempted suicide incidents. The remaining 36 referrals were all adult referrals with concerns around self-neglect, mental health and hoarding following home fire safety visits.

Greater Manchester Police:

194. In May 2020, a new GMP Adults at Risk Policy and procedure was published containing the Vulnerability Assessment Framework in order to improve our operational response to both children and adults who may be at risk of neglect.

195. Sept 2020 - Mandatory training rolled out for staff who attend Adult Safeguarding Incidents and to support the A-G Vulnerability Assessment Framework (Risk Assessment tool).

Exploitation, complex and contextual safeguarding:

196. In 2020 – 2021 Wigan Safeguarding Children Partnership commenced Local Child Safeguarding Practice Reviews on 2 young people (connected) who were considered to have been victims of criminal exploitation, and two young people (also connected) who were victims of child sexual exploitation.

NHS Wigan Borough Clinical Commissioning Group (WBCCG)

Health provision within Wigan's Multi-Agency Complex Safeguarding Team

197. WBCCG commission the health provision within Wigan's Multi-Agency Complex Safeguarding Team which is currently one whole-time equivalent Complex Safeguarding Specialist Nurse who is based within the Multi-Agency Complex Safeguarding Team.

198. The objectives of the role are to:

- Be a resource for health professionals in relation to complex safeguarding offering expert advice and guidance.
- Contribute to the screening of referral to the team as a statutory partner and to ensure a multiagency response.
- Gather analyse and share relevant health information with partners in the complex safeguarding team in a way that partners understand its impact on risk of exploitation.
- Use knowledge of health and health services to inform assessment and plans.
- Ensure that plans include health needs of children and ensuring smooth and timely access to appropriate health services.
- Have oversight that all children referred into the complex safeguarding team have their health needs assessed and plans in place to address unmet needs.
- Provide professional challenge to the partnership where required.
- Ensure information in relation to risk of exploitation is shared across the health economy.
- Profile the health needs of the complex safeguarding team caseload to inform future commissioning intentions and service development.
- Provide specialist resource is available to health economy and partner agencies.
- Support children and young people to access universal health provision.

199. This is achieved in a flexible way; either through direct work with the child or young person or in partnership with other health professionals who may already have an existing relationship with the child. The aim is to nurture and empower the children and young people to have the skills to know how and when to access health services in the future.

Greater Manchester Complex Safeguarding Peer Audit 2020/21.

200. The 2020-21 annual complex safeguarding peer review process was replaced by a peer audit due to the Covid-19 social distancing measures. The audit was undertaken in Wigan during January 2020.

201. The Multi-Agency Complex Safeguarding Team in Wigan work with children and families in relation to both child sexual exploitation and child criminal exploitation and are based at Wigan Police Station.

202. The audit tool developed for Greater Manchester Police/ Children's Social Care was not suited to be used as a health audit tool. A bespoke tool was therefore developed by GM Designated Nurses for Safeguarding Children, informed by Specialist Complex Safeguarding Nurses across the Greater Manchester footprint.

203. The health records for children open to the were audited by the WBCCG Safeguarding Team and they concluded the following:

Areas of Good Practice:

- Information sharing was evident in the health records from Sexual Assault Referral Centre (SARC), Multi-Agency Risk Assessment Conferences (MARAC), North West Ambulance Service (NWAS) and the Children in Care Nursing Team and about missing episodes for children.
- Recording of legal status, child protection plan, and complex safeguarding on SystmOne electronic community health records.
- Health was represented at Core Group Meetings and Child Protection (CP) conferences.
- Evidence of communication between School Nurses and Social Workers on SystmOne community health electronic records.
- The Complex Safeguarding Specialist Nurse is informed immediately at daily governance meeting of any new cases.
- Information was shared by the Complex Safeguarding Nurse with School Nurses and GPs in a timely manner identifying the risk and why open to the team.

Areas for Improvement included:

204. Theme 1 : Workforce Development and Training

b. The audit highlighted that we to raise awareness regarding Child Sexual Exploitation and Child Criminal Exploitation specifically with staff working in unscheduled care settings such as Accident and Emergency and Walk in Centres.

205. Theme 2: Voice and Lived Experience of the Child

c. The voice of the young person is not always clear in the health records, and health professionals need to seek children and young people's views more actively on their health provision.

206. Theme 3: Professional Challenge and Escalation

d. It was identified that there needs to be a more robust and coordinated multi-agency response to 'Was Not Brought', previously referred to as 'Did Not Attend' appointments. We also need to empower health staff to feel more confident to professionally challenge and escalation when children are subject to numerous child protection plans and Public Law Outline (PLOs).

207. Theme 4: Holistic Care Planning

e. It was identified that there is work to do to ensure that all health information is evident in the health record such as Education, Health and Care Plans. We need to ensure that there is a consistent approach to the way in which multiple health services co-ordinate assessments and responses (Looked After Children health assessments, Education, Health and Care Plans, medical assessments, mental health assessments). There is some clarity needed regarding the offer for children post 16 open to the multi-agency Complex Safeguarding Team.

Mersey Care NHS Foundation Trust (Mid-Mersey Division, formerly North West Boroughs NHS Foundation Trust).

208. To improve the awareness of contextual safeguarding within adult facing services- such as those delivered to parents and carers, core safeguarding training was updated to include a contextual safeguarding model, understanding push/pull factors within extra-familial harm and recognising vulnerabilities of exploitation. Within the training local CE screening tools and referrals pathways are explored.

209. Contextual Safeguarding was also included as a quarterly learning theme where all child facing services were provided with learning presentations, reflective group discussions on theme and local resources for responding effectively to child exploitation.

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

210. The Trust have a whole time Specialist Nurse Complex Safeguarding who is based within Wigan's Multi-Agency Complex Safeguarding Team. The

Multi-Agency Complex Safeguarding Team in Wigan work with children and families in relation to both child sexual exploitation and child criminal exploitation and are based at Wigan Police Station.

211. The role of the Specialist Nurse for Complex Safeguarding is outlined in the WBCCG section above. The Nurse attends and contributes to the team's daily and monthly governance meetings, sharing relevant health information and contributing to the plan.

212. The Specialist Nurse also delivers a slot on Safeguarding Level 3 Children mandatory training and also delivers bespoke training to identified groups. She has delivered training in relation to learning from recent reviews which includes use of language when referring to victims of exploitation.

213. The Trust Safeguarding Team has a system for flagging high risk victims of sexual and criminal exploitation on the child's electronic patient record (SystemOne).

We Are With You (Substance Misuse Service):

214. We Are With You commission external County Lines training to develop and up-skill the team to further understand this area and enhance knowledge in relation to child sexual exploitation, criminal exploitation and the link to County Lines which are pertinent issues for the borough.

215. The service attends the exploitation sub board and exploitation task and finish group to explore available data and work towards the development of a dashboard for ease of information sharing. The data informs local services plans and interventions

216. The Young Persons Service has a dedicated CSE Lead, and she attends a fortnightly forum with the Complex Safeguarding Team, and this covers all high cases that are linked to CSE.

217. The service completes a CSE screening tool with young people where a risk is identified this allows clear indication of the risk posed and this leads to a referral direct to the CSE Team and a partnership approach to support and reduce risks. This has led to community work that included detached Outreach in hot spots areas where young people have been congregating and using substances, this has led to harm reduction and referrals into treatment. This was a joined-up approach with Targeted Services and has reduced anti-social behaviour within the identified community.

Children's Social Care

218. We continue to have a dedicated response to CSE and CCE in the form of the multi-agency complex safeguarding team. We know that we need to develop our case recoding system to allow us to strategically understand the demand and outcomes for these children and this work has commenced.

219. Improvements to the response to children who go missing form home have been identified and an action plan is now in place. We will improve our oversight of these young people and continue to offer assurance to the partnership on this over the next year.

220. We are keen to develop our transition arrangements for those entering adulthood.

Start Well Early Help and Targeted Youth Support Service:

221. Early Help / Start Well have close ties with Complex Safeguarding Team. There is a bank of resources and tools to use regarding online safety and other direct work being completed with children and YP as well as parents which is easily accessible to staff on the Local Authority intranet.

222. The updated threshold document also allows professionals to identify what level the case should be at when there are issues around Exploitation.

Targeted Youth Support Service –

223. TYSS have a Youth Justice Worker seconded into the complex safeguarding team. We have a significant number of cases in common with the complex safeguarding team and have good partnership working arrangements in place. Information from the Daily Governance report is shared with TYSS on a daily basis to ensure checks can be made on our case management system and information shared.

Greater Manchester Police (GMP):

224. GMP have a dedicated Complex Safeguarding team which covers both Child Sexual Exploitation and also wider Criminal Exploitation- such as county lines activity

225. We have a dedicated Exploitation group sitting under the WSCB/CSP-Joint chaired by Police and Social Care with a bespoke action plans with key priority areas namely

226. Priority 1: Ensure single and multi-agency processes and procedures deliver effective protection, support and guidance for victims and potential victims of exploitation and their families

227. Priority 2: Develop and embed a whole system (early age / stage) model of assessment and intervention rooted in Contextual Safeguarding policy and practice. Ensuring that our approach incorporates current learning from key areas of work (youth justice etc.)

228. Priority 3: Deliver an effective and co-ordinated workforce development and awareness raising plan across organisations and within communities, schools and the wider SDF footprint

229. Priority 4: Measure our effectiveness of the support and interventions we provide and analyse the risk factors of people at risk of exploitation so that this influences future delivery of services.

230. Priority 5: Proactively identify and disrupt exploitation activity
231. Priority 6: Ensure perpetrators are brought to justice.
232. Each of these priority areas have an identified senior lead across the partnership, ensuring full strategic support is given to the operational delivery of tasks to achieve the priority areas
233. This year we embarked on a very successful multi agency week of action around child Exploitation, drawing on the support and active participation of partners such as Wigan Council, Wigan Children Safeguarding Partnership, Wigan Youth Zone, TYSS, We Are With You (Young Peoples Drug and alcohol service), Spectrum, Wigan Athletic, Wigan Warriors, Leigh Rugby and Leigh Centurions, educations providers, and health services providers amongst others.
234. Training sessions have been held with Youth Workers, Targeted Youth Support Service workers to increase awareness of exploitation, spotting the signs and how to respond to concerns.
235. Local High and Primary Schools were contacted to offer online group session/ assembly / staff training in addition to a number of one-to-one sessions scheduled in with young people.
236. GMP also held a number of proactive operations under the heading of "Operation Flood". Working with GMP resources such a Tactical Aid Units, District Proactive teams, CSE teams, Road's policing unit and other units we embarked on a number of days activity dedicated to targeting groups involved in drug trafficking across county lines. Using both covert and overt tactics a total of 25 arrests were made during the operation, a number of vehicles seized, and class A, B and C drugs recovered alongside numerous weapons. We were also able to safeguard a number of children being made to participate in county lines activity.
237. Alongside those proactive operations there have been many successful convictions for a number of serious and serial child sex offences in 2020 and children saved from further harm.

Education Service:

238. Wigan engagement centre staff have all completed Wigan Safeguarding Children Partnership training for FGM, CSE, Prevent, county lines, online safety and trauma informed practice. This is of specific importance as this setting supports the inclusion and reintegration of some of the most vulnerable children in Wigan schools.
239. Designated Safeguarding Lead network events, Governor Briefing and the Education settings subgroup have continuously promoted this training offer to their schools.

Mental Health:

240. In the year 2020-2021, due the Covid-19 pandemic the challenges to children and young people's mental health, and that of their carers was

unprecedented. Nonetheless, partners have stepped forward with innovative ways of supporting the needs of young people in Wigan.

NHS Wigan Borough Clinical Commissioning Group (WBCCG)

241. In December 2020 NHS WBCCG, in partnership with Children's Social Care, hosted a Complex Children and Young People Workshop. The workshop was attended by over 30 professionals from various organisations including:

242. NHS Wigan Borough CCG, Wrightington Wigan & Leigh Teaching Hospital NHS Foundation Trust, Northwest Boroughs Healthcare NHS Foundation Trust, Wigan Council, GM Rapid Response Team, Health and Social Care, GP clinical leads, Advancing Quality Alliance (aqua), school leads and looked after children leads.

243. The workshop was convened due to an increasing number of children and young people presenting to unscheduled care with complex health and social care needs. They children are often admitted despite the acute setting not being the correct place to meet their health and social care needs. Senior health and social care leaders recognised the importance of committing to a Borough wide, multi-agency approach to support these children and young people.

244. The workshop resulted in the development of a multi-agency plan overseen by the Mental Health Programme Board which sets out how we will improve the journey for children and young people. The action plan includes things such as:

245. Improved data and information-sharing informing effective interventions.

246. Clear workforce strategy for early intervention and support.

247. Support time for shared learning and ensuring what we do is based on good evidence of what works.

248. Integrated practice.

249. No 'wrong front door' for service users.

250. Ensure continuity of care is maintained through different stages of a child's life and through their preparation for adulthood.

251. Coordinated 0-19 pathway and seamless, effective, and timely step up/step down transition arrangements.

252. Seamless approach to supporting confident Families as a team around the child and family.

253. Effective and appropriate, outcome-based commissioning of services.

254. Engage in positive challenge and hold each other to account for outcomes for families

255. Continuously review and evaluate services.

256. Children, young people, and families are involved in the design, delivery, and evaluation of the services they use.

257. The WBCCG Safeguarding Team is working in partnership with commissioning colleagues to develop a system wide toolkit to better respond to children and young people presenting with complex health and social care needs. All relevant multi-agency partners are contributing to this work with the intention of ensuring children, young people and their families receive the right care, at the right time and in the right place.

Mersey Care NHS Foundation Trust (Mid-Mersey Division, formerly NWBH Trust)

258. As an organisation that provides MHLD Services the Trust has been proactive in leading on the creation and delivery of Parental Mental Health related safeguarding training and learning events for partnership agencies. The impact of COVID was seen in the suspension of this training which was typically delivered in a face-face context. However, the opportunity was taken to revisit the contents and key messages of this training and re-create a current version that can be delivered most effectively via virtual platforms. This package is now live and includes interactive and scenario-based activities to deliver key learning around the impact of parental mental health on parenting capacity.

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

259. The Trust recognises that there has been an increasing number of children and young people presenting to unscheduled care with complex health and social care needs. These children are often admitted despite the acute setting not being the correct place to meet their health and social care needs. As a result in December 2020 representatives from the Trust attended a workshop in relation to Complex Children and Young People, with relevant partners from various organisations.

260. Health Visitors in the Trust are trained to undertake 'New Born Observations', the primary goal is to promote an understanding of baby behaviour and development and to foster strong infant-parent relationships. The Healthy Child Programme focuses on a universal preventative service; there is a focus on promoting emotional wellbeing in families, delivered by Health Visitors. Training has been completed by Health Visitors in relation to mental health in children.

261. Health Visitors and Midwives use screening tools to consider and recognise mental health in parents including ante-natal and post-natal depression.

262. Staff are aware of how to make referrals to specialist services, including Child and Adolescent Mental Health Services (CAMHS).

263. The Children in Care Team provide training to Foster Carers and Residential Care Staff in relation to emotional and mental health issues.

Children in Care also receive an annual health assessment which includes completion of Strengths and difficulties Questionnaire with appropriate interventions and referrals as required.

Children's Social Care

264. We continue to work with adult colleagues on life course approach to ensure that we work with families holistically, taking key learnings from SCR where by parental metal health has been a consistent factor in a number of national SCR. We continue to offer training for staff to identify adult mental health needs and utilise our practice model to helps us understand the needs of all of family.

Start Well / Early Help and Targeted youth support services:

Early Help / Start Well:

265. The iThrive principles have been being implemented across the service in 2020-21. There are systemic consultations with CAMHS. CAMHS have trailed a MARH, which is now being implemented across Wigan. This ensures that advise and support is offered at the right time, and no long waiting lists to be seen by a CAMHS worker.

266. Start Well/CAMHS/Paediatrics all work together and meet on a regular basis around young people with additional needs. This includes sign posting families to services they can self-refer to such as IAPT course, which is extended within Start Well. Regular check in meetings with staff are held, and the updated threshold document is used to ensure that the Early Help / Start Well service is the right level support for the child / YP.

Targeted Youth Support Service:

267. As part of the Greater Manchester i-THRIVE (GM i-THRIVE) to improve mental health outcomes for the children and young people of Greater Manchester, we have an i-Thrive subject expert within TYSS who will link in with the Greater Manchester youth justice network of i-Thrive champions. Two members of staff attend the multi-agency referral hub, which triages CAMHS referrals and directs cases to appropriate services. A café where young people can chat about their mental health and get expert advice is due to open in September headed up by Family Welfare voluntary organisation. TYSS are supporting this initiative by assisting in recruiting a Youth Worker to work in the café.

Education Service:

268. Staff in Wigan Engagement Centres have completed training on the Effects of Parental Mental Health to support ongoing social inclusion for children and families. They have a whole setting wellbeing action plan in place.

269. Targeted Education Support Services, Education Psychology Services (EPS) and the Virtual school have worked closely to further develop the emotional friendly school's programme. This has been delayed due to COVID response but will be refreshed in the Autumn term.

270. Four education team managers and senior staff have completed the trauma informed training delivered through WSCP. These staff can now deliver training to support education services and settings understanding of the impact of early trauma in supporting mental health in young people.

271. The EPS service have developed and delivered wide training and support opportunities through the Wellbeing for Education Return programme. This has included a programme of supervision for school leaders across Wigan. The programme has been further extended to the end of the academic year and leaders from the EPS programme are supporting the development of a supervision and peer support model for DSLs. Schools and education colleagues have been supported to complete the EPS staff wellbeing survey.

272. Early learning and childcare services deliver wellbeing training as a focus in the nurseries and childminders. This includes children, staff and parents. They have shared the shine a light free course with all EY settings and promoted Mental health week and wellbeing celebrations.

273. Mental health and wellbeing are a standing item focus at training events for managers of childcare settings and nurseries.

Front Door' arrangements to help and protection

Children's Social Care

274. It is fair to say that the pace of change at the front door was impacted by Covid, however we did achieve some key developments. The front door now has more virtual partners than it previously did, this is a positive development and allows for more timely and meaningful information sharing to inform our decisions. There is improved quality assurance process in place to examine and understand decision making at the front door and this has been crucial to us growing in our confidence of the accuracy application of thresholds. We have made some permanent appointments in the Front Door and duty teams with team manager, service manager and service lead positions. This will strengthen the front door and ensure that the teams are supported and challenged in their decisions making. We have more work to continue with over the next year, and this will coincide with the review of early help to ensure that we have seamless process for transfer of cases between thresholds enabling families to have a smoother experience that embeds the changes that have been made.

Section 4: Key Themes and Learning from Reviews:

Overview:

275. Wigan Safeguarding Children Partnership runs a range of review processes; from Brief Learning Reviews which pick up on the systemic

learning on cases that do not meet the thresholds for Rapid Reviews, through to the statutory responses of Rapid Reviews and Local Child Safeguarding Practice Reviews.

276. In early 2021 Wigan Safeguarding Children Partnership redesigned the Case Review procedures to align with the overall ethos of accelerating the learning from reviews into the work force development processes and effective practice change.

277. Some of the key themes of concern emerging from children's case reviews over 2020 -2021 include:

278. Children who have experienced long term and intergenerational intra-familial neglect, which is underpinned by parental substance misuse.

279. Intra-familial and trans-generational sexual abuse.

280. Criminal exploitation and influence on adolescents at risk of offending.

281. Non accidental, traumatic or fatal injury to babies.

282. Concerns around safe sleep of babies, especially where parental alcohol use was a factor.

283. Understanding within risk assessment and thresholds of extra-familial risks of Child Sexual Exploitation and Criminal exploitation.

284. Concerns around the impact of Covid lockdowns on parental mental health / visibility of children to services.

285. **Practice themes:**

286. Inconsistent attendance by agencies at review meetings across the thresholds of need.

287. There are both systemic and practice reasons, as are explained in the audit work undertaken on this theme, for this. These include technical connectivity problems around compatibility of systems, timing of requests creating difficulties to secure availability of all stakeholders, and professionals perhaps not being aware of another agencies involvement in a case.

288. Professional optimism / Professional curiosity

289. This is a theme which has been recurrent over a number of years in Wigan and on a national footprint, and a great deal of workforce development effort has gone into this area of practice. Our reviews often touch on families where there is long term, sometimes chronic areas of need. In that context, interventions need to focus on the longer-term impact on the child or children in a family and be cautious of measuring 'successes' being over a short period. Agencies also need to be resilient to having their concerns for the children in the family reduced by either deliberate misleading statements or overstating progress. A further issue in case reviews aligned with this is the need for partner agencies to feel confident in challenging parents / carers in a constructive manner when there is drift in progress and to refocus that issue on the impact on the child.

290. Disguised Compliance

291. This is again a theme familiar from our previous annual reports and present through over half of the reviews undertaken in 2020-2021. This involves parents or carers giving the appearance of meaningfully co-operating

with agencies with the effect of it either avoiding raising suspicions or lessening concerns.

292. Information Sharing

293. Within the majority of reviews information sharing and disconnect is a key recurrent theme for a number of years both nationally and in Wigan. The issue we observed in recent reviews is not usually of the existence of the relevant information, but the sharing of it in a timely way and the adherence to an infrastructure that supports joint planning.

294. Adverse Childhood Experiences

295. Our reviews frequently touch on young people who have experienced adverse childhood experiences either as subject of the review, or as a parent / carer who themselves have a background of traumatic experiences. From the reviews that have been undertaken 2020-21 we can see evidence of systems across the partnership becoming more trauma informed, but sadly we can also see some occasions where we need to improve. For example, in two of our reviews there is evidence of professionals pathologizing or 'blaming' adolescents for behavioural issues that are clearly rooted in their early childhood experiences. Similarly, it is apparent in more than one of our reviews that we have not perhaps applied a trauma informed approach to parental behaviours of non-engagement.

Bereavement / Loss

296. Bereavement / Loss is a theme that has been apparent with children's reviews and shared with the Safeguarding Adult Board across the life course. Some significant progress has been made on this front from a boroughwide Bereavement Support Strategy led by Wigan Safeguarding Children Partnership including creation of Bereavement Support Lead professionals and the development of a model policy for bereavement for schools, colleges, and early years settings. The purpose of the group is to equip the bereavement support leads to support families and to sign post them to necessary services. This remains an active workstream for the partnership.

297. The partnership team have acknowledged difficulty and issues highlighted in the pace at which learning from case review processes is disseminated to partners. The learning and improvement officers will take a more active role in panel meetings with new tools which promote a succinct and effective pathway towards drawing the learning from every meeting, with the potential for learning products to be developed throughout the process, where this had previously followed the dissemination of the final report.

298. **Ongoing review processes**

Ongoing LSCPR's Q1-Q3 20/21	**6**
Completed Rapid Reviews Q1-Q3 20/21	**8**
Completed Brief Learning Reviews Q1-Q3 20/21	**7**

299. **Learning Products and Website:**

300. The Partnership team produce 7-minute briefings to provide key messages and support reflective discussions with practitioners and agencies on embedding the learning from Local Children's Safeguarding Practice Reviews. Briefings are published on the WSCP website to help practitioners and agencies reflect on their practice and systems and gives tools and guidance on our practice model signs of safety.

301. Thematic briefings are also produced on key themes from Rapid Reviews Brief Learning Reviews and Local Children's Safeguarding Practice Reviews. These briefings allow the Partnership Team to share learning relating to themes which may have been highlighted in several cases and/or those cases were ongoing processes prevent publication and therefore a case specific briefing.

7-minute briefings	Count
Published case specific 7-minute briefings	**7**
Case specific 7-minute briefings awaiting publication	**5**
Theme specific 7-minute briefings awaiting	**7**

302. The WSCP website is subject to further development. This will improve accessibility and the quality of resources. There is an ambition for the website to become a useful tool for practitioners in promoting multi-agency work and understanding of roles across the partnership, alongside providing opportunities for personal development and learning outside of the partnership training offer.

Multi-Agency Audit processes

303. Multi-Agency Audit Processes were significantly impacted during 2020 - the Covid-19 Pandemic resulted in reduced capacity and increased demand across all partnership agencies. Many members of the Partnership team were re-deployed to support frontline working during the first national lockdown and did not return to their statutory roles until September 2020. This resulted in no multi-agency audit activity undertaken between April 2020 and December 2020.

304. The Partnership Team have facilitated partners to develop an audit timetable for the remainder of 2021. The Partnership Learning and Improvement Officers will develop audit tools based on each individual audit

and the required learning for partners to implement learning and development from these processes. The Learning and Improvement Officers will facilitate the planning and completion of audits, the gathering of audit findings and production of reports for review and agreement of involved partners before wider dissemination is undertaken through relevant sub-groups and to the wider workforce. On-going work following the completion of audits will be tracked and monitored via the Learning & Improvement Outcomes tracker and will inform audit work in the future.

Month	Audit Theme	Area of Focus	Completion Date
December 2020	Partner attendance at statutory meetings	Partner Attendance at: CP Case Conferences; Strategy Meetings; and Core Groups Gaps in invites and attendance at statutory meetings have been identified via CSC single agency audit work. Cohort initially identified by CSC then shared with Partners in Health, Police, Housing and Substance Misuse services to further understand potential systematic issues in the recording of invites and attendance where further evidence was available via respective systems 305. .	April 2021
January 2021	Babies born during the pandemic	Government Directed Audit - Letter from Vicky Ford MP (Parliamentary Under-Secretary of State for Children & Families) Across government, we are very concerned about the increased number of serious incidents reported for babies who have died or been seriously harmed in comparison to the same period last year. Under ones continue to be the most prevalent age group for serious incident notifications. Since April, almost 38% of all notifications have been children aged under one, with over half of those incidents (55%) being notified because the child has died. I am conscious that this is very much a multi-agency endeavour.	May 2021

Outcomes and Assurance Tracking

306. Action plans for each case are developed based on the recommendations of review processes. The partnership work directly with

case review panel members and representatives from relevant agencies to break down recommendations into agency specific actions. Action completion will be tracked and monitored by the Learning and Improvement officers and reported on through the Case Review Sub-Group.

307. Average partner completion rate for actions from all review processes is currently 76%. Seeking assurance on action completion from smaller agencies which sit outside of the partnership requires further work and accounts for the majority of actions with no update. With continued efforts to develop smarter processes, the partnership team hope to facilitate higher completion rates in the coming year.

Section 5: Impact of Covid

NHS Wigan Borough Clinical Commissioning Group (WBCCG)

308. The Covid 19 pandemic has proven to be an unprecedented challenge for the NHS. WBCCG Safeguarding Team has worked with NHS Providers and multi-agency partners to ensure that statutory processes were fulfilled, and that vulnerable children, young people and adults remained a priority during this challenging period.

309. At the start of the pandemic the Safeguarding Team worked with NHS Providers to adapt service delivery to prevent disruption to statutory safeguarding processes. An example of this would be that child protection medicals could not proceed in the usual format therefore potentially leaving children with unassessed injuries and at risk of further harm.

310. The Assistant Director Safeguarding Children/Designated Nurse worked with the Designated Doctor to devise a Covid 19 protocol for child protection medicals. The protocol included risk assessment and minimised face to face contact by utilising virtual platforms to reduce Covid 19 transmission.

311. The Safeguarding Team adapted quickly to using virtual platforms to communicate with partner agencies and took the lead in convening and chairing multi-agency teleconferences. This proved useful in highlighting concerns and rapidly making changes.

312. During the first wave of the pandemic, the Deputy Designated Nurse Safeguarding Children assisted the Quality Team in the delivery of infection prevention and control training to Care Homes.

313. The Safeguarding Team contributed to daily and weekly teleconferences for the National Network for Designated Health Professionals (NNDHP) for safeguarding children, Wigan Safeguarding Partnership, GMHSCP and NHS England North.

314. Throughout the pandemic the Assistant Director Safeguarding Children has worked with partners from Children's Social Care, Education, 0-19 health services, Named Nurse for Safeguarding Children and Children in Care Specialist Nurses to review the lists of vulnerable children in the Borough to co-ordinate care and reduce duplication and risk.

315. The WBCCG Safeguarding Team developed a monthly GP safeguarding newsletter to alert GPs to safeguarding issues expected to increase during the Covid-19 lockdown such as domestic abuse and child abuse due to; isolation, financial issues and increasing mental health, alcohol, and drug consumption. This included a focus on non-accidental head trauma in infants and being alert to domestic abuse and child abuse when conducting consultations using virtual platforms.

316. Greater Manchester Health and Social Care Partnership (GMHSCP) funded the ICON programme for all GM localities. ICON information was disseminated to all health providers and relevant

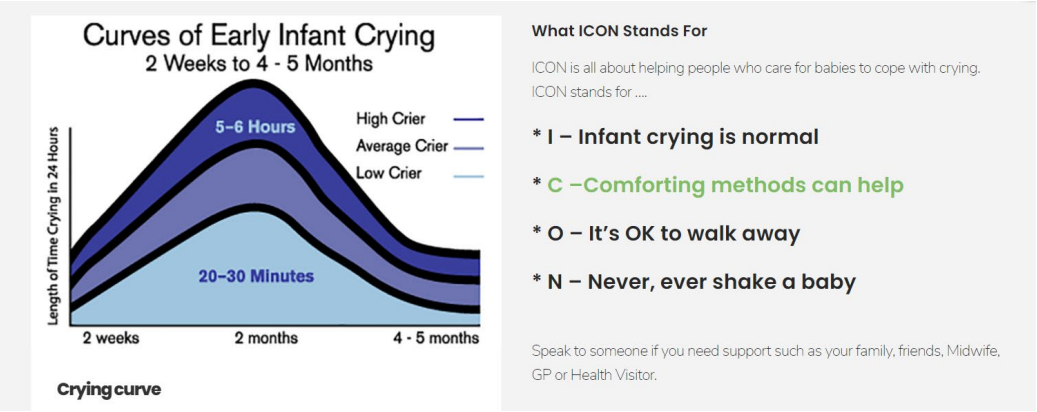
317. In Quarter 4, the Assistant Director Safeguarding Adults and Assistant Director Safeguarding Children were both redeployed to an NHS Provider Safeguarding Team for a period of 10 weeks to support their response to the pandemic and impact of the same in terms of increased workload on their service.

318. To capture some of the learning from the pandemic the Healthier Wigan Partnership convened an 'Impact of the Pandemic on Children & Young People Activation Board' which took place at the end of Quarter 4. This included reference to education, mental health and wellbeing, demand for services and a perspective from Children's Social Care. The Assistant Director Safeguarding Children attended, presenting local, regional, and national observations from a safeguarding perspective.

319. <u>ICON Programme</u>

320. On the 1st of April 2020 ICON resources were disseminated by the WBCCG Safeguarding Team to NHS Providers (Acute, Community and Mental Health) Primary Care, Children's Social Care and Public Health and Wigan Safeguarding Partnership colleagues.

321. ICON is an evidence-based programme consisting of a series of brief 'touchpoint' interventions that reinforce the simple message making up the ICON acronym. ICON was conceived following years of study and research into prevention of Abusive Head Trauma (AHT).



322. NHS England North made the decision to fund the ICON programme for all CCG areas as lockdown restriction were introduced at the start of the Covid 19 pandemic. The ICON programme highlights that stress in families increases the likelihood of babies being shaken. Safeguarding strategic leaders predicted that the increasing restrictions related to COVID 19 could potentially tragically result in increased incidence of abusive head trauma therefore ICON Programme resources were distributed across organisations as a priority.

323. Resources included:

- ICON letter to Maternity services; this can also include the health visiting service
- ICON leaflet and poster
- ICON crib sheet- The leaflet text forms a helpful 'script' to include in conversations with parents/caregivers.
- Social media campaign video

324. The ICON Programme has been fully implemented by the Named Midwife for Safeguarding Children in maternity services provided by WRIGHTINGTON, WIGAN AND LEIGH. In 2021/22 WBCCG will continue to work with health providers to fully embed the ICON programme in Health Visiting Services and in General Practice.

Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

325. The Trust has developed new ways of working with children and young people, their families and also partner agencies to ensure that safeguarding has remained a priority. The Named Nurse Safeguarding Children has worked with the Designated Doctor and Nurse and the Named Doctor for Safeguarding to devise a Covid 19 protocol for child protection medicals.

326. The Wrightington, Wigan and Leigh Safeguarding team utilised virtual ways of working to ensure multi-agency discussion and shared work could continue despite the pandemic. Front line practitioners, such as midwives, health visitors and school nurses, also quickly adapted to virtual platforms to attend multi-agency safeguarding meetings, such as child protection case conferences and core groups. This method of attending safeguarding meetings has also been adopted by frontline practitioners.

327. Wrightington, Wigan and Leigh Safeguarding Team, Children in Care Team and -0-19 services worked with multi-agency partners to review children identified as vulnerable within the borough. This allowed us to ensure the right care was offered, prevent duplication, and reduce risk.

328. Whilst there was redeployment of frontline NHS staff, those with statutory safeguarding responsibilities for safeguarding remained in post and safeguarding children has remained a priority. The Safeguarding Team have also remained in post during this period and have not been redeployed.

329. The Trust is in the process of implementing the ICON Programme, ICON is an evidence-based programme consisting of a series of brief 'touchpoint' interventions that reinforce the simple message making up the ICON acronym. The ICON programme highlights that stress in families increases the likelihood of babies being shaken and concerns regarding this were highlighted during the first wave of the pandemic. The midwifery service have now rolled this out and the Health Visiting Service are in the process of implementing.

330. Safeguarding Mandatory Training has continued throughout the pandemic although Level 3 is now delivered virtually.

Children's Social Care

331. Children's Social Care is a key priority for the Council, both politically via the Leader of the Council and the Lead Member for Children's Services; alongside the senior leadership team, including the Chief Executive and the DCS. Significant investment in children's services has been agreed over the next four years to enable Wigan's Children's Social Care Services to continue with the pace of improvement that is required.

332. The last 12 months (March 2020-April 2021) have been incredibly challenging for all involved in children's services, and in particular for Wigan. Alongside responding to the COVID-19 pandemic the local authority has also been working to address issues in the quality of social work practice as part of a wider Improvement Journey for Children's Social Care.

333. In early 2020 a number of changes were made to the leadership of Children's Services, an interim Director of Children's Services (DCS) was appointed from January 2020 to July 2020 whilst awaiting the start of the permanent appointment of an experienced DCS Colette Dutton in July 2020. We also successfully recruited to the permanent Practice Director post in August 2020 and Sandie Hayes joined us in January 2021.

334. There have been a number of key actions that have occurred since the permanent DCS came into post in July 2020, these were progressed at the same time as successfully responding to the pandemic and ensuring that children remained safe and protected. Some of these are highlighted below:

335. Significantly increased the resources and capacity of front-line children's social workers to support our increased demand (following a review of thresholds in November 2019) through the use of a reputable social work agency, ensuring robust quality assurance through tight contract arrangements.

336. Been a key enabler in the Establishment of the Children's Safeguarding Executive meetings, improving governance across the Partnership in Wigan.

337. Established the Wigan Deal for Children and Young People's Board, with an experienced and credible Independent Chair from an 'outstanding' Children's Service. This Board has driven change and offered robust challenge to Children's Social Care and the Partnership, and has focused on the improvements necessary to deliver consistently good services.

338. Commissioned a number of external reviews to scrutinise performance and assure ourselves that our self-assessment is accurate.

339. Established opportunities to listen to staff through a variety of forms to ensure that morale is supported, and that staff feel listened to and heard.

340. With staff, developed a workforce strategy to support staff through the significant period of change and to ensure they feel part of planning services for the future. The plan focusses on three key areas – resourcing and induction, employee experience and culture and leadership, all aiming to improve the outcomes for our children and families.

341. Refreshed the approach to Quality Assurance and Performance Management, working to ensure that the two work in hand in hand to identify and understand the impact of the work we are doing to improve practice.

342. Significantly invested in our Commissioning Service to ensure that we develop the required sufficiency to ensure we can meet the needs of our children who come into our care.

343. Brokered, with support from the Department for Education, additional support for the service from the Partners in Practice Programme. Our agreed PiP is Essex and work is commencing with them in April 2021.

344. Throughout this period of Improvement we need to mention the fantastic, creative work that has occurred during the pandemic across council departments, to ensure that children have remained safe, seen and supported. This stemmed from virtual visits and virtual tea parties, to cookery classes with our care leavers; in the same way that families across the country communicated differently, so did we. At the beginning of the pandemic, we worked hard to identify who our most vulnerable children were, COVID risk assessment were put in place for all of the children we work with and all of the councils' departments worked together to do their bit and see these children in line with the risk assessment.

345. In October 2020 we were visited by Ofsted when they undertook a Focussed Visit under the ILACS (Ofsted) framework, this was a challenging visit under the circumstances but there were positives. Notably Ofsted recognised that:

346. "The improvement programme following the focused visit (Jan 2020) had only begun to take shape when the crisis of COVID 19 surfaced and emergency management arrangements were implemented across the council... The shift in focus slowed the pace of improvement in children's services. However, this **has been significantly reinvigorated in the last few months. New arrangements have now been established to provide external scrutiny and governance to progress the extensive improvements required**."

347. As a permanent and experienced new leadership team the scale of the improvement activity is owned, we know that there are challenges across the services for Children and Young People in Wigan, and we have a robust plan in place and the necessary scrutiny and governance arrangements in place to improve the quality of our services, have an impact and improve the outcomes for children who we work with.

Education

348. During 2020/2021 the education psychology service was involved in supporting the wellbeing of Children and Young People in schools. This included: training resources on topics such as:

- Wellbeing and resilience
- Transition, belonging and relationships
- Curriculum adaptation and re-engagement with learning
- Managing anxiety and uncertainty
- Education psychology support was also available for adoptive families and foster careers.
-

Section 6: Listening and collaborating with Children and Young People:

349. There is a plan around the engagement opportunities for families and young people which will take shape in the coming year. The partnership team are developing new ways to work with communities to ensure our work is understood and informed by the voices of those people it impacts.

350. We have been able to work with the Youth Cabinet and a primary education setting to develop a brief questionnaire to support the development of our engagement plan. Our new 'Safeguarding Soldiers' are routinely meeting to feedback to us their experiences and help us shape priorities for the partnership.

What we learned:

351. The partnership team need to work on the accessibility of our safeguarding information and resources for young people. The youth Cabinet told us that the readability of our questionnaire was impacted by the language we use in safeguarding. We need to make sure our tools and resources are accessible for young people and avoid laborious documentation to maintain interest.

352. Children told us that they did not know that Wigan had a Safeguarding Partnership, but that they had seen our logo before. None of the children had visited the WSCP website, but they did want the WSCP to engage with them more, suggestions included using the website, via zoom, Microsoft teams or TootToot. The children told us that we need to explain what neglect is to children and young people and communicate with the community better about detection and prevention. Most of the young people asked, suggested that we should visit their school to talk to them. When asked what young people thought the WSCP did responses included:

- ***"to keep kids and young kids safe and happy, they talk to children to make sure they are happy"***
- ***"I think they try to keep everyone safe, happy and healthy"***
- ***"they make sure teachers are doing their job properly"***
- ***"they build things to help us be more happy"***
- ***"if someone gets abused or hit they should go in class and discuss and try make them happy and let them colour and other things what make them happy"***

353. When asked what the WSCP could do to learn more about what was important to young people, suggestions included:

- **“making a group of children to inform Wigan Council of how people are getting on”**
- **“talk to us”**
- **“come into school and ask our parents”**
- **“have safeguarding soldiers”**

354. Two key themes emerged when young people were asked about the things that are important to them, these were online safety and traveling to and from school safely. Young people also suggested they would like to know more about how to access support outside of school.

- ***“who to contact after school”***
- ***“helping people how to know how to ask for your help”***
- ***“keeping safe traveling and online safety”***
- ***“online safety and don’t talk to strangers”***

355. Our ambition in this forthcoming year is to co-produce a primary and secondary newsletter with children and young people. This provides an opportunity to share and give support and advice on safeguarding issues that matter to them.

Section 7: Designated officer for allegations (previously known as LADO) update 2020-21

356. The Wigan Safeguarding Children Partnership (WSCP) has a duty to ensure that all allegations of abuse or maltreatment of children by a professional, staff member, foster career or volunteer are taken seriously and are treated in accordance with consistent procedures. The WSCP ensures that there are effective inter-agency procedures in place for dealing with allegations against people who work, or volunteer with children, and monitoring and evaluating the effectiveness of those procedures.

357. It has been a busy year, with a new designated officer for allegations coming into role in September 2020. Covid 19 led to more people working from home, and children not in school and less referrals into the service. However, leaving lockdown has led to a slight increase in activity.

358. Most referrals received were made by Schools and Social Care. Schools have the most contact with children across Wigan and Social Care refer as part of their safeguarding investigations. The Early Years Team provides support to Child Minders and regular updates are shared and discussed with designated officer for allegations to promote support and ensure referrals are made to designated officer for allegations appropriately.

359. There has been a fourth threshold added to the criteria for referral which is where any adult working with children has behaved or may have behaved in a way that indicates they may not be suitable to work with children. An example of this is in a domestic abuse situation where their judgement could be affected.

360. A significant portion of outcomes were unsubstantiated. Following designated officer for allegations involvement, the majority of Agencies will put some form of safeguarding awareness training or actions to the staff involved. In a lot of cases, the Agency's policies and procedures are re-visited and reinforced as a preventative measure moving forward.

361. Substantiated allegations will result in direct (formal) actions such as written Final Warnings, disciplinary procedures, or suspension. The designated officer for allegations will support the process and continue to co-ordinate with agencies as required.

362. Due to Covid 19 restrictions there was no designated officer for allegations training in 2020/21. However, the training programme has re-started in 21/22. The designated officer for allegations delivers four half day training sessions per year in respect of the role of the designated officer for allegations and managing allegations. This is open to anyone who accesses the Safeguarding partnership training courses.

363. The designated officer for allegations is also delivered two half day training sessions to our Early Years Providers. Training is set up for foster carers about how to manage allegations.

Section 8: Workforce Development

Background

364. On an annual basis the Wigan Safeguarding Children's Partnership (WSCP) will review and develop a safeguarding led training offer in line with key priorities, thematic outcomes of case reviews and on a need, basis led by reflective practice. This training offer is developed using a multi-agency approach, with all learning available to multi-agency colleagues.

365. In 2020/21 Wigan Safeguarding Partnership (WSP) coordinated an offer of learning that combined eLearning and classroom-based learning, consisting of 26 classroom-based courses and 21 eLearning courses. WSP also worked with a number of organisations to develop bespoke safeguarding learning and development opportunities to meet their needs. WSCP In 2020/21 was operating as Wigan Safeguarding Partnership (WSP), which included the Wigan Safeguarding Adult Partnership (WSAP), resulting in the training offer being life course. Since February 2021, WSCP and WSAP have been operating independently from each other.

Covid-19

366. In March 2020, WSP made the inevitable decision to postpone all face-to-face classroom-based learning due to the Covid-19 pandemic. Due to work from home guidance, restrictions on movement and capacity to deliver training from some agencies a number of courses could not be delivered and had yet to be developed to be delivered in a virtual capacity. Partner organisations found a number of staff were required to be deployed to other services to support the Local Authority during the initial stages of the Covid-19 pandemic, meaning capacity to deliver and attend training fell short of

requirements. A number of courses had been scheduled to take place, however at the point of cancellation a number of courses had yet to have dates confirmed.

Covid-19 Recovery – Workforce Development

367. Moving forward WSCP will work on developing all courses to be delivered in a virtual capacity, with the pandemic being a lesson in modernising our course delivery to fit a new way of working.

368. Although the pandemic has brought about many difficulties, we have used this opportunity to develop our delivery techniques and to use technology to our advantage, providing more opportunities to a wider number of colleagues who operate on a remote or home working model using new software, digital communications, webinars, and eLearning.

Section 9: Priorities for 2021 – 2022

WSCP Priorities

369. The Children's Executive have determined that the priorities for this year remain the same as those in 2020-2021. While progress has been made we are conscious that the impact of COVID-19 has had on each priority and we would want a further 12 months to focus on these further.

370. These are our priorities:

- Neglect
- Front Door arrangements
- Children's mental health within the context of families
- Domestic abuse within the context of families

Appendix 1: Financial data

This reflects 2021 actual spend and 2022 projected spend

FINANCIAL REPORT – CHILDREN'S SAFEGUARDING BOARD **APPENDIX 1**

	2018 / 2019 Actual £	2019 / 2020 Actual £	2020 / 2021 Actual £	2021 / 2022 Budget £
EXPENDITURE				
Salaries & Expenses	243,050	260,298	263,418	206,406
Professional Fees	60,510	26,195	32,714	17,982
Equipment & Supplies	12,346	11,140	24,803	0
Conference & Meetings	8,803	7,472	396	0
Marketing & Publicity	29	515	0	0
External Training	34,355	15,515	0	0
Total Expenditure	**359,093**	**321,135**	**321,331**	**224,388**
CONTRIBUTIONS				
Wigan Council – General Fund	-75,206	-75,206	-59,206	-59,206
Training Income	-53,490	-77,600	-82,050	-73,400
Wigan Borough Clinical Commissioning Group	-54,000	-54,000	-54,000	-54,000
Bridgewater Community Healthcare Trust	-5,994	0	0	0
NWB / 5BP NHS Foundation Trust / GMMH (new provider with effect from 1/4/2021)	-11,988	5994	-5,994	-5,994
WWL NHS Foundation Trust	-5,994	-5,994	-5,994	-11,988
Greater Manchester Police	-14,400	-14,400	-14,400	-14,400
National Probation Service	-1,800	-1,800	-1,800	-1,800
Wigan & Leigh Homes	-3,600	-3,600	-3,600	-3,600
CAFCASS	-550	-550	0	0
Wigan & Leigh College	0	0	0	0
Miscellaneous Income	0	-300	0	0
Total Income	**-227,022**	**-227,456**	**-227,044**	**-224,388**
Net Position (Expenditure exceeds Income for all financial years)	**£132,071**	**£93,679**	**£94,287**	**0.00**

CHILDREN'S RESERVE POSITION	**2018 / 2019 Actual £**	**2019 / 2020 Actual £**	**2020 / 2021 Actual £**	**2021 / 2022 Budget £**
1st April Reserve Position	**-£111,894**	**£0**	**£0**	**£0**
Transfer from Reserve	**£111,894**	**£0**	**£0**	**£0**
31st March Reserve Position C/Fwd	**£0**	**£0**	**£0**	**£0**
Children's Unfunded in Year Expenditure (Funded from Adults Reserve)	**£20,177**	**£93,679**	**£94,287**	**£0**

FINANCIAL REPORT – CHILDREN'S SAFEGUARDING BOARD **APPENDIX 1**

	2020 / 2021 Actual £	2021 / 2022 Projection £

EXPENDITURE		
Salaries & Expenses	263,418	231,664
Agency (3mths agency agreed covering G12 post)	0	23,841
Professional Fees	32,714	41,155
Equipment & Supplies	24,803	17,650
Conference & Meetings	396	0
Marketing & Publicity	0	0
External Training	0	0
Total Expenditure	**321,331**	**314,310**
CONTRIBUTIONS		
Wigan Council – General Fund	-59,206	-59,206
Training Income	-82,050	-64,648
Wigan Borough Clinical Commissioning Group	-54,000	-54,000
Bridgewater Community Healthcare Trust	0	0
NWB / 5BP NHS Foundation Trust / **GMMH (new provider with effect from 1/4/2021, yet to be received)**	-5,994	-5,994
WWL NHS Foundation Trust	-5,994	-11,988
Greater Manchester Police	-14,400	-14,400
National Probation Service	-1,800	-1,800
Wigan & Leigh Homes	-3,600	-3,600
CAFCASS	0	0
Wigan & Leigh College	0	0
Miscellaneous Income	0	0
Total Income	**-227,044**	**-215,637**
Net Position (Expenditure exceeds Income for all financial years)	**£94,287**	**£98,673**

Children's Unfunded in Year Expenditure (20/21 Funded from Adults Reserve). 21/22 unfunded pressure	**£94,287**	**£98,673**

Appendix 2: Independent Scrutineer's Report

Wigan Children's Safeguarding Partnership Scrutiny Report

371. This report seeks to comply with the requirements of Working Together 2018 which sets out the role of independent scrutiny "to provide assurance in judging the effectiveness of multi -agency arrangements to safeguard and promote the welfare of all children in a local area. The three safeguarding partners should ensure the scrutiny is objective, acts as a critical friend and promotes reflection to drive continuous improvement. In addition, arrangements should be agreed by the key partners for independent scrutiny of the annual report.

Methodology: This report is informed by:

372. Individual discussions with the three key partners who hold delegated authority and responsibility for the arrangements: the Director of Children's Services Wigan Council, the Chief Nurse from Wigan Borough Clinical Commissioning Group, and Detective Superintendent Greater Manchester Police. All three made positive contributions and were open and honest in their conversations.

373. Meetings with key managers and the Safeguarding Team supporting the partners

374. All relevant documentation including minutes of meetings and performance information has been made available including Ofsted finding during the last year.

375. Observation of the Safeguarding multi-agency senior leads group, the Complex and Contextual Safeguarding and the Education Settings subgroup.

376. **Context:** The new Wigan Multi agency Safeguarding Arrangements **(**MASA) were published and launched in October 2019. A short video with contributions from the Independent Chair and the key partners was developed to promote the new arrangements. Wigan had chosen to bring together children and adult safeguarding arrangements under the auspices of the Wigan Deal. The Wigan Deal aims to work closely with local communities and enable and empower all its residents through ensuring public services are shaped by residents and in partnership.

377. **Strategic context of the MASA** Working together 2018 sets out expectations that the relationships between MASA and other bodies and partnerships should be explicit. In Wigan, the published arrangements set out in diagrammatic form, visually illustrate how MASA is strategically placed in relation to other partnership arrangements within Wigan but is not explicit on how this will work. The Annual Report makes reference to work between the Community Safety Partnership and the MASA, but it is unclear what the relationship is between bodies such the Health and Wellbeing Board, MARAC, MAPPA and the Local Family Justice Board. The positive opportunities for a strong safeguarding partnership to influence these bodies and ensure that the safeguarding of children and young people remains in sight of all partnerships in place across Wigan cannot be overestimated.

378. The structure of the arrangements was published which combined governance and accountability as well as joint leadership for safeguarding arrangements for both children and adults (appendix one). The existing

independent chair of the Safeguarding Adult Board was appointed as chair for the Joint Executive and Wider Leadership Groups.

379. Agreed priorities of work across whole life were:

- Domestic Abuse
- Neglect/self-neglect
- Mental Health
- Exploitation
- Learning back to front line practice

380. Four subgroups were tasked with driving these priorities forward: Partners improving Practice, Complex and Contextual Safeguarding, Education Settings and Early Intervention and Prevention.

381. It should be noted that while these new arrangements were being embedded the restrictions imposed by Covid 19 and the requirement to work very differently to provide services safely took place. While this provided new opportunities, for example, a more efficient meeting system it also provided challenges, not least for front line staff needing sight of children potentially at risk.

Analysis of Effectiveness of the Wigan Multi Agency safeguarding arrangements

Leadership

382. There is no doubt that Wigan has been ambitious in its aspiration to adopt a whole Life Course in its safeguarding arrangements. The Partnership recognised that young people do not stop being vulnerable, exploited or abused simply because they have reached the age of eighteen and therefore it sought to ensure that agencies and organisations worked seamlessly together to meet the needs of all those requiring safeguarding and services irrespective of age through the merging of the two safeguarding arrangements. The vision and priorities are set out clearly in the published document although it is not clear how such priorities were identified. All three delegated senior officers were committed to improving services and ensuring a strong Wigan Partnership was in place. Significantly however, in my recent discussions and in preparation of this report all three leaders raised concerns that the new arrangements meant there was insufficient focus, analysis and scrutiny of children in need of safeguarding and the multi-agency response to these. The views of the two partners in post in Wigan early in 2020 had been further informed by the findings of the Ofsted Focus Visit in January 2020 which stated, “there are significant issues remain in terms of the consistent application of thresholds and timely allocation of children’s services. Weaknesses are also evident in the response to children, in terms of the quality of work in assessments of need, partnership working with the police, and timely decision making in relation to child protection enquiries.” In discussion all three leaders recognise the need to change, strengthen and focus on children’s services as a partnership.

MASA Structure

383. While the structure is compliant with the requirements of Working Together 2018 there have been significant difficulties in ensuring the work required has been undertaken to improve practice and services. There has been insufficient oversight of the work of the subgroups and work plans, for example the Early Help and Prevention subgroup had not met since January 20. A strong Early help offer for children and families is one of the cornerstones of good and excellent children's services across the partnership and this lack of activity is a significant omission. It is not clear why the subgroup did not meet and why this was not challenged until recently.

384. Other subgroups have had a very wide remit and therefore it was difficult to see how there could be a strong focus on children's issues. Partners Improving Practice for example held responsibility for Practice Learning Reviews, training and its impact and audits. There was a very large attendance list and consequent difficulties in arranging meetings. The chair of the subgroup had a difficult task in ensuring the effectiveness of the group. Gaps inevitably remained, for example there were no multi agency audits which would have provided rich qualitative information on how the partnership delivered services children and families at the front line. This would also have provided a clear line of sight for the Executive on the views of practitioners and any barriers they encountered as well as providing assurance.

385. The Complex and Contextual Safeguarding Subgroup observed was well attended and there was good input from both children's and adult services. The lack of performance information meant that it was difficult to identify what were the high-risk areas and where the priorities for action should be for this subgroup. The chair noted that the absence of the Safeguarding Unit Service Manager due to illness had left a significant gap in terms of progressing actions. Transition between children and adult services for young vulnerable people experiencing exploitation for example remains a gap but this reflects the national picture and has been identified as an area for development.

386. **Reviews from serious safeguarding children cases** are being undertaken and there is a clear process set out in the published arrangements. The Rapid Reviews are chaired by the Board Manager using best practice from the previous Wigan Adult Safeguarding Board. This arrangement is currently being reviewed as the Chair and Review Panel needs to be of sufficient seniority with oversight from the three key partners to ensure decision making is transparent and robust. This will also provide an opportunity to revisit the current model of reviews which at times has adopted the pre-existing Serious Case Model which often took considerably more than six months to complete. Messages from the National Panel encourage localities to use different models which can identify and disseminate learning swiftly.

387. A number of reports require completion and publishing. It is notable and concerning that Wigan Safeguarding Partnership under the previous arrangements has not published a review since 2014. Such publications and subsequent actions provide assurance and learning for all agencies, and it is

important that the MASA complies with national expectations to publish. Lack of publication has continued since the establishment of the new arrangements and needs to be addressed.

Capacity and Resources

388. Senior leaders ensured there were sufficient capacity and resources to support safeguarding partnership and its work. There is a substantial Safeguarding Team which provides support across the Life Course safeguarding work and staff have attended all necessary meetings. The joining together of the children and adults safeguarding teams has been challenging and the need to develop a culture which reflected the changed requirements of the new MASA including the move towards equal partnership across the key agencies may have been underestimated.

389. It is not clear what role the team plays in reporting back work of the Greater Manchester Alliance or how this has subsequently influenced the work of the Partnership. This is potentially a missed opportunity to collaborate with other localities and drive-up improvement

Performance information

390. This requires further development to ensure the partnership is clear on potential areas across all agencies that need additional focus. This information is key and should be readily available to senior leaders who are responsible for driving the partnership work and improvement forward. It is difficult to see how this can be achieved without a performance scorecard. There is no Risk Register to formalise leaders' concerns.

Scrutiny arrangements

391. The role of scrutiny was not set out in detail when the MASA was published in Wigan, this has now been addressed and a clear work plan to provide the required level of constructive challenge will be in place during the coming year. This will include scrutiny of the reviews of serious safeguarding cases and dissemination of learning given the concerns highlighted above.

Annual Report

392. Working together 2018 requires a published annual report from each locality. "The report must set out what they have done as a result of the arrangements, including safeguarding children practice reviews, and how effective they have been in practice. It should include evidence of impact of the work including training, on outcomes for children and families, from early help to looked after children and care leavers. In addition, an analysis of areas where there is has been little or no evidence of progress on agreed priorities "

393. Wigan Annual Report covers the period April 2019 to March 2020 so straddles the work of Wigan Safeguarding Board until September 2019 and the first six months of the new arrangements as set out in Working together 2018. The report has recently been accepted by the Children's Safeguarding Partners and is due to be published shortly.

394. The Annual Report provides a brief picture of children receiving services in Wigan, progress on priorities, achievements, learning from seven serious case reviews since 2016 and progress on the actions following the Ofsted findings in January 2020 referred to above. It is a transparent picture

of the partnership and its work and the work required to improve safeguarding work across the locality.

395. The three key partner agencies have provided evidence of progress, some challenge to agencies for example concerning the lack of publication of Serious Case Reviews, and some achievements during this period.

396. Achievements include:

397. Significant increase in resources by GM Police to triage and referral of domestic abuse, adults at risk and child protection incidents

398. Co-location of Police and Childrens Social Care to develop a single front door approach

399. GP safeguarding leads meetings which covered injuries in non-mobile babies and an overview of Wigan safeguarding serious case reviews.

400. Innovative validation visits to health providers took place to seek assurance on embedding the learning from a number of Serious Case Reviews. Three health providers were visited, and detailed assurance was provided. This is a positive example of Partnership working.

Progress on Priorities

401. The report provides good evidence on progress on some of the priorities, for example the Complex and Contextual Safeguarding subgroup has been active and strengthened the approach to contextual safeguarding.

402. Domestic abuse remains a serious issue for Wigan including the significant impact on children who witness abuse and violence, reflecting the national picture. Operation Encompass has been embedded and now includes early years settings which is a positive development.

403. Identified emerging themes from Serious Case Reviews have been analysed and responsibility for embedding learning sits with the Partners in Practice Delivery Group. Given the wide remit of this group it may have been more effective for a dedicated group led at senior level to undertake this work.

404. Progress on the priority neglect/self-neglect has been difficult to clarify. It is understood that a tasks and finish group will be established by the end of 2020 to address this and provide a clear focus on this area.

405. Mental health was identified as a priority and again it is difficult to identify progress or a work plan to address agreed areas for development.

406. This section of the Annual Report will require strengthening and elaboration in next year's Annual Report, specifically addressing where progress was insufficient and what actions are planned to address them.

Training

407. Training delivered by the partnership has been set out in the report and as required in Working Together 2018. Some comments from participants provided evidence of impact but further work is required in this area. This period also saw the rolling out of the Signs of Safety, Wigan's Safeguarding Partnership preferred model of working with families. Models of working are challenging to fully embed and good leadership is required to promote a common culture and language to ensure the success of implementation of the

model. This also holds true for the use of the Graded Care Profile 2 for families where neglect is an issue. Progress will need to be monitored closely. Overall training was well attended and a range of relevant training courses were delivered.

Contributions from children and young people

408. There is a clear expectation set out in Working Together 2018 that partners should evidence how they utilised feedback from children and young people to influence priorities, services and understand the impact of intervention on their lives. The MASA arrangements do not reference any specific input by children and young people. The Annual Report references events that have taken place which involved children but does not provide any information about the outcomes of such events or impact on service delivery.

Contributions from practitioners

409. Some views from practitioners have been provided in the Annual Report as well as single agency work to involve staff. There is no multi agency arrangement within MASA to seek out views and identify areas for future development to improve working together. The Safeguarding Partnership website is significantly out of date with the exception of policies and procedures and a small number of recent updates. As a result, the website does not provide a "go to" tool that all practitioners would seek to access to keep them updated with national and local developments or use as part of their daily practice. This is a significant gap given the high value placed on staff across Wigan.

410. Finally, it should be noted that there are some gaps in the report, for example there are few details about early help and the support families can expect when there is early identification of need or the impact. While numbers of looked-after children are provided there is no information about how this group of children and young people are safeguarded, particularly those placed outside of the locality. and no mention of care leavers

Conclusion

411. Wigan's Multi Agency Safeguarding Arrangements have in the main complied with the requirements set out in Working Together but with some significant weaknesses. The whole life course while ambitious was a significant challenge to Children's Services which were displaying serious difficulties in delivering good services during the period covered by the Annual Report. As a result, there was insufficient progress on embedding the new arrangements, limited evidence of effectiveness and impact or progress on priorities. Senior leaders across the Safeguarding Partnership have recognised this and the limitations of the existing arrangements. At the time of writing, they have decided to disaggregate Childrens and adults safeguarding arrangements including the Safeguarding Team which provides support to the current arrangements. This will be fully implemented in early in 2021. This decision is welcomed and the subsequent clearer focus on children's safeguarding arrangements and priorities will allow for deficits identified to be addressed. In addition, the changes implemented by Wigan Council earlier

this year in the appointment of a new Director of Children's Services and team have had a positive impact which has led to a fresh focus on safeguarding children in Wigan to address deficits while strengthening partnership work. This was noted by the recent Ofsted focus visit and the subsequent publication of findings.

The following recommendations aim to strengthen the new arrangements and are all achievable

- Publish revised MASA as soon as possible, making explicit the strategic role of the Partnership and its links and working arrangements with other existing bodies such as the Community Safety Partnership and the Greater Manchester Alliance as set out in Working Together 2018.
- Relaunch MASA, and in particular use the updated Website to inform staff of the priorities of the Partnership with success criteria.
- Strengthen the contribution of children and young people to shape priorities and services as result, this commitment should be demonstrated by ensuring that in future at least one section of the Annual Report is written by children and young people
- Promote a culture of publication and learning from reviews of serious children's safeguarding cases.
- Develop a strong performance framework including the use of multi-agency audits which test out whether learning has been embedded across the locality from reviews. This must include performance information on children receiving early help services, children with child protection plans, looked after children and care levers.
- Strengthen oversight of the work plans of the subgroup including progress on agreed priorities making use of a Risk register to support the work. Analysis of progress to be included in the next Annual Report.
- Increase the contributions from practitioners systematically to promote "buy in" for good and effective partnership working.
- Develop the work on transition that is planned in the Complex and Contextual Safeguarding subgroup

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Wigan Safeguarding Partnership.
December 2020