Wigan Council

Wigan Safeguarding Children's Partnership

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7.0	Independent Scrutineers response to the WSCP Annual Report

Introduction:

Welcome to the Annual Report of Wigan Safeguarding Children Partnership for the planning year 2021 – 2022.

Over 2021-2022 the changes made to move from an all-age Partnership to a separate Wigan Safeguarding Children Partnership and Wigan Safeguarding Adults Board to bring refreshed strategic focus on Children in the borough were accelerated and embedded.

The report outlines the priorities, activity and commitment from across the Partnership agencies as they responded to new challenges in 2021-22.

As a Strategic Partnership we still have more to do moving into 2022-23 to see that process of improvement mature, particularly around how the Partnership gains assurance of the quality of safeguarding across the borough and how we can continue to ensure that help and support is offered to children and their families at the earliest possible opportunity.

The partners remain resolutely committed to this continuous improvement and welcome the opportunity to show the progress made in 2021-22 through this report.

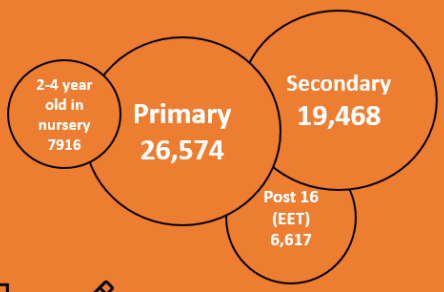
Colette Dutton
Director of Children's Services, Wigan Council Chair
of Wigan Safeguarding Children Partnership.

Section 1: What we know about the safeguarding experiences of children in Wigan:

1.1

What do we know about Children in Wigan?

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



2488 children have an EHCP

6848 children receive SEN support

28% of children receive Free School Meals – an additional 988 since August 2021

90% of Wigan schools are Good or Better. 95% of all Wigan leaners in good or better Primary School, 100% of children in good or better special schools, and 72% of children attend a good or better secondary school

75 children were missing from education

10 children had a Part time timetable

349 children registered as being Electively Home Educated at end of August (+35 from August 2021)

In the academic year 2021/22

- There were 94 permanent exclusions
- There were 3489 suspensions (which equates to a suspension rate of 5.95)
- The average attendance rate was 92.4%
- On average 30.1% of children were persistently absent (+17.9% from 2020/21)

*data as at end August 2022

Safeguarding activity in the last 12 months

5370 referrals for Children's Social Care in the last year – (Police 28%, Education 17%, Health 13%)

We initiated 1902 Section 47 investigations, and held 696 initial child protection conferences

At the end of March 2022 we had 3131 children and young people open to Childrens Services.

At the end of March there were 450 CPP. 624 started in last 12 months (23.7% of these for the second or subsequent time in last 12 months) 559 CPP ended in the year

We completed 6076 assessments in the last 12 months

At the end of March 2022, 614 of the children open to us were looked after

199 Care Leavers,
59 aged 17-18
140 aged 19-21
We are in touch with 89.9%
86.4% in suit. Accommodation
44.7% in EET

220 children started to be looked after in last 12 months
215 children ceased to be looked after in the last year

67.8% of our looked after children live in Wigan

As at end March 2022

1.2 : The Priorities for Wigan Safeguarding Children Partnership 2021-22 were:

- Neglect.
- Front Door arrangements i.e., how a multi-agency safeguarding system responds at the initial points of contact and management of concern.
- Children's mental health within the context of families,
- Domestic abuse within the context of families.

To provide some context; in spring 2021 the statutory partners and non-statutory stakeholders of Wigan Safeguarding Children Partnership, were still being challenged by the dynamic effects of the Covid-19 Pandemic- whilst some partner agencies services were returning to pre-pandemic delivery models, others were still in resilience models with increased demand and back-logs from the children and families we work with and workforce pressures.
Resultantly, the Wigan Safeguarding Children Partnership Priorities for 2021-22 were a continuation of those from 20-21; the achievement of which had been affected by the Covid-19 Pandemic and resultant disruption to services. Some of these priorities (for example Children's mental health) when set in 2020 were based upon identified need at that time but were further significantly adversely affected by the Pandemic.

1.3 Priority Area: Neglect

Neglect for children in the borough is chronic, long lasting and the adversity and trauma it precipitates has lifetime impact.

1.4 Activity around the Neglect priority in 2021-22:

During April and May 2021, the Wigan Borough Neglect Strategy was launched along with the new Threshold of Need document. To support this launch there was the inception of a multi-agency task and finish group around the neglect strategy. 2 sessions of Multi-agency Threshold of Need briefings were facilitated online to 234 professionals across the Partnership, representative of the statutory partners

Key areas of work taken forward by the group 2021 into early 2022 included training for staff on identification of neglect, preventing it and promoting permanency for children. Specifically gaining an understanding of the barriers to consistently applying the Graded Care Profile 2 (GCP2) tool. A core issue identified was the limited number of practitioners who have been able to access the training which was in the main due to the lack of trainers across agencies in the borough. Subsequently in spring 2022 Wigan Safeguarding Children Partnership committed the finances to train twenty more trainers across the partnership, an initiative being actualised in the 2022-3 cycle. This will lead to a re-launch of the tool in Wigan and following this we will be able to re-audit and collect data on its use and put in more support and challenge across the partnership to create confidence in working with children and families where neglect is an issue.
In another positive move in 2021-22, the GCP2 was embedded into Clinical Systems, supporting health partner practitioners in ease and accessibility of use.

Over 2021-22 Children supported the work of the Partnership around this neglect priority. A good example of this is the fantastic work produced by the "Safeguarding Soldiers"; a self-named group at a local primary school who have been brought together by the Designated Safeguarding Lead at the school with co-facilitation by the Wigan Safeguarding Children Partnership business team. Over 2021 – 22 the group helped produce newsletters around online safety, gambling and who to talk to when worried about something and offered some great insights into what abuse, and neglect would mean in child centred language. 'Safeguarding' to them means; being safe, helping people, having respect, protecting others and being kind, amongst an array of other terms.

Furthermore, our 'Safeguarding Soldiers' work has now expanded to encourage similar conversations with high school students. Although more premature than our primary Safeguarding Soldiers, they have also released a newsletter covering bullying, hate crime, sexual exploitation and harassment.

1.5 Priority area: achieving a good quality multi-agency front door:

Prior to this planning year, Local Child Safeguarding Practice Reviews and previous Serious Case Reviews provided a rationale for systemic review of the 'front door' arrangements, and this continued into 2021-22 with the learning from Child Y Serious Case Review and the Child 3 Local Child Safeguarding Practice Review (both completed June 2021). All these cases identified various opportunities to improve how information is exchanged, and how agencies apply the threshold of need across the partnership

1.6 Activity, impact and next steps around the 'Front door arrangements' priority in 2021-22

As the year 2021-2022 started Wigan Safeguarding Children Partnership were concerned about the demand on what was a constantly improving multi-Agency front door and understanding the reasons for this. In March 2021, around 50% of contacts from across agencies into the Multi Agency Safeguarding Team (MAST) did not progress beyond an advice threshold and this inevitably diluted resource from the cases that required response. Alongside the refresh and relaunch of the Wigan Safeguarding Children Partnership thresholds mentioned earlier, a remodelling of the MAST was undertaken.

1.7 Priority Area: child mental health:

In 2020-21 the partnership was already strategically engaged in building improvements at all levels, or 'tiers', of mental health awareness, support, and intervention following learning from LSCPR's.

1.8 Activity, impact and next steps around the Mental Health priority in 2021-22:

As the Covid-19 pandemic progressed in early 2021 we knew from local data that children's mental health services were receiving more referrals than the monthly rate before the pandemic and the demand surge continued for some time. Statutory and non-statutory services noted that the complexity of mental health presentations was much greater than ever before which impacted on the required staff skillset, interventions and duration of support delivered. Despite the substantial challenge, it is commendable how local services continued to work collaboratively to maintain a sustainable mental health offer throughout the pandemic; often delivering beyond the remit of the service to ensure children, young people and their families continued to receive high quality mental health support.

In response to the pandemic Wigan Borough Clinical Commissioning Group (CCG) worked in collaboration with our local CAMHS provider (North West Boroughs NHS FT at the time) to continue to adapt the offer to a digital offer to allow children and young people to continue receiving urgent support when needed, and we listened to the voice of the children by setting up a digital One Voice group designed to understand how the pandemic was affecting their daily life. This group was later replaced by Greater Manchester's BeeHeard group.

From April 2021, there was continuation of the transformation work and the implementation of the Wigan CAMHS Mental Health Support Team (MHST) who work alongside select schools in Wigan to provide 3 core functions:

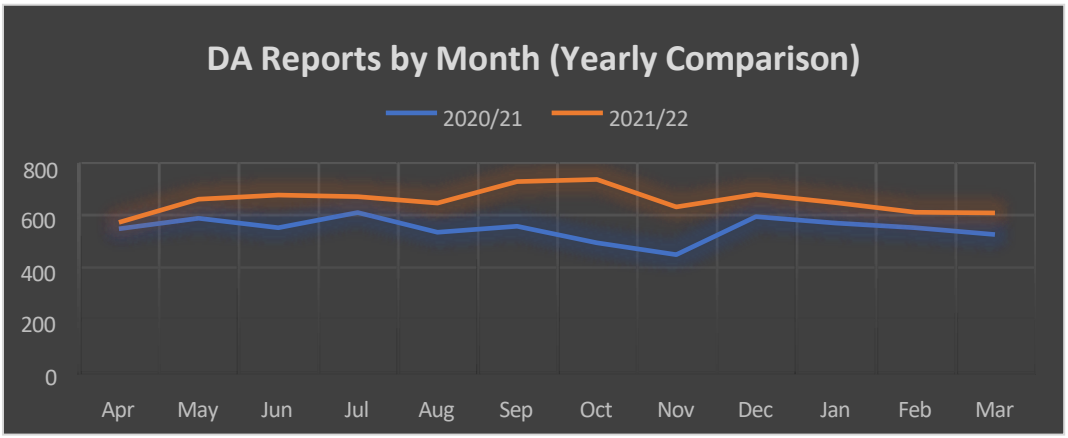
- To deliver evidence-based interventions for mild-to-moderate mental health issues
- Support the senior mental health lead (where established) in each school or college to introduce or develop their whole school or college approach
- Give timely advice to school and college staff and liaise with external specialist services to help children and young people to get the right support and stay in education.

In summer 2021 the Partnership received a referral for a Local Child Safeguarding Practice Review which centred on the availability of appropriate provisions and placement for a young person with severe emotional and mental health difficulties who had spent an extended time on a general paediatric ward; the case had been subject of a public High Court ruling. This case review, which was completed in 2022 prior to the completion of this Annual Report, will play an important role in the shaping of services.

1.9 Priority Area; Domestic Abuse:

Domestic abuse, and the impact on children in the borough has been a constant issue for Wigan Safeguarding Children Partnership over many years so the partnership wanted to put the lived experiences of children at the forefront of our practice when working with families for whom domestic abuse is a feature.

Over 2021-22 there was an increase in Domestic Abuse in the borough compared to the previous reporting year, illustrated by the below:



1.10 Activity around the Domestic Abuse priority 2021-22:

The partnership has driven increased use of the evidence-based assessments via the use of tools (DVRIM and CAADA DASH), and work with the family as a whole; to implement realistic and sustainable changes, and effective safety plans. We have supported working together as a partnership strategically and operationally to ensure a co-ordinated approach to reducing the risk to children, working as a whole family approach. A specialised resource was agreed with a re-aligned resource creating a domestic abuse team based with Childrens service, focusing on everyone in the household and family there has been a successful appointment of a Children's (IDVA) Independent domestic violence advisor who works with children specifically with families where homeless has occurred due to Domestic Abuse. The partnership has also collaborated with the service user experienced group to support changes in service delivery.

Section 2: Governance and Scrutiny of Wigan Safeguarding Children Partnership 2021-22

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

Responsibilities:

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:

- 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.
- Ensuring that safeguarding plans and processes actively contribute to the Wigan Deal 2030 objectives and outcomes.
- 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.
- Delivering and ensure the provision of guidance, support, and workforce development to partner agencies to enable them to discharge their safeguarding responsibilities effectively.
- Producing annual business plans and strategic planning documents in line with statutory requirements.
- 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).
- Ensuring that an appropriate and effective infrastructure is in place to support the Board in delivering the local safeguarding strategy and business plans.
- Overseeing the commitment of resources to support safeguarding in Wigan including income generation and financial support to the partnership.

Values:

Our values illustrate the approach the partnership will take in delivering its vision.

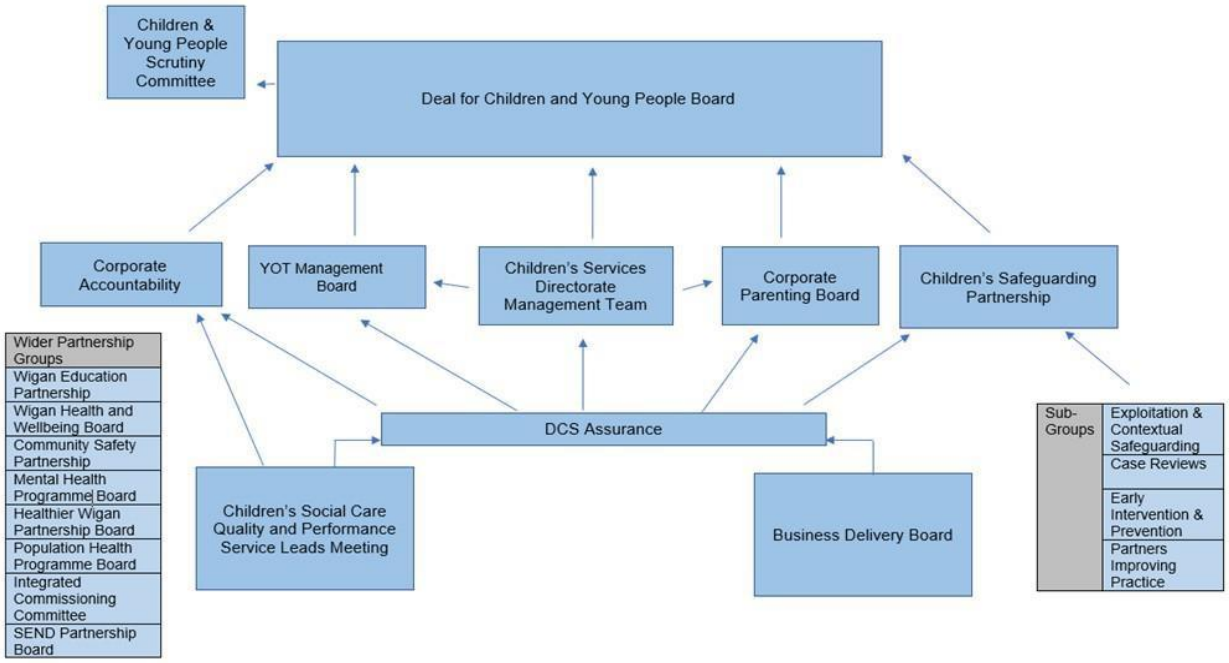
- Children have the right to live their lives free from violence, abuse, and neglect and to feel safe in their homes and communities.
- All children and young people should have the opportunity to grow up safely and be protected from abuse and neglect, crime and anti-social behaviour.
- Safeguarding children is a shared responsibility of all agencies and agencies commit to holding each to account.
- 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.
- High quality multi-agency working based on consensus, equality, respect, and collaboration is essential to good safeguarding outcomes.
- There is a commitment to continuous improvement and learning across the partnership.

Ambitions:

Our Ambition is that in achieving this we will:

- Champion the interests and rights of children, young people, and adults at risk of abuse and neglect
- Ensure there is an emphasis on outcomes for children, young people, families, and adults at risk of abuse and neglect.
- 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.
- Involve all partners, not just police, health, and the local authority, with a clear platform and duty to co-operate.
- 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.
- 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.
- Meet the leadership challenge of connecting multiple partners together and collaborate to achieve common goals and within new ways of working.
- Ensure that every child and young person becomes a confident, resilient adult.

The Governance of the Partnership sits within the Wigan Council structure outlined below:



The structure of how Wigan Safeguarding Children Partnership facilitated its objectives 2021-22 is described in the following diagram:

2.2 Independent Scrutiny:

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. In spring 2022 the incumbent Independent Scrutineer retired from the role, and a process commenced to identify a new Independent Scrutineer for 2022-23.

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's 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

In our last annual report (2020-21) Wigan Safeguarding Children Partnership's Independent Scrutineer made the following recommendations for the Partnership:

1. Publish revised Multi Agency Safeguarding Assurance (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.

2. Relaunch MASA, and in particular use the updated Website to inform staff of the priorities of the Partnership with success criteria
Update: Both of the above recommendations were actioned in Autumn 2021 with a refreshed MASA and some changes to the Wigan Safeguarding Children Partnership Website (an ongoing project into 2022-23). Whilst we launched the Safeguarding Effective Framework in this period we did not progress the piece of work on success criteria.

3. 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.
Update: Over 2021-22 children and young people have become increasingly active stakeholders in the Wigan Safeguarding Children Partnership work through our Safeguarding Soldiers Work, however it is an area where we have further improvements as we have not secured their direct input into this year's annual report.

4. Promote a culture of publication and learning from reviews of serious children's safeguarding cases.
Update: Wigan Safeguarding Children Partnership has made significant progress in this, publishing 'legacy' Serious Case Reviews and driving faster learning cycles on Local Childrens Safeguarding Practice Reviews (LSCPRs). Over 2021-22 there was a great increase in the amount of learning product sharing, facilitated learning opportunities for both single agencies and multi-agency. As the Partnership enters 2022-23 the learning culture is strong and increasingly active.

5. 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.
Update: The Multi-agency audit schedule over 2021-22 was planned to be monthly but did not achieve this aim; greater prioritisation of this work across the Partnership is needed in 2022-23. Nonetheless, as is detailed in the learning and improvement section of this report, several multi-agency audits did take place with improvements made on previous years around tracking of actions thereafter. The development of a Performance framework with accompanying analysis will be priority area for the partnership in 2022-3.

6. 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.

Update: A risk register was developed in late 2021-22 and as we move into 22-23 the Partnership will have a dynamic reviewable version of this to inform strategy.

7. Increase the contributions from practitioners systematically to promote "buy in" for good and effective partnership working.
Update: Involvement of practitioners through various routes has increased greatly over 2021-22; for example, the DSL Network has evolved, interactive learning products have been distributed, training returned to a partially face-to-face offer, and we have involved more practitioners in Multi-agency audit sessions.

8. Develop the work on transition that is planned in the Complex and Contextual Safeguarding subgroup
Update: This work continued to be mobilised over 21-22 with an increasing focus on transition not just in the Complex and Contextual Safeguarding subgroup but across the whole partnership.

Over 2021-22 WSCP sought to start to establish a framework to benchmark our safeguarding effectiveness based on:

1. Effectiveness - What is the impact of the new multi-agency safeguarding partnership?
2. Efficiency - How efficient is the new multi-agency safeguarding partnership in working together to achieve their strategic priorities?
3. Leadership - How effective is the new multi-agency safeguarding partnership in influencing outcomes to safeguard and promote the welfare of children?

2.3 Wigan Safeguarding Children Partnership Sub-Groups:

The Subgroups are each co-chaired by Senior Leaders from around the Partnership relevant to their areas.

2.4 Early intervention and Prevention Sub-Group Report on Activity and Impact 2021-22:

The Early Intervention and Prevention Group has met regularly over the past twelve months. Membership has been largely consistent although attendance has waned from time to time, picking up again in more recent meetings.

The following work has been overseen by the group and delivered by a small early help project group with partnership support.

The review of Early Help activity commenced in April 2021 and ended in December 2021. It included exploration of the resources that make up the current offer, the existing Early Help Strategy, performance, and practice. The analysis of practice follows the refresh of the Safeguarding Partnership's thresholds of need document and sought to understand what support is available to children and families, review

its effectiveness and recommend improvements. The Early Help offer has been considered in the context of partnership and the wider programme of improvement and reform at both local and national levels.

Following completion of the evaluation an action plan has been produced that sets out 52 actions. Work has commenced on many of these key actions, and most will be driven by the project workstreams set out in the new Family Hub Transformation Work programme.

- As part of the Early Help review children, young people, families, and professionals were consulted.
  - The themes from the Family Voice consultation will be disseminated across the professional network for the staff to address in their services.
  - The areas of focus identified through 'Family Voice' will be incorporated into the Family Hub transformation programme and we will identify those who are willing to be part of the co-production work projects.

- There has been an initial review of Early Help Pathway, policies and procedures including the further design and implementation of an Early Help Hub as part of an Integrated Front Door.

- Think Family Pilot: A 'Think Family" pilot project has been underway between September 2021 and is due to end July 2022.The pilot has sought to improve the Early Help service practice and processes and feed into wider system reform linked to the development of family hubs. The review of practice, procedures and policies with staff, partners and families will harness best practice leading to improved outcomes for children. There have been 2 interim reports completed with the final evaluation due in August 2022. The initial findings are that risk factors have reduced, and protective factors increased. There has been significant improvement for majority of the families by utilising a multi-agency approach for the whole families. We analysed data on the impact of improving the situation for parents and the influences upon children and young people and seen a clear correlation. The pilot has ensured a clear focus on children's experiences demonstrating that children's services are critical, but adults' services also have a crucial role to play in determining children's achievements and future life chances. The work with adult services has impacted upon the whole family intervention.

  The quality of children's assessments and plans have significantly improved with the introduction of the revised assessment. The assessments of need do not focus on recent events, but try to consider the cumulative impact of harm, so that the interventions have a clear impact. The close monitoring of the outcomes for children and effective reporting processes have ensured that children's circumstances have improved before the work has ended. The full offer in the "Think Family" pilot has allowed for step down from Early Help into the community offer so that families are always surrounded by support mechanisms. The second review has shown significant improvements for

families in relation to each outcome and the scores they give themselves. The revised assessment, plan and review are designed to ensure that Supporting Families Outcomes are captured.

- A comprehensive and detailed Lead Professional Handbook has been developed by the partnership to encourage staff across the workforce to embrace this role.

The ability to produce and make effective use of performance reports for Early Help has progressed 2021-22. The EH&P agenda includes a standing item for performance, and we can monitor the timeliness of work as well as the through put. Whilst a further achievement is that the QA framework now includes level three Start Well work, and this has evidence good quality work and learning from audits both with in locality and family centre teams. This is not routinely reported to the subgroup and should be going forward.

- Development of Family information Service: There has been considerable work in updating a central database of services so that the full partnership can be aware of all the services available to support families. This has improved family's circumstances as families can access the help, they need at the time they need it.

- Reducing parental conflict is a theme identified within the Family Hub model. Additional capacity has been created for a reducing parental conflict coordinator.

- Development of the Early Help webpages to provide a resource for families to find out the Early Help process and signpost them to support such as the Family Information Service. There will also be a section marked as a resource for wider professionals to get support in leading on Early Helps, resources for training, resources for working with families

2.5 Exploitation and Contextual Safeguarding Subgroup Report on Activity, Impact and next steps 2021-22:

The Exploitation sub-group is a well-attended board. The introduction of mandatory six weekly reporting into the sub-group for both police and children's social care has improved the transparency of processes, operations, and cases within the Complex Safeguarding Hub. There is an ambition that this will morph into a joint police / children's social care monthly report to better reflect the strong partnership reliance and ethos.

The subgroup has had learning circles on WSCP Practice Reviews to support our work plan development (which has been recently refreshed) and GM Complex Safeguarding Hub colleagues joined us for a development session.

Within the 12-month reporting period, the multi-agency Missing from Home protocol and governance has been ratified and introduced. Over the next annual reporting period there needs to be a focus on embedding this and ensuring strong joint governance and accountability.

The 'Achieving Change Together' (ACT) model with a focus on building trusted relationships with children, young people and their families has been introduced which will strengthen the offer to those who are at risk of exploitation. Childrens Social Care have moved away from a case holding model to facilitate adopting ACT fully this year. To complement this, there has been an increased CAMHs offer.

Some staff have received trauma informed practice training, but there is work to do to ensure Exploitation subgroup embraces trauma informed practice and supports role out across the partnership.

Multi agency performance data remains underdeveloped within the partnership, with single agencies holding relevant data however we are now improving triangulating data across key agencies to understanding if we are improving outcomes for children.

There is an acceptance that transition arrangements can be enhanced. A learning circle was used to audit cases supporting the development of the transition policy reflected the experiences young people were having. There are constructive and informative contributions from adult social care that continue to be explored. A key aim for the upcoming year would be an operational offer for young people up to the age of 25.

The links between those children identified as victims of child criminal exploitation and those involved in Serious Youth Violence need to be further explored. There is an ambition to regard Serious Youth Violence as a form of exploitation and review ways to provide an operational response to this.

2.6 Case Review Subgroup Activity, impact and next steps 2021-22

The case review subgroup operates to provide assurance and a governance structure for the ongoing Local Child Safeguarding Practice Review work across the partnership, the completion of Action Plans relating to these cases and to oversee the learning products that the Partnership shares through these processes.

The Case Review Subgroup also provided a line of sight for Wigan Safeguarding Children Partnership on the wider work being undertaken in single agencies to gather assurances, such as the validation work undertaken by the Clinical Commissioning Group with their provider NHS Trusts and Primary Care and the various NHS review cycles around Serious Incidents.

Consideration will now be given to widening the remit of this sub group going forward to include all learning.

2.7 Partners Improving Practice Subgroup Report on Activity and impact 202122

The Partners Improving Practice (PIP) Sub-Group became well established and well attended with representation from across the partnership including the advocacy service over 2021-22 with increased engagement from GMMH and GMP. The group has influenced the WSCP training offer, and the partnership are engaging in a training needs analysis to inform this work further as we move into 2022-3. Over 2021-2 the group oversaw increased in additional training briefings for DSL (designated safeguarding lead) in schools as a key area for improvement previously identified.

PIP has a key role in ensuring that a 'signs of safety' framework approach continues to be embedded in agencies, and over the year there was joint delivery of training between children's social care and GMP to raise awareness of signs of safety with frontline officers.

Participation and co-production have resulted in a group of primary school children becoming safeguarding soldiers, providing their feedback to the partnership via this group. However, we want to drive single agencies demonstrating to the partnership how they listen to children and families and how this influences systems and services.

A major focus of the group over 2021-2 was reviewing the effectiveness of the child protection planning system. Agencies have worked well together to identify areas for improvement, and this has led to timeliness in multi-agency child protection conferences and reducing children on repeat plans. Each agency reviewed their interventions with families and one good practice example is how the alcohol and drug service 'We are with you' identified they wanted to develop a specific programme for parents.

The group are driving the work to establish a multi-agency data set, this work has not happened at the anticipated pace, however a dashboard has been agreed, scrutiny of partnership data to identify themes for the work of the wider board will be the focus of a newly established subgroup.

2.8 Education settings subgroup Report on Activity, impact and next steps 2021-22

The Education Settings Subgroup has been part of the Wigan Safeguarding Children Partnership delivery structure for over 8 years under the older Safeguarding Children Board into the development of the Partnership. Despite the changes outlined in Working Together 2018, Wigan Safeguarding Children Partnership took the decision that the strategic engagement of Education partners working across the 0-19 age group was essential. The groups responsibilities include:

As the education sector returned to more of a normal operation in mid – late 2021 the focus of the group changed. The group established work streams and themed focus groups to respond to some of the emerging key issues of policy and risk: sexual violence in schools; embedding safe knife and weapon protocols; refreshing drug and alcohol protocols relevant to the settings and information sharing across points of transition (EYFS to Y1, Y6 to Y7 and transition into HE / FE).

A key piece of work for the Education Settings Subgroup over this period, and an opportunity afforded by the Teams technology evolving from the pandemic, was the development of a Designated Safeguarding Lead virtual network. This has brought together groups of up to 80 DSLs for briefings, training support and sharing of case review learning on a termly basis and went from strength to strength over 2021-22.

The group has also met several challenges over the year; school absence has increased which makes safeguarding harder to achieve, numbers of electively home educated children have increased, and reporting requirements have altered. Emerging from the pandemic, children and young people's mental health was a national acute need and the education sector at all levels have observed this – whilst there are positives discussed in the mental health priority area of this Annual Report the very scale of the issue and the impact creates demand for support that cannot always be met. The Group also reflected and built on some key areas of case review learning in 2021-22 and will continue to do so in 2022-23; fixed term and/or permanent exclusions and planning of provision were areas that are live for the group.

Finally, the continuing need for there to be an efficient, well understood Early Help offer led by schools who have capacity to implement it within a system that can elevate to more intensive support where needed was a key area of need identified and driven forward by the group.

Section 3: Learning from Case Reviews

3.1 Review Activity 2021 -22

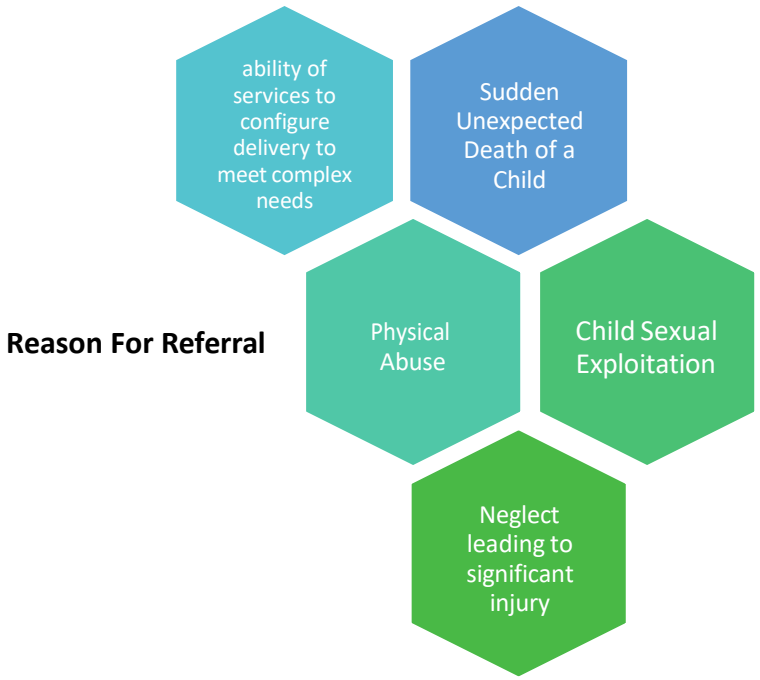
Child Safeguarding Notification (CSINS) Notifications / Rapid Reviews undertaken 1.4.21 – 1.4.22	Number of Rapid Reviews that progressed to Local Child Safeguarding Practice Review
5	3

In the year Wigan Safeguarding Children Partnership completed notifications and subsequent Rapid Reviews on 5 cases. These covered the following reasons: On

the 2 cases that did not progress from Rapid Review, action plans were written and completed to respond to learning identified.

3.2 Analysis of Key Themes

Thematic analysis of cases referred for full LCSPR in 21/22 and those cases where the review cycle was completed in 21/22 is considered here. There was a total of 3 referrals which progressed to LCSPR and 6 SCR's/LCSPR's which reached completion/publication.



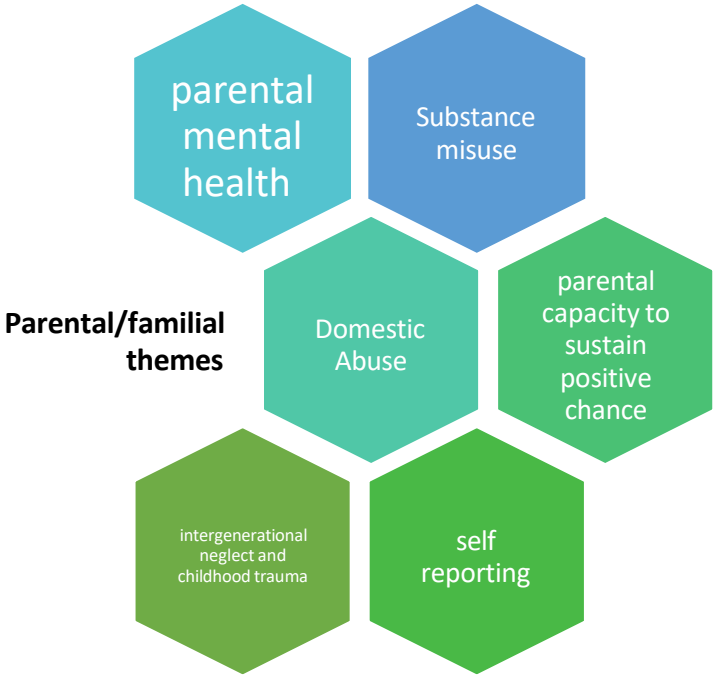
Key issues relating to recurring thematic areas across case reviews were extracted as follows:

- Family / Parental themes included mental health parental mental health domestic abuse and substance misuse; analysis showed that these key areas interreacted negatively across other themes, for example parents' capacity to achieve outcomes and motivation / capacity to change.

- Intergenerational neglect was a theme in almost all the reviews considered. The impact of this required further analysis to understand how parental experience of childhood trauma and neglect were impacting upon their relationships and perception of services and their ability to maintain positive change.

- Reliance on self-reporting was apparent across multiple reviews and was apparent within multiple agency records. The impact of the COVID-19 pandemic and restrictions on agency contact undoubtedly had a significant

impact and in certain cases carrying on into 2022-3 this is even more pronounced. Despite this work should continue to ensure that service responses are designed to withstand national incidents such as the Pandemic in the future.



Practitioner skills / knowledge –

- Disguised compliance was evident in over half of the cases considered here, many of these cases had significant histories with services and individuals in volved could be capable of manipulating service responses. We do not currently understand this from a service user perspective.

- Professional challenge and analysis within agency records; this was and is impacted by a lack of clarity around professional roles and responsibility. Lack of root cause analysis is seen through repeated similar interventions, negative language, and failure to record or understand the true lived experience of children and families.

- Learning from review process shows deficits in the application of Trauma Informed practice, particularly in those cases where statutory intervention has featured throughout the life course. There is an evident lack of clarity between the recording of the voice of the child and the capturing and understanding of the child's daily lived experience throughout agency records.

3.3 Learning products:

The Partnership team over 2021- 22 continued to 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 were published on the Wigan Safeguarding Children Partnership website to help practitioners and agencies reflect on their practice and systems.

Thematic briefings were also produced on key themes from Rapid Reviews, Brief Learning Reviews and Local Children's Safeguarding Practice Reviews, allowing 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**
case specific 7-minute briefings	**5**
Case specific 7-minute briefings awaiting publication	**3**
Theme specific 7-minute briefings	**7**
Positive Practice 7-minute Briefings	**4**

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.

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.

3.4 Multi-Agency Audit in 2021-22

The Partnership Learning and Improvement Officers developed the audit cycle within 2021/22

The impact of agency capacity due to the ongoing period of business resilience resulted in fewer audits completed than anticipated. During 2022/3 we regained pace and to reintroduce face to face multi-agency auditing on a bi-monthly schedule.

Month	Audit Theme	Area of Focus	Summary of Findings
Jan 2021 *(approved Apr 21)*	Partner attendance at statutory meetings	Partner Attendance at: CP Case Conferences; Strategy Meetings; and Core Groups	-Recording of invite ant attendance within Liquid Logic was inconsistent despite system functionality -Invites lack consistency for most partner agencies, impacted by timeliness of invites and inaccurate contact details for relevant agency representatives -Those agencies who do not attend ICPC would not receive invite to reviews due to process flaw. -Partner agencies should be accountable for recording their own reasons for nonattendance

May 2021	Babies (under ones) born during the pandemic that died or were seriously harmed	WSCP Response to concerns highlighted in the Safeguarding Reform Implementation Letter Received 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."*	-Despite challenges posed by the COVID19 pandemic, multi-agency discussions were able to take place in a timely manner -There was a lack of analysis in relation to the potential increased pressure and therefore risk presented to a new baby following a recent closure to services for another child during periods of national lockdown. -Inconsistencies in information sharing and recording in relation to an unborn child, impacted by their information being recorded in another child file until after their birth. -Safeguarding concerns raised where recorded and initiated a response before the 12-week viability scan in ¾ cases. -Use of available tools to measure and assess risk was lacking across agencies. -A quarter of cases were rated as poor, most frequently in relation to the quality of analysis.

June 2021	Non-accidental injuries in infants	Serious Case Reviews featuring Non-accidental Injury in Infants have highlighted several opportunities for Multiagency Learning. A cohort of the 10 cases of non-accidental injury known to CSC and Health will be cross referenced. The most recent 10 known to both agencies will be included.	-Whilst not predictive of NAI the presence of psychosocial risk factors may be a useful tool in measuring for potential risk. - Recording in children's files should be child centred and reflective of their daily lived experiences- Health records identified system issues in recognising and recording gender identity and preferred pronouns. -The concise and effective recording of complex family networks requires further work and managerial oversight. -Tripartite agencies demonstrate good information sharing processes -Consideration given to the role of adult services where parental mental health, DA and substance misuse were impacting parental capacity to parent was lacking. -The introduction of CSC "bottom lines" appears to promote robust planning around outcomes which are achieved in a timely manner.
Nov 2021	Parental Mental Health	Parental Mental Health has been highlighted as a theme in Local Children's Safeguarding Practice Reviews and Serious Case Reviews over the last 2 years. Consideration given where there has been / should have been joint working between mental health services with parents as part of the child's plan. Independent Reviewing Officers identified 10 families and 8 of these were audited.	-The disparity between statutory children's services and voluntary adult services impacts the co-ordinated delivery of interventions. -There was a lack of think family recording in adult service records. -Consideration for the child's role as a young carer was limited and lacked assessment -lack of availability of GP records in statutory meetings risks availability bias in understanding risk.

3.5 Tracking, Monitoring and Assurance gathering from Review Cyclesrecognising.

The completion and authorisation of action plans from statutory review processes (LCSPR's) was below expectations. The partnership recognised that action plan completion was being impacted by several factors. Partners across the tripartite were recovering from an extended period of business resilience following the COVID-19 pandemic. Staff sickness and redeployment throughout this period had impacted assurance gathering, tracking, and monitoring of action plans. Delays were also impacted by staff turnover and changing of roles within the partnership.

The partnership business team began the development and embedding of new assurance gathering processes. The process has undertaken several revisions of the course of the year and progress has continued to be impacted by those issues outlined above.

Revisions have seen the introduction of thematic work currently ongoing to draw legacy action plans to a close. Despite delays, the partnership team have seen an increase in assurance submitted against action plans. This is supported by better working relationships with partner agencies and a mutually agreed process for doing this.

Section 4 Training and workforce development, and next steps:

Over 2021-22 Wigan Safeguarding Children Partnership continued to offer a broad range of training assisting the Partnership agencies in continuously developing the workforce and ensuring that their statutory responsibilities were met. A training needs analysis was undertaken across the whole partnership which evidenced that the offer aligns with the priority areas emerging from case review activity, and with the needs of partner agencies individually. The review of the training offer remains iterative through the use of the Safeguarding Effectiveness Framework and multi-agency quality assurance cycle, and over 2021-22 a wide range of additional learning products were developed over the year which evidence a quick line from identification of learning need to training offers.

The restrictions of the Covid-19 pandemic dictated that the majority of Wigan Safeguarding Children Partnership's training offer was virtual through our online platform, Virtual College. However, as we moved into late 2021 and early 2022 the face-to-face training offer was able to be increased.

Key parts of the 2021-22 offer were the start of the roll out of the training that will develop the multi-agency workforce to be trauma informed, and the continued commitment to both raising competence and embedding a Signs of Safety approach across the partnership.

There was, as usual, over a thousand training opportunities facilitated through levels 1 and 2 Safeguarding in Education across the sector. This comprehensive coverage and consistent offer to the education sector is achieved through a robust 'buy back' offer and is complemented by model policies for the sector around core safeguarding (in line with revisions to Keeping Children Safe in Education), bereavement support and online learning. As we returned to a Level 3 face to face offer in spring 2022 it opened opportunities for more interactive learning, and the partnership has started to review the Level 3 package with a view to refreshing it for 2022-3.

Designated Safeguarding Lead training was again successfully delivered to over 200 learners and coupled with the DSL virtual network described in the Education Settings Subgroup element of this report, provides a good quality approach to maintaining standards for our education leads.

The training with the highest levels of engagement were where senior leaders in the partner agencies had asked their workforce to prioritise attendance: Early Help, Professional Curiosity and Challenge, Signs of Safety and Threshold. Whilst this is encouraging, some of the training offer around priorities areas such as Domestic Abuse and Parental Mental Health are less well attended so as we move into 22-23 the Partnership will review how the training offer is communicated.

This period also saw Wigan Safeguarding Children Partnership introduce a Professional Curiosity and Challenge training product which was a response to earlier case review learning, but also underpins a key area for continued development in 2022-3.

Section 5 Wigan Safeguarding Children Partnership Financial Report 2021-2022

FINANCIAL REPORT – CHILDREN'S SAFEGUARDING PARTNERSHIP

	2021 / 2022 Actual £	2022 / 2023 Estimate £
EXPENDITURE		
Salaries & Expenses	248,927	309,127
Agency	4,967	0
Professional Fees	47,082	35,000
Equipment & Supplies	20,688	23,612
Conference & Meetings	321	0
Total Expenditure	**321,985**	**367,739**
CONTRIBUTIONS		
Wigan Council – General Fund	-64,206	-51,255
Training Income	-63,857	--73,469
Wigan Borough Clinical Commissioning Group	-54,000	--56,160
Greater Manchester Mental Health NHS Foundation Trust	-5,994	-6,234
WWL NHS Foundation Trust	-11,988	-12,468
Greater Manchester Police	-14,400	-14,400
National Probation Service	-1,800	-1,872
Wigan & Leigh Homes	-3,600	-3,744
Supporting People	-28,705	-50,775
Total Income	**248,550**	**270,377**
2021 / 22 Net Position – Overspend (See Note 1)	**£73,435**	
2022 / 23 Net Position – Overspend (See Note 2)		**£97,362**
Note 1 – 2021 / 22 overspend of £73,435 was funded by the CCG. NET POSITION	**£0**	

Note 2 – 2022 / 23 overspend of £97,362 – Unfunded pressure		**£97,362**

Section 6: Wigan Safeguarding Children Partnership next steps into 2022-23

The priority areas for Wigan Safeguarding Children Partnership moving into the next year will remain as set for 2021-22 but will be reviewed and changed in Quarter 1 and 2 2022-23.

Some key areas that will continue to develop are:

- Wigan Safeguarding Children Partnership have decided to refresh priorities, and this will be done as a collaborative piece of work as we move through 2022.

- There will be an impetus around early help and intervention as a way of responding to emerging need. This will, in the short to medium term, start to build strength into the partnership agencies to prevent children and family's needs escalating into needing safeguarding.

- There is a key need to continue to have systems that identify and respond to variable practice, a challenge that affects the partnership and is apparent across case review activity and performance data.

- Streamlining the governance structure will take place with a view to giving the extended partnership agencies and community and voluntary sector more of a role in setting the strategic direction including raising the profile of WSCP through communication.

- Capitalise wider system learning including developing the safeguarding performance data framework that provides better intelligence and insight and will inform quicker identification and response to emerging issues.

- A full Wigan Safeguarding Children Partnership training needs analysis exercise will be undertaken. The current training offer in place is based on a Training Needs Analysis from 2018 and in that interim, there has been significant strategic changes across the workforce with some major projects across the Partnership that affect training needs such as the embedding of a Trauma informed approach, the maturation of the Signs of Safety approach.

- In order for the training offer expansion of the training offer will require support from across the partnership through formation of a pool of training facilitators.

- Three thematic areas that are recurrent in case reviews will be developed over 2022: Critical Thinking and challenge; Capturing the daily lived

experience of the child and Working with Families where engagement is reluctant or sporadic.

Section 7 Independent Scrutineer's response to the WSCP Annual Report

Statutory guidance requires the three safeguarding partners (which for the period covered by this report are Local Authority Chief Executive, Chief Constable of the local Police Force and Accountable Officer, Clinical Commissioning Group, or their delegated representative) to make arrangements for independent scrutiny of the yearly report they are required to publish.

I was appointed to the role of Independent Scrutineer in July 2022 and was therefore not in post for the period covered by this report. My lack of direct involvement in the safeguarding partnership arrangements during this period does not however preclude me from being able to provide an objective and critical friend perspective of the content of this report against the requirements of statutory guidance Statutory guidance requires that statutory partners address the following in their yearly report:

- what they have done as a result of the arrangements, including on child safeguarding practice reviews, and how effective these arrangements have been in practice.
- evidence of the impact of the work of the safeguarding partners and relevant agencies, including training, on outcomes for children and families from early help to looked-after children and care leavers
- an analysis of any areas where there has been little or no evidence of progress on agreed priorities
- a record of decisions and actions taken by the partners in the report's period (or planned to be taken) to implement the recommendations of any local and national child safeguarding practice reviews, including any resulting improvements
- ways in which the partners have sought and utilised feedback from children and families to inform their work and influence service provision.

The report provides detailed information about the work carried out to develop arrangements for the delivery of early help support to children and families and, of note, are the Think Family pilot and the Family Hub Transformation work programme. In terms of impact, an interim finding from the Think Family pilot is "significant improvement for the majority of families by utilising a multi-agency approach for the whole family". The pilot has also identified the valuable contribution adult focused services make to improving outcomes and life chances for children in the borough.

Partners report they have undertaken activity to review the effectiveness of the child protection planning system and this has resulted in an increase in the timeliness of Child Protection Conferences and decrease in repeat Child Protection Plans. Both of

which indicate that the child protection system is now more responsive to the needs of vulnerable children.

The report provides a narrative of work carried out in relation to agreed priorities, some of which, it would appear, was led by either other strategic partnerships or commissioning bodies. This suggests a need to further develop a recommendation made last year by my predecessor to “clarify links and working arrangements with other existing bodies such as the Community Safety Partnership and the Greater Manchester Alliance”.

In relation to impact of the work of safeguarding partners and relevant bodies, as outlined above, the report provides some examples of impact. The report is transparent in identifying the need to develop a multi-agency performance management framework which will play a pivotal role in aiding partners to evaluate the impact of their activity. This should be underpinned by an outcome focused approach (success criteria) and robust governance arrangements regarding the development and implementation of delivery plans.

The report provides assurance that there has been good progress in publishing statutory learning reports and disseminating the learning as well as the completion of rapid reviews. I am informed that statutory partners have received positive feedback from the National Panel on the quality of the rapid reviews that have been completed. The partnership has identified the thematic learning arising from serious child safeguarding cases and there is evidence that this is informing the learning and development offer. The report does not however provide information of the actions taken by partners to implement the recommendations arsing form statutory learning reviews or any improvements secured as a result of the action taken. Further, there is no information as to how the findings from National Child Safeguarding Practice Reviews have been considered or acted upon at a local level.

The report details that the voice of children and families have informed the Early Help review and provides assurance that the issues identified by the “family voice” will inform the Family Hub Transformation work programme including through coproduction. There are other examples as to how the voice and experiences of children have been obtained i.e. Digital One Voice group to understand the impact of the pandemic on the lives of children and safeguarding solders initiatives that have been set up in primary and secondary schools. The report positively identifies that a future ambition of the partnership is for “single agencies to report on how they listen to children and families and how this influences systems and services”.

The impact of the pandemic, in terms of needing to re-prioritise focus and resources and operate in a virtual space, is appropriately identified as a factor that has impacted on the progress of the work programme. At the time of reviewing the annual report, I have been in post for 3 months and I have observed a strong and shared commitment to continuous improvement and the value of partnership working. The decision to re-define priorities will aid the partnership to focus its attention on the issue(s) that will have the greatest impact on improving outcomes for children and families.

I will conclude by providing a small number of ‘critical friend’ considerations for statutory partners and relevant bodies to support them in their shared endeavour to improve the safety and wellbeing of children and young people:

- What are the outcomes that you are seeking to achieve and how will you measure progress and evidence impact?
- How do/will you influence the priorities and work programmes of other strategic partnerships/commissioning bodies to facilitate a whole system approach to safeguarding children?
- How do/will Executive leads have oversight of the development and implementation of delivery plans?

My final comment is to say that I fully support the work to develop multi-agency performance management arrangements and resolve the unfunded pressure in the Wigan Safeguarding Children Partnership budget.

Liz Murphy
WSCP Independent Scrutineer, 7.10.22