Wigan Safeguarding Partnership

Children's Annual Report 2019/20

Email: wscb@wigan.gov.uk

Website: www.wiganlscb.com/home.aspme and my life."

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 it's 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 is 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 / child 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'***

Paul Kingston, Independent Chair of Wigan Safeguarding Partnership
Alison McKenzie-Folen, Chief Executive, Wigan Council
Craig Harris, Managing Director, Wigan Borough Clinical Commissioning Group
Stuart Ellison, GMP Divisional Commander, Wigan

Under Working Together 2018 this report is our first Children's Annual Report of the new Wigan Safeguarding Partnership, we wanted an opportunity to recognise the profound and real effect COVID-19 global pandemic has had on our communities, families and individuals.

The report covers the period from 1st April 2019 to 31st March 2020, so the start of the pandemic, it also incorporates key summary of activity regarding 2018/19. This report recognises the progress the Wigan Safeguarding Partnership (WSP) has made whilst transparently highlighting the challenges we face to improve our offer and effectiveness that we will continue to address in 2020/21.

Very quickly at the start of the pandemic the council and partners had to adapt the way its services were delivered, from working out how to keep services effectively supporting our residents without face to face contact, to keeping our schools open for key workers' children and vulnerable children to ensuring key workers are able to operate safely and within safeguarding requirements.

Families have lost loved ones and we have seen firsthand the real impact that lockdown has had on people's ability to live normal lives; for some of our families and children this has been particularly tough. As public sector services and a safeguarding partnership, we are proud of the continued efforts of our communities and all of our partnership's employees to constantly go above and beyond in making sure our most vulnerable children, families and individuals are safe as possible and have access to what they need. As a collective leadership team, we are thankful to those communities and staff who have gone above and beyond in extraordinary circumstances in unprecedented times. What they have done and achieved exemplifies the principles of the Wigan Deal and we thank everyone involved in working so hard to help those who need it in new ways.

The second issue we'd like to highlight (and is a key issue we've been working on) is the specific challenge we face as a partnership regarding the improvements we know we need to make regarding the outcome of our OFSTED focused visit from January 2020. We know and OFSTED told us we need to improve in a number of key areas.

An important part of making that change happen is how we harness the power and resources of the partnership to assist in making real those changes. Over lockdown, we reviewed our new partnership, and you will hear within this report how we have made some changes that allow us to strengthen that partnership focus and what those focused priorities will be over the next few months. We believe that these changes and new leadership will enable us to make those changes that demonstrate how we effectively safeguard children and support their families to do so.

Contents

Section 1 - Values and Ambition of the Wigan Safeguarding Partnership

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

- People have the right to live their lives free from violence, abuse, and neglect
- 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 adults and 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

Our Ambition is that the broader partnership and the new partnership leaders group undertakes its role and 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
- That every child and young person becomes a confident, resilient adult.

Section 2 – What We Know About Children in Wigan 19/20

- There are **68,916** Under 18-year old's in Wigan. (ONS mid-year population estimates April 2019
- **20.2%** approximately **13,921** children live in low income families (based on 2019 most recently available data). This has been increasing steadily over the last 5 years. This is lower than our statistical neighbours (SN) at 22.6% but higher than the England average (18.4%) (ONS)
- **20.6%** of primary school children are eligible for and claim free school meals and has increased steadily since 2017. We are in line with SN (20.67%), North West (20.4%) but higher than England (17.7%) Based on 19/20 data.
- **17.1%** of secondary school children are eligible for and claim free school meals and has increased steadily since 2017. We are lower than our SN (18.93%) and NW (18.8%) but higher than England (15.9%) Based on 19/20 data.
- 2131 Early Help Assessments were carried out in 2019/20, a rate of 309 per 10k
- 3274 Open referrals within the Service (Children in Need), a rate of 475 per 10k as at 31st March 2020.*
- 21.6% of those referrals were a re-referral for that child*
- 376 Children in need of protection, 55 per 10k as at 31st March 2020*
- 26.5% of Children protections plans were a second or subsequent plan for that child as 31st March 2020
- 534 Looked After Children, a rate of 77 per 10k as at 31st March 2020*

*NB: These figures are draft until final publication by the DfE following the Statutory Return Process.

- School age children in need in Wigan – 1164 – of those; 133 on a Health and care plan, 355 receiving SEN Support, 621 eligible for free school meals, 390 were the subject of a Child Protection Plan.

Overall, comparing local indicators with England averages, the health and wellbeing of children in Wigan is worse than England. The rate of child inpatient admissions for mental health conditions at 93.4 per 100,000 is similar to England. The rate for self-harm at 581.9 per 100,000 is worse than England. Dental health is worse than England. 44.6% of 5-year old's have one or more decayed, filled or missing teeth. ***(Source Child Health Profile – Public health England March 19)***

Section 3 - Summary of Activity and Progress Against Priorities 2019/2020

3.1 Joint Working / Life Course

- Throughout 18/19 the Children's and Adults Boards began to hold joint boards and started to develop a joint work programme.

- Building on the above joint approach, 2019/20 focused on reviewing and developing the two safeguarding boards delivery and strategic structures as a life course partnership and in response to legislative changes under Working Together 2018. These changes are detailed above within our current partnership structure.

Whilst the Complex and Contextual Safeguarding Group, Education settings and Early Intervention delivery group within the new structure (summaries below) were launched from October 2019, new leadership within Children Services in March 2020 prompted a review of where an enhanced focus on children's partnership activity was required. This is being undertaken currently and will form part of the Annual Report for next reporting year (2020/2021).

3.2 Complex and Contextual Safeguarding

- The Complex Safeguarding Group from the previous Wigan Safeguarding Children's Partnership continued to provide a focus on strengthening our approach on what then was the focus of child sexual exploitation. The group undertook a review of performance and outcome measures, which concluded early in 2019, as well as considered and contributed to key findings from serious case reviews regarding child sexual exploitation.
- In February 2019, the group organized a multi-agency workshop to undertake scoping of what a wider partnership response to other forms of exploitation might entail. This was borne out of local learning and audits undertaken by the Safeguarding Team regarding the commonalities of victims of child sexual exploitation who are also vulnerable to other exploitation such as criminal exploitation. The workshop also considered key audit findings regarding how the vulnerabilities of young people transitioning into adulthood often present as complex needs. These often go unaddressed, or present barriers to support.
- The workshop agreed key actions including:
    - ❖ Review of the existing co-located Child Sexual Exploitation Team to incorporate wider forms of exploitation (beginning with criminal exploitation).
    - ❖ Identify avenues to begin raising awareness with both professionals and young people
- WSP utilised partnership Serious Violent Crime grant funds to engage targeted schools in a drama production regarding criminal exploitation. The performance was presented to 6 secondary schools in targeted geographic areas, as well as performed for safeguarding professionals at the 2019 Annual Conference.
- The Child Sexual Exploitation subgroup reviewed and refreshed its form and function to become the new Complex and Contextual Safeguarding Group from October 2019 (and as part of the overall new multi-agency safeguarding arrangements highlighted at the beginning of this report)
- The new group reviewed its overall priorities and approach as part of that refresh, and in early 2020 produced an overall action plan to address the following immediate priorities:
    - ❖ Ensuring the new Complex Safeguarding Team co-located at the police station had the right resources to undertake and support young people at risk of wider forms of exploitation and to develop a new risk

assessment tool in line with broader exploitation types. The new team also received a Greater Manchester Peer review at the end of 2019 which contributed to an action plan focusing on the above.

- ❖ Children's Social Care to lead on developing core operational procedures for the new team
- ❖ To consider and plan for a wider system wide response to managing complex cases across children's services and using new contextual practice best practice
- ❖ Review and refresh the safeguarding partnership's training offer for professionals regarding awareness of exploitation in its broadest sense and what the Wigan support framework consists of.
- ❖ Updating children's case management systems to ensure capability in capturing wider exploitation types to be managed and for reporting performance information

- Additionally, in 2019, through joint work with the Community Safety Partnership, the group commissioned a broader awareness raising programme with young people. Working with Mother Mountain Productions, and through engagement with young people in early 2020, an immersive educational virtual reality product focusing on criminal exploitation / youth violence / mental health and well-being began to be developed. Originally planned for Easter term in 2020, this has been pushed back to 2021 due to Covid-19 issues.

3.3 Domestic Abuse

The partnership is committed to a life course, boroughwide coordinated response to Domestic Abuse, and this is a core issue that affects many aspects of effectively safeguarding children.

This work is led and governed in Wigan by the Community Safety Partnership. In 19/20 the partnership continued to develop it is coordinated community response model with continued investment and commitment in our approach to Domestic Abuse across the Borough resulting in:

- ❖ a mainstreamed and extended Independent Domestic Violence Advocacy team,
- ❖ the commissioning of emergency refuge provision and the creation of specialist DA safeguarding roles within the hospital setting.
- ❖ the development of Operation Strive supporting low risk victims and families,

- ❖ the embedding of Operation Encompass as exemplary practice across all schools (primary, secondary, tertiary and by the end of 2019 early years settings as well). This intervention provides information to schools when a young person in their care has experienced domestic abuse within the family home
- ❖ continuation of the Young Persons Violence Advisor sitting within the Victim Hub as part of our overall Public Service Reform approach.
- ❖ Our acute trust in 2019/20 mainstreaming the provision of hospital based IDVAs

- At the end of 2019, the Domestic Abuse partnership began to review its overarching strategy, based on the premise that whilst good progress was being made, predominantly the focus of interventions was in large part reactive to abuse and violence already happening, with services being reactive and concentrating on minimising the impact and consequences on both adults and children.

- Work in 2020/21 will refresh the brough's overall approach and both in commissioned services and mainstream responses, build on the positive work achieved to focus on prevention and developing our Co-ordinated Community Response model to be inclusive of a proactive system wide approach that prevents domestic abuse and violence from occurring in the first place.

Section 4 – Partnership contributions

Partnership Working

As the three local safeguarding partners have a duty to develop and oversee local safeguarding arrangements we remain committed to working with our tripartite partners, and wider stakeholders locally, to continuously improve systems to safeguard and promote the welfare of children, young people in the Borough

4.1 Children's Social Care

- Children's Social Care have started to lead the roll out of the Signs of Safety practice model and this has started to gain some traction in 2020 across the partnership. The model aligns with our Wigan Deal based principles to provide a framework which recognises and builds on the assets of children, families, and the wider community to generate and sustain positive change. The scope of the programme is to incorporate the entire children's workforce to be trained in the

approach, recognising the importance of partnerships and our communities in supporting children and families and their understanding of and engagement in the approach

- Children's Social Care refreshed and re-launched the service's minimum practice standards and began to implement a new quality assurance approach.

- Children Social Care and Greater Manchester Police began to co-locate and test out an approach to a single front door approach within the Multi-Agency Safeguarding Team (MAST).

- During 2019/20 Ofsted undertook a Focused Visit for Wigan Council's Children's Services on 21 January 2020. Inspectors considered arrangements for receiving referrals to children's services (our front door), how we make decisions about further action and our assessments of need for children and families.

- Inspectors looked at a range of evidence including case discussions with social workers and team managers. They also looked at performance management and quality assurance information alongside children's case records. The Inspectors told us**:**

  Over the last six months, the local authority has undertaken a planned review of the operation of thresholds. This has been in relation to decision-making for referrals and to ensure that children in need work is allocated appropriately to social work services rather than to early help. Development work has been undertaken, and this has ensured that there is now a single effective front door response for early help and social care.

  However, as a result of the strategic review of thresholds, workloads in social work teams have significantly increased, and the local authority did not plan ahead effectively to meet these demands. This resulted in high levels of unallocated cases over the course of three months. Extra resources have now been put in place in response to this increased demand. A wider recruitment strategy is in place with agreed funding. While this response has enabled the local authority to allocate all current work, significant issues remain in terms of the consistent application of thresholds and timely allocation of children's cases.

  Weaknesses are also evident in the responses 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. This means that children and families are not receiving a timely or consistently good quality of service. For many children, outcomes are delayed, and some children remain at risk or in situations of harm for longer than they should. Poor supervision and ineffective management oversight in many instances mean that progress, or delay in

progress, is not always being recognised, and senior managers are less aware of practice quality.

- The inspection team highlighted **5 areas of improvement identified for our referral and front door processes:**

    - ❖ Partnership working with the police to ensure that strategy meetings and child protection enquiries are prioritised as soon as possible.

    - ❖ Work with the police to ensure that the local authority is informed of domestic violence incidents where children are present as soon as possible.

    - ❖ A reduction in social worker caseloads to manageable levels to help ensure a more focused and timely delivery of services.

    - ❖ Assessments and plans that have children's needs as a central focus and are written in a way that enables parents and carers to better understand the impact of their actions on their children.

    - ❖ Casework audits to have a focus on the quality of work as well as on compliance with policy, and moderation of audits to be extended to better provide an accurate picture of practice to the local authority.

- The most immediate impact of these considerations was to make some changes in leadership at the Director of Children's Services level and Practice Director level. An interim Director for Children's Services was appointed, and the Director for Adult Social Care and Integrated Community Services also took on the role of Practice Director on an interim basis, to guide the service in creating a development plan that responded to the identified actions and other identified issues in the service.

- Internal quality assurance activity during 2019/20 from Children's Social Care assisted to identify key improvement points outlined below:

    - ❖ There is limited evidence of coordinated multi-agency support being provided to families by Universal and Targeted Services, sometimes resulting in situations for children deteriorating, and resulting in the need for a statutory service, which could have been negated by earlier intervention.

    - ❖ The quality of assessments overall require improvement to be good. A number of assessments lacked evidence of professional curiosity and respectful challenge, and conclude over-optimistically; the history of children is not always used to inform decision making, and whilst the

views of children are routinely sought, their daily lived experiences are not consistently understood. In addition, forming a judgement in terms of parental capacity to change, assessing the impact of experiences upon children, and analysis, are areas which require a real focus. Assessments of children who live in families where domestic abuse is a worry, remains an area of concern, in terms of failure to sufficiently explore parental capacity to protect, a lack of safety planning, and limited evidence of tools being used to support evidence based assessments.

- The quality of plans has improved with the use of Danger/Worry Statements and Well-being/Safety Goals which make worries and goals clearer to families; however, these could be improved by being more specific and using simpler language, and plans are not always SMART or bottom lines made clear.

- The majority of direct work with children undertaken by CYPF workers is of good quality; however, more of this needs to be undertaken by the key social worker. Interventions with parents/carers are not always effective in terms of achieving change, they are repeated as recurrent problems continue to arise, and for children who do experience recurrent issues, decisive action is not always taken early enough; chronologies are not kept up to date, preventing access to a coherent written story of the child's journey, and plans are not always robustly reviewed, particularly for children subject to child in need plans who do not have the additional oversight of a Child Protection Chair/IRO, resulting in the absence of routine analysis of the child's journey and daily lived experience, and therefore impacting upon the ability to achieve permanence in a timely manner.

- Audit activity in relation to both PLO cases and children at home subject to interim Care Orders, has evidenced that robust assessments are not always completed in the pre-proceedings stage and intervention provided in this period is not always sufficient. For some children, this has meant that their situation has deteriorated, and the Local Authority have issued care proceedings; however, the Local Authority has not always been able to provide evidence to the Courts that the welfare of the child has demanded immediate separation, given the lack of front-loading, and this has led to an increase in the number of children looked after at home.

- The number of older children entering care suggests again, that decisive action has not been taken early enough; these children have lived in worrying situations for too long, and have developed complex issues, sometimes resulting in the need for specialist placements.

- Children benefit from good working relationships with their social workers in the Children in Care Service, where interventions and direct work are of better quality.

- Adoption tracking is effective.

4.2 Clinical Commissioning Group

The well-being of children, young people and their families is at the heart of everything we do in the NHS. Safeguarding is firmly embedded within the core duties of all organisations across the health system.

It is the responsibility of every NHS-funded organisation and all staff working in the NHS, to ensure that the principles and duties of safeguarding children and adults are holistically, consistently and conscientiously applied.

Safeguarding is ‘everybody’s business’ and NHS Wigan Borough Clinical Commissioning Group (WBCCG) works with health providers in the Wigan Borough to ensure that it continues to be the ‘golden thread’ running through all commissioned health services.

The WBCCG works collaboratively with key stakeholders to oversee safeguarding arrangements of commissioned health services to respond to adults and children who have been harmed or are at risk of harm. The intention being to deliver improved outcomes for the most vulnerable people in the Borough.

WBCCG provides safeguarding assurance to Greater Manchester Health and Social Care Partnership (GMH&SCP) and WBCCG Safeguarding Team members are active participants of the GM Designated Professional Clinical Networks for Safeguarding Children, Safeguarding Adults and Looked After Children. These Clinical Networks bring together GM Safeguarding Designated Professionals to identify GM safeguarding improvement priorities. These Clinical Networks contribute NHS England (NHSE) North Regional Safeguarding Sub-Groups and the NHSE National Safeguarding Steering Group (NSSG).

WBCCG Designated Safeguarding Professionals have a statutory responsibility to guide and advise the local safeguarding leadership and be actively engaged in supporting the implementation of local safeguarding arrangements in line with the

NHS England and NHS Improvement Safeguarding Accountability and Assurance Framework (SAAF) (2019). As such the WBCCG Assistant Directors for Safeguarding/Designated Nurses act as expert advisors to the Wigan Safeguarding Partnership.

The work activities undertaken by WBCCG during 2019/20 in respect of safeguarding have been comprehensively documented within the Safeguarding Children and Adults at Risk Annual Report 2019/20. This report provides an overview of WBCCG safeguarding governance arrangements and a retrospective view of the work completed by the WBCCG Safeguarding Team from 1st April 2019 to 31st March 2020 to ensure the CCG meets its statutory safeguarding responsibilities in respect of children and adults at risk.

WBCCG Safeguarding Assurance Activity

Commissioners have a statutory responsibility to assure themselves of the safety and effectiveness of the services they have commissioned (NHS England, 2019).

NHS Providers

WBCCG assess NHS Provider compliance with statutory safeguarding responsibilities by assessing them against the 'Clinical Commissioning Groups Safeguarding Children, Young People and Adults at Risk Contractual Standards'.

These contractual standards are developed and agreed by the GM Safeguarding Clinical Networks and contain safeguarding audit frameworks which are based on Care Quality Commission (CQC) Fundamental Standards, Section 11 of the Children Act 2004 and the Care Act 2015.

'Safeguarding Validation Visits' are undertaken to each NHS Provider annually and a formal report is produced which details the evidence submitted by the Provider and a detailed response from WBCCG regarding the rating given/level of assurance. The outcomes of this assurance process are shared within the CCG, and with GMH&SCP and Wigan Safeguarding Partnership.

General Practice

WBCCG assess General Practice compliance with statutory safeguarding responsibilities by assessing them against the WBCCG 'General Practice

Safeguarding Assurance Toolkit'. This assists GP Practices to demonstrate that they are fulfilling statutory and professional responsibilities as set out in 'Working Together to Safeguard Children' and 'Protecting Children and young people: The responsibilities of all doctors' General Medical Council.

The returns from each Practice are reviewed by the Named GP for Safeguarding Children who considers the self-assessed ratings along with the evidence submitted. Practices are given comments and guidance to improve evidence and guide them in continuous quality improvement.

The WBCCG Designated Professionals also facilitate GP Safeguarding Lead meetings with our 59 GP Practices in the Wigan Borough. The agendas in 2019/20 encompassed the following safeguarding thematic areas:

- Injuries in Non-Mobile Children
- Overview of Wigan Serious Case Reviews and thematic learning
- MCA Update

WBCCG Designated Safeguarding Professionals also contribute to 'Quality Peer Reviews' which provide GP Practices in each locality with an opportunity to share good practice and identify areas for improvement in relation to safeguarding.

Health – Embedding the Learning from Serious Case Reviews

In April 2019, WBCCG led and undertook validation visits in order to establish Wigan NHS Provider progress against recommendations and subsequent action plans from Serious Case Reviews (SCRs) commissioned by Wigan Safeguarding Children Board (WSCB), now known as Wigan Safeguarding Partnership (WSP).

WBCCG Safeguarding Team was acutely aware that there had been a significant number of SCRs with numerous recommendations requiring action plans to change practice and embed learning. WBCCG arranged to meet each NHS Provider to review the action plans they had developed along with the accompanying evidence.

The WSP Business Manager was invited to take part in the visits to provide an independent view from a non-NHS perspective. This helped to facilitate discussion with Named Nurses for Safeguarding Children to explore whether the actions taken addressed the recommendations made by the SCR Independent Authors. It also

allowed participants to explore reoccurring themes within the recommendations from all the SCRs.

The Validation Visit was conducted by the Assistant Director Safeguarding Children/Designated Nurse and the WSP Business Manager and reviewed evidence in respect of SCR for Child K, Child L, Child M, Child O and Child R.

The Reviewers concluded the following:

- Bridgewater Community Healthcare NHS Foundation Trust (BWCHFT)
  BWCHFT WWLFT Safeguarding Team had a clear oversight of the SCR Action Plans had been fully completed and supporting evidence was seen and reviewed on the day.

- North West Borough Partnership Mental Health Trust (NWBFT)
  The NWBFT Safeguarding Team had a clear oversight of their SCR Action Plans. A significant number of actions had been fully completed which was supported by evidence seen on the day. Any outstanding actions were clearly explained and deemed to be reasonable.

- Wrightington, Wigan and Leigh NHS Foundation Trust (WWLFT)
  WWLFT Safeguarding Team had a clear oversight of the SCR Action Plans and had rigorously pursued any outstanding actions. A significant number of actions had been fully completed which was supported by evidence seen on the day. Any outstanding actions were awaiting ratification of policies and dates were provided for when this would take place.

Validation Visits had been implemented by WBCCG due to concerns that NHS Providers may have experienced difficulties in implementing recommendations and actions from SCRs due to the significant number of them taking place. 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.

4.3 Greater Manchester Police

GMP, like a number of public sector organisations, has faced significant issues over the preceding year.

2019 brought in the introduction of the largest IT transformation programme in UK policing namely iOPS (Integrated Operational Policing System)

iOPS replaced several aging systems and is intended to bring GMP to the forefront of modern policing and ultimately enable us to work more effectively with key partners to make the Greater Manchester community a safer place to live, work and visit.

iOPS provides modern data storage infrastructure and more structured data entry which over time, will reduce duplication and improve quality. This, combined with culture and behaviour change, will result in significant improvements in the information GMP is able to access to keep our people and communities safe.

However, given the scale of the project it was not without some teething difficulties which did have an initial impact on the timeliness of information sharing and referrals to partner agencies impacted further by the fact that the Wigan District is the one of the busiest district within Greater Manchester for reported incidents involving child protection matters or domestic abuse.

However, due to the strong and close partnership arrangements we have in Wigan we were able to work closely with our partners to resolve these matters to ensure timely information sharing and referral procedures

To support the introduction of IOPS and improve our safeguarding response GMP has

- Increased by 500% the resources allocated to the triage and referral of Domestic Abuse, Adults at Risk and Child Protection incidents from 3 members of staff to 15
- Developed a Co-located Multi Agency (MAST) team and embedded 6 staff into Children's Social Care to improve the referral, review and response to child protection notifications
- Developed a Vulnerability board, chaired by an Assistant Chief Constable, to oversee and improve GMPs response to vulnerability and to ensure Child Protection is and will remain a priority for Greater Manchester Police
- Embedded and developed a Detective Superintendent and a Detective Chief Inspector into vulnerability roles across Wigan to support the Wigan Police Senior Leadership team in driving forward our response to vulnerability in all its guises
- Developed a Child Protection Action plan bespoke to Wigan whilst aligned to the National Vulnerability Action Plan
- Further strengthened its already strong tripartite partnership arrangements.

- Developed and embedded safeguarding and vulnerability as key priorities in all our performance framework for the Crime investigation departments , Complex Safeguarding and First responder frontline practitioner functions.
- Chair/Co-chair of the Complex and Contextual Safeguarding Group
- Police Chair of the Domestic Abuse Steering Group

GMP, also faced significant issues during the 2020 Covid Crisis not unlike many organisations. We have ensured our estate has become "covid secure" to protect its workforce and despite some significant abstractions as a result of Covid we have continued to maintain an operational 24/7 policing response.

Working closely with partners around our covid response we have maintained , and in some areas improved, our response to vulnerability in areas such as:-

- Joint work with colleagues from Probation to ensure visits to high risk offenders have been maintained or increased
- Joint visits with our IOM, Probation and CRC colleagues to prisoners released early due to Covid
- Work with Independent Domestic Abuse Advocates and Colleagues within our PSR hub to increase contact to current and previous victims of domestic abuse
- Worked with Social Care and the Local Education authority to ensure identification of children who may be at further risk due to Covid isolation
- Moved to an Exceptional Delivery Model under our Multi Agency Public Protection Arrangements
- Moved to an Exceptional Delivery Model for MARAC and moved to daily MARAC to ensure those potential High-Risk families receive a more timely partnership response

We remain committed to developing our tripartite partnership response and look forward to strengthening our partnership response to safeguarding and vulnerability and the part we play in the "Wigan Deal" in 2021 and beyond.

Section 5 - Learning from reviews- Developing the offer of support to people who have experienced Bereavement:

- Statutory review processes (SCRs, SARs) were showing that lack of appropriate support through bereavement was a ‘modifiable’ factor in several cases. Lack of

available support for bereaved individuals is a background marker in patterns of poor mental health, physical health, substance misuse.

- In some cases, the link between bereavement, lack of accessible support and further harm was clear and previous experience (especially recent experience) is one of the statistical markers over-represented in cases where people have ended their own lives.
- In late 2018 the Safeguarding Children's Board and Adults Boards took bereavement support as one of both Boards priority theme. The work linked existing strategic groups and partnerships and work in 2018 work began to bring these streams together. In summary, in January 2020, the new Early Intervention and Prevention Delivery Group considered progress made across the preceding 18 months as follows:
    - ❖ Creation of Bereavement Support Strategy Group from November 2018 onwards.
    - ❖ Development of organisational pledge across the partnership.
    - ❖ Development and recruitment of Bereavement Support Leads (BSLs) across the partner agencies (Adult Social Care, Startwell, Complex Dependency Team, GMP staff, Wigan Homes, Addaction, Education settings including 16-18's, WWL Acute Hospital and community services, Early Years, Registrars, CCG, NWB, IRO).
    - ❖ At the end of 2019 there were over 30 BSL's trained through three cohorts of Introduction to Bereavement course facilitated by Derian House Children's Hospice financed by safeguarding partnership. This network has continued to be supported into 2020/21 regarding continuing professional development with specialist training workshops covering some of the more complex areas of bereavement (e.g. Coronial processes, Police involvement in deaths etc.)
    - ❖ BSL's are the 'go to' for additional information, support and direction where it comes to supporting our communities with bereavement and our staff**.**
    - ❖ As regards wider pathways, we developed improved links with tertiary centres such as Royal Manchester Children's, Alder Hey, Broad Green etc. to allow better alignment of local offers
    - ❖ A model Bereavement Policy for Schools was completed in December 2019 and will be rolled out across 2020/21. Additionally, a project offer from Child Bereavement UK to train school staff was agreed in January 2020 and is being developed by Safeguarding Partnership and the portfolio holder for Children and Young People.

- ❖ Development of resources library by the Safeguarding Partnership Team.

- Work will continue across 2020/21 to embed the approach, including specific training for professionals in educational settings.

Section 6 - Learning from Case Reviews

In 19/20 the safeguarding partnership adopted a brief learning review model for systems learning in cases that do not meet Serious Incident Notification threshold but do evidently give learning opportunities to the partnership.

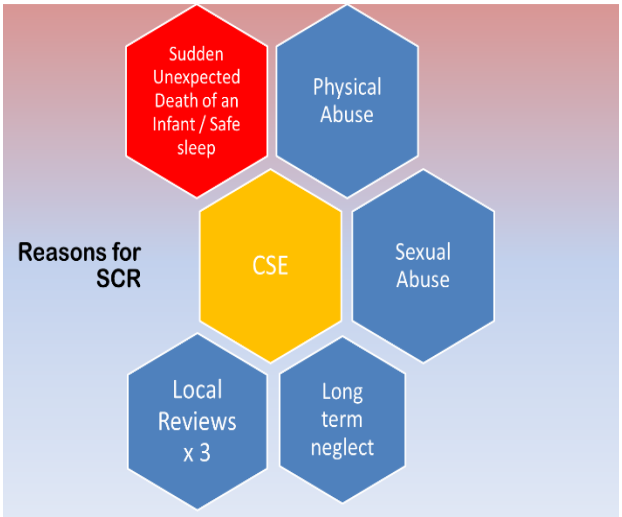
6.1 Analysis of Key Themes

A thematic analysis of key themes within children's Serious Case Reviews was completed in 18/19 analysis covered all cases completed from September 2016. The thematic analysis informed the development of the new MASA arrangements described at the start of this report and identified key areas for the partnership to consider.

The analysis covers 7 serious case reviews, demographically these included:

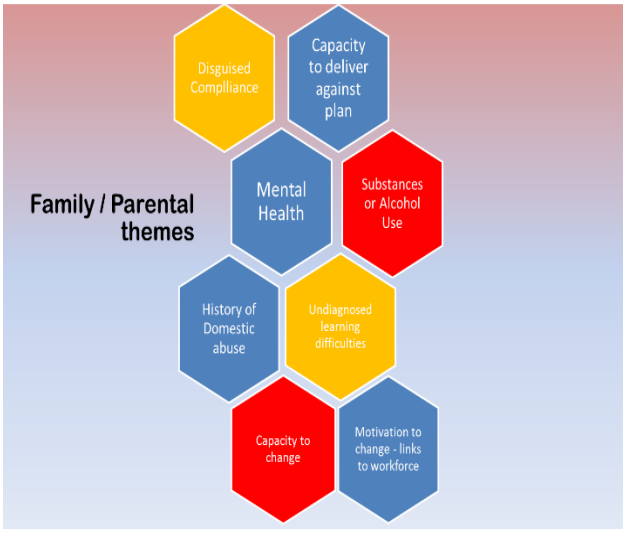
- Children between 7 weeks of age and 16 years at the time of the index incident that led to Serious Case Review
- All had ethnicity recorded as White British.
- 5 of the 7 were the second or third born child in their family.

The primary reasons for referral for Serious Case Review was as follows:

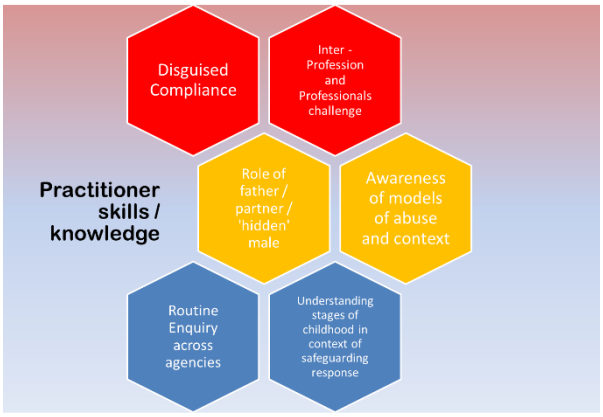


- 3 cases of Sudden Unexpected Death of a Child (infant).
- 2 cases where there was long term physical and sexual abuse
- 1 case where death was a result of multiple injuries sustained in a road collision in broader circumstances of sexual exploitation.
- 1 case where a young person was unknown to all services, including those he required access to, for several years whilst being electively home educated.

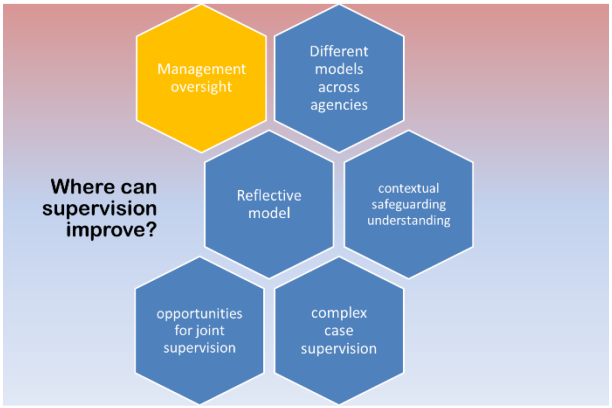
Key issues relating to recurring thematic areas across case reviews were extracted as follows:



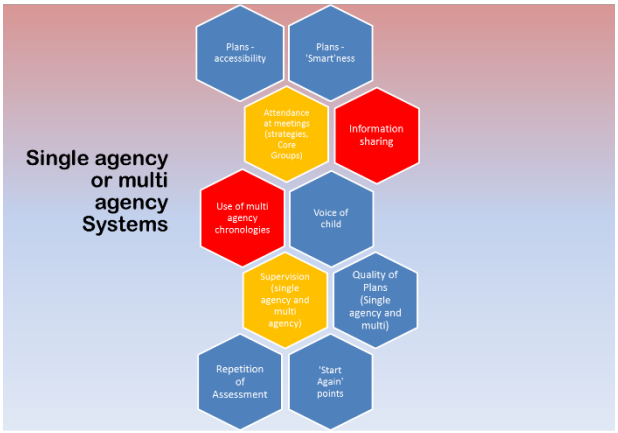
- Family / Parental themes included mental health (of both young person and parent / guardian), domestic abuse and substance misuse; analysis showed that these key areas interreacted negatively across other themes, for example parents capacity to deliver and effect change against child protection plans outcomes and motivation / capacity to change.
- A key finding in at least half of the case reviews analysed was undiagnosed learning difficulties of either the young person / parent or guardian / both.



- Practitioner skills / knowledge – key recurring issues included inter-profession and professional challenge and routine enquiry across agencies.
- Disguised compliance was prominent in at least four of the cases analysed.
- A key theme headed under “role of father / partner / “hidden male” covered various thematic areas such as male roles within child protection processes and how a practice model could ensure participation right the way through the process.



- Supervision is a key theme running throughout the SCRs, highlighting the need to embed a more reflective model, especially on complex cases that require enhanced oversight and supervision
- Contextual safeguarding was an emerging theme highlighting the need to consider how extra familial risk is managed effectively



- Analysis highlighted key single agency system areas for improvement including the accessibility of child protection plans for young people and families, the degree to which plans were SMART and genuinely involved young people (lack of voice of the child was a key issue) and families and describe goals and outcomes that evidenced positive change
- Repetition of assessment as more complex cases were “stepped down” and then escalated when change apparently was not sustainable was highlighted as a recurring theme and again the quality of plans in several SCRs from both a single and multi-agency perspective

The key findings from the analysis informed the development of the new Safeguarding partnership structure and priorities, in particular the creation of the Partners Improving Practice Delivery Group that will focus on the key aspects of practice that the above learning identified

6.2 Auditing learning Into Practice during 19/20

- Case Review Meetings were embedded
- Summary of Actions Tracker was put in place
- Young Carers Pathway work was developed further to learning in Serious Case Reviews.
- Scoping and audit work on Elective Home Education Cohort in response to a Serious Case Review put into place.
- Developed and led a Core Group Dip Sample.
- Learning products produced and distributed (7 min Briefings on 3 child SCRs).
- Facilitating Early Intervention Youth Fund project.
- Support given to Safe Sleep Subgroup – scoping around evidence base, linked to SCR’s.
- Developing child obesity Pathway in partnership with Startwell and IHL.

- Started to refresh the Neglect Strategy- still work in progress.
- Domestic Abuse Audit
- Learning opportunities started to be developed in response to SCRs.
- Learning +Improvement led audit on Criminal Exploitation Cohort
- Bereavement Pathway work and Partnership Pledge
- Non-Accidental Injury – scoping work first stage of new learning model.
- New Learning Model design and development undertaken.
- Carers Pathway and transitional work undertaken.

Section 7 - Workforce Development and Engagement - Key Achievements 2019-2020

- The Safeguarding Partnership across 2018/19 and 2019/20 has continued to review and update its training offer, work undertaken regarding a children's offer include:

    - ❖ Implementing the NSPCC Graded Care Profile training for multi-agency front line staff
    - ❖ Reviewed and updated courses on the intercollegiate level offer against key findings from case reviews and wider partnership priorities
    - ❖ Updated and relaunched an improved learning platform (Virtual College) that will allow not only the impact of training on changed practice to begin to be undertaken, but allows for a wider set of learning opportunities to be made available to practitioners
    - ❖ Worked in partnership with Start Well to develop courses relating to Professional Curiosity and Challenge
    - ❖ Run our largest ever Safeguarding Conference as a life course event, with over 1500 practitioners receiving input on complex safeguarding, trauma informed practice, Prevent and Domestic Abuse
    - ❖ Held a Young Person's Safeguarding event hosted by the Portfolio Holder for Children and Young People and the Director of Children Services.
    - ❖ Switch over and launch of the new Virtual College (Enable) platform
    - ❖ Continued to provide both face to face and online training to front line practitioners and across 2019/20 in greater volume; training is modelled against key partnership priorities and key findings from case reviews. The tables below detail that life course offer in more detail.

Training data for year 2019/20 (April 2019 - March 2020)

Face to Face training		Online training	
Course name	**Places allocated**	**Course name**	**Completions**
Achieving Excellence in Practice	34	An Introduction to Safeguarding Children	389
Building Resilience in Young People	37	Awareness of Child Abuse and Neglect - CORE	291
Child Sexual Exploitation	84	Awareness of Child Abuse and Neglect - Foundation	568
Children's Advocacy	17	Awareness of Forced Marriage	10
Designated Safeguarding Lead Training	308	Child Accident Prevent	12
Eyes and Ears	275	Deprivation of Liberty Safeguards	41
Fabricated and Induced Illness	28	Domestic Abuse in Wigan	42
Graded Care Profile 2	99	E-Safety - Guidance for Practitioners	132
Local Authority Designated Officer	32	Female Genital Mutilation	34
MAPPA	30	Get Moving, Get Healthy	29
Mental Health and Parenting	19	Hidden Harm	31
Mental Health Disorder and Parenting Capacity	84	Keep them Safe - Protecting Children from CSE	20
Modern Slavery and Human Trafficking	107	Medication Awareness	0
Safeguarding and Early Help	20	Mental Capacity Act	142
Safeguarding and Working with Adolescents	16	Parental Mental Health	54
Safeguarding Children from Sexual Abuse	30	Safeguarding Adults	155
Safeguarding for Foster Carers	120	Safeguarding Children from Abuse by Sexual Exploitation	80
Safeguarding for Taxi Drivers	100	Safeguarding Children in Education	763
Safeguarding Level 3	159	Safeguarding Everyone	700
Safer Recruitment in Education	59	Safer Recruitment	81
Safer Sleep - Reducing the Risk of SIDS	104	Safer Working Practice	46

Safer Working Practice	8	Self-Harm and Suicidal Thoughts in Young People	87
Section 42	22	Understanding Animal Welfare in Violent Homes	9
Tier Training - Safeguarding Adults	791	Understanding Young Minds	33
Whole School Level 1	1786	Working with Adults who Self-Neglect	17
WRAP (Workshop to Raise Awareness of PREVENT)	105	Working with Children with Disabilities	99
Total	**4474**	**Total**	**3865**

7.1 Examples of impact comments from practitioners

Safeguarding Level 3 training:

"Excellent – it has re-affirmed my knowledge and allowed me the opportunity to be updated with current and relevant information"

Safeguarding and Working with Adolescents:

"Excellent – this will help with working with young people and I have gained the knowledge on how to approach particular age groups"

Child Sexual Exploitation:

"Excellent – as a Safeguarding Lead this will give me the confidence to ask the questions needed if I feel or see something I feel is not right"

Graded Care Profile:

"I feel more confident carrying out the Graded Care Profile now. It will enable me to track families progress. It is a tool I can use to show outcomes. It will help me to work better with other professionals. The trainer was very passionate about the subject she was delivering and made it easy to follow"

Section 8 – Strategic Priorities for 2020-2021

- Implement overarching Governance framework
- Improving quality of assessment, professional curiosity and critical analysis across the workforce
- Implement Signs of Safety Model into practice.
- Lead the partnerships readiness for Inspection
- Implement Case Review learning.
- Domestic Abuse
- Transition
- Neglect
- Complex Safeguarding
- Suicide prevention

Appendix 1

FINANCIAL REPORT – CHILDREN'S SAFEGUARDING

	2017 / 2018 Actual £	2018 / 2019 Actual £	2019 / 2020 Actual £	2020 / 2021 Forecast £
EXPENDITURE				
Salaries & Expenses	224,577	243,050	260,298	272,375
Professional Fees	65,075	60,510	26,195	51,203
Equipment & Supplies	10,118	12,346	11,140	21,227
Conference & Meetings	2,148	8,803	7,472	782
Marketing & Publicity	49	29	515	0
External Training	23,483	34,355	15,515	0
Total Expenditure	**325,450**	**359,093**	**321,135**	**345,587**
CONTRIBUTIONS				
Wigan Council – General Fund	-75,206	-75,206	-75,206	-59,206
Training Income	-73,907	-53,490	-77,600	-78,500
Wigan Borough Clinical Commissioning Group	-54,000	-54,000	-54,000	-54,000
Bridgewater Community Healthcare Trust	-5,994	-5,994	0	0
NWB / 5BP NHS Foundation Trust	0	-11,988	5994	0
WWL NHS Foundation Trust	-5,994	-5,994	-5,994	-5,994
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	-550	0
Wigan & Leigh College	-1,400	0	0	0
Miscellaneous Income	-1,373	0	-300	0
Total Income	**-238,224**	**-227,022**	**-227,456**	**-217,500**
Net Position (Expenditure exceeds Income for all financial years)	**£87,226**	**£132,071**	**£93,679**	**£128,087**

CHILDREN'S RESERVE POSITION	2017 / 2018 Actual £	2018 / 2019 Actual £	2019 / 2020 Actual £	2020 / 2021 Forecast £
1st April Reserve Position	**-£199,121**	**-£111,894**	**£0**	**£0**
Transfer from Reserve	**£87,226**	**£111,894**	**£0**	**£0**
31st March Reserve Position C/Fwd.	**-£111,894**	**£0**	**£0**	**£0**
Children's Unfunded in Year Expenditure (Funded from Adults Reserve)	**£0**	**£20,177**	**£93,679**	**£128,087**

Appendix 2 Glossary

CAFCASS	**Children and Family Court Advisory and Support Services**
CAMHS	**Child and Adolescent Mental health Service**
CCG	**Clinical Commissioning Group**
CIN	**Child in Need**
CME	**Children Missing Education**
CPP	**Child Protection Plan**
CSA	**Child Sexual Abuse**
CSC	**Children's Social Care**
CSP	**Community Safety Partnership**
CWD	**Children with Disabilities**
DA	**Domestic Abuse**
DHR	**Domestic Homicide Review**
EHE	**Elective Home Education**
EHWB	**Emotional Health and Wellbeing Board**
EIP	**Early Intervention and Prevention**
FGM	**Female Genital Mutilation**
GCP	**Graded Care Profile**
GM	**Greater Manchester**
GMCA	**Greater Manchester Combined Authority**
GMP	**Greater Manchester Police**
HWB	**Health and Wellbeing Board**
JSNA	**Joint Strategic Needs Assessment**
LA	**Local Authority**
LAC	**Looked After Child**
MAPPA	**Multi Agency Public Protection Arrangements**

MARAC	**Multi Agency Risk Assessment Conference**
MARAM	**Multi Agency Risk Assessment Model**
MFH	**Missing from Home**
NPS	**National Probation Service**
OCG	**Organised Crime Group**
PCSO	**Police Community Support Officer**
PRU	**Pupil Referral Unit**
SCR	**Serious Case Review**
SEN	**Special Educational Needs**
SUDI	**Sudden Death in Infancy**
YPP	**Young Person's Plan**
YPVA	**Young Person's Violence Advisor**