WSCP Annual Report 2019-20 Addendum September 2020 -March 2021



# Safeguarding Children Partnership

## WSCP Annual Report 2019-20 Addendum September 2020 – March 2021

**Overview** 

Wakefield Safeguarding Children Partnership (WSCP) has produced this addendum to its first annual report 2019-20 covering the period **September 2020 – March 2021.** 

The addendum details progress achieved by the partnership documenting the impact made and sets out for the key areas of focus for 2021-22

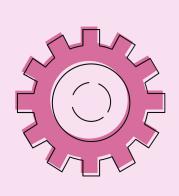
## What is the role of WSCP?

Since being established in September 2019, the partnership's remit has been to have effective multi-agency safeguarding arrangements in place to safeguard children and promote their welfare.

Wakefield Council, West Yorkshire Police and Wakefield Clinical Commissioning Group (CCG) have joint responsibility for WSCP and are supported by a range of agencies who work with children and families, including schools to drive the business of the partnership forward.

For further information on WSCP arrangements, please refer to WSCP Annual Report 2019-20.





#### Child Safeguarding **Practice Review** Sub-Group (CSPRG

Learning & Development Sub-Group

Safeguarding Effectiveness Sub-Group (SEG)

Multi-Agency Child Exploitation (MACE) Sub-Group

Child Death Overview Panel (CDOP)

Safeguarding Advisor for Education

Review and Assurance Activity

Areas of Focus for 2021-22

### **Function of** the **CSPRG**

**Considers serious** safeguarding incidents concerning children where abuse and/or neglect has been suspected to have caused or contributed to the incident, with a view to undertaking reviews to identify multi-agency learning to develop safeguarding systems and practice.



## **Key Areas of Development**



Considered four serious incidents concern reviews to identify multi-agency learning, alo the Suicide Cluster Review Action Plan.



3

Initiated a new referral process, where agen the CSPRG which do not meet the serious i multi-agency learning.

Developed an overarching review action lo greater oversight across all open reviews generated is being implemented across safeg

Updated the Rapid Review template to enabl development to be identified more effect agencies to consider which are SMART.

- Sub-Group to implement



# What impact has this made?

rning children and undertook ongside progressing actions on	1.1	System and practice responding to a suicid Cluster Pathway led by I
	1.2	The pathway coordinate bereaved by a suicide i wider community. Since no suicide cluster death
	1.3	Majority of the four revi babies and unsafe slee place to support the w sleep information to f Wakefield Multi-Agency The Lullaby Trust to de there have been no se concerning unsafe slee
encies can identify incidents to incident criteria but consist of	2.1	CSPRG is now able to rather than exclusively to the Department of Ec
	2.2	The ability for agencie agency review to be Learning which was strengthen the child Fabricated Induced Illne
og, providing the CSPRG with to monitor how the learning guarding systems and practice.	3.1	This has provided a g needs for the children a opportunities being alig district.
	3.2	Learning from individua learning more impactfu efficient.
ble good practice and areas for ctively to inform actions for	4.1	The new template has achieved, leading to c quicker rate than previo
	4.2	The learning identified Local Child Safeguardi level of detail captured Reviews carried out in fedback positively on the a further review would r

• Strengthen the learning identified within Local Child Safeguarding Practice Reviews to be more SMART • Create a process to engage and seek the voice of parents and where appropriate children within reviews • Establish a process whereby the CSPRG can identify actions from reviews which can be stepped across to the Learning & Development

• Demonstrate the impact reviews make on system and practice development more consistently



development has been achieved in relation to de. Agencies are now joined up through a Suicide Public Health.

tes agencies to provide postvention support to those including family, friends, education settings and the ce the development of this pathway there have been ths amongst children.

views (3) have concerned the tragic deaths of young ep practices. System wide development has taken workforce's understanding and ability to deliver safe families. This has included the development of a cy Safer Sleep Standard and the commissioning of eliver safer sleep training. Since these developments sudden unexpected deaths amongst young babies

consider incidents based on multi-agency learning based on severity where those incidents are notified Education (DfE) National Panel.

es to refer incidents to the group enabled a multiundertaken in February concerning a near miss. otherwise unknown in respect of the need to dren and families workforce understanding of ness was identified.

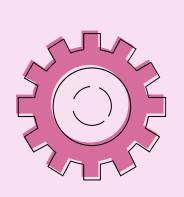
greater understanding as to the thematic learning and families workforce. This has resulted in learning ligned with safeguarding practice needs across the

al reviews can now be addressed collectively, making ul and the processes in implementing learning more

as resulted in deeper analysis of incidents being clearer learning for agencies being identified at a iously.

l at a Rapid Review has negated the need for further ling Practice Reviews to be undertaken due to the ed. This has been highlighted within the three Rapid in this period where the DfE National Panel have the learning detailed and agreed with WSCP's decision not identify additional learning.





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**Function of the** Learning & Development **Sub-Group** 

Responsible for responding to the learning and development of needs of the children and families workforce by developing, coordinating and delivering learning opportunities such as multi-agency training, conferences, masterclasses and safeguarding resources.



# **Key Areas of Development** Development of a wide range of Wakefield learning opportunities **Development of the Wakefield Safe Sleep** 2 training



Creation of One Minute Guides providing bit variety of safeguarding topics

- workforce as identified within practice reviews and audit activity
- the children and families workforce to access



d specific virtual safeguarding	1.1	Services have been abl into staffing briefings a
	1.2	Due to the extensive to bought in by WSCP has saving which is being re- learning and developme

ping Standard and safe sleep	2.1	Children and families we safe sleep practice practitioners with an bed sharing and overla parents, key messages
	2.2	The safe sleep training with the knowledge confidence in how to practices.
	2.3	Wakefield has experie WSCP was established training there have be sleep.
oite-sized information across a	3.1	Information is now n safeguarding more pro been developed on inte

• Develop and deliver an integrated learning and development offer which is closer aligned with the needs of children and families

local policy..

• Support the integration and learning and development needs of services as part of the Wakefield Families Together programme • Further develop safeguarding resources across different mediums including video and podcast to enhance learning opportunities for



le to access training on demand and incorporate this and inductions.

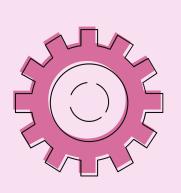
the virtual learning, the previous generic e-learning s been ceased. This has resulted in a significant cost reinvested to enhance and further develop additional nent in Wakefield.

workforce now has a range of guidance in relation to in a single toolkit. The guidance helps to equip understanding on sudden infant death, co-sleeping, rlaying, what best practice looks like, how to engage es, resources for parents and practitioners.

ng, complementing the standard, equips practitioners and approaches to identify unsafe sleep and the o engage parents to support them with safe sleep

rienced a number of sudden deaths of babies since ed in 2019. Since the development of the standard and been no sudden deaths of babies concerning unsafe

more accessible and for many services makes oportionate to their area. One Minutes Guides have telligence sharing, continuum of need, neglect and children who are not attending school. Services have been able to signpost to the guides in staff briefings, training, induction and within



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#### **Function of** the SEG Sub-Grou

**Oversees the multi-age** effectiveness of service work in relation to safeguarding children through data analysis a assurance activity.



	Key Areas of Development
p	<b>1</b> Overseen multi-agency audits in relation to during Covid-19 and Private Fostering
ency es	
nd	
	2 Refined the focuses within the WSCP Perfor
	<b>3</b> Wakefield CCG and Wakefield Council Child worked jointly to improve arrangements to engaged with and included within multi-agen

- established process



		what impact
o Safeguarding Young Babies	1.1	Throughout Covid-19 re new families were iden rising. The audit carrie babies and their families
	1.2	<ul> <li>Learning identified from consisted of:</li> <li>improving informate</li> <li>GPs being invited to</li> <li>the use of the negle</li> <li>updating the needs makes impact</li> </ul>
	1.3	<ul> <li>Learning from the Privious implement consists of the improve staff under respond should the fostered;</li> <li>GPs are notified a chagency meetings are agency meetings are district;</li> <li>develop Private For families workforce</li> </ul>
rmance and Data Report		<ul> <li>The multi-agency data great focus on specific has been required. High</li> <li>health provider a consistently high improvement in cor</li> <li>police data is now a Data Report, enabli other indicators</li> </ul>
dren's Social Care (CSC) have to enable GP practices to be ncy safeguarding meetings	3.1	Following a range of de CSC has improved. This and involved in multi-ag
	3.2	<ul> <li>The developments have</li> <li>new form for gathe</li> <li>secure email system information and minimation and minimat</li></ul>

• Develop an audit report action log to enable the SEG to oversee recommendations from audit activity is implemented by services • Create a multi-agency procedures working group to enable services in Wakefield to identify and address gaps in guidance via an



## What impact has this made?

estrictions, nationally young babies (< 1 year olds) and ntified as a vulnerable cohort with serious incidents ied out sought assurance locally as to how young es were being supported by services.

rom the audit which services have implemented

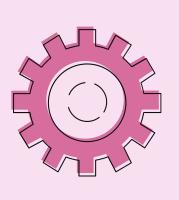
- tion sharing process;
- o multi-agency meetings;
- ect toolkit;
- ds of families within assessment when intervention
- ivate Fostering audit which services have begun to the following:
- lerstanding of what Private Fostering is and how to they identify a child who may be being privately
- child is being privately fostered and included in multiand planning;
- vate Fostering as an area can be overseen across the

ostering resources and training for the children and

- a is aligned to WSCP priorities which have enabled c areas where improvement in systems and practice hlights have included:
- attendance at strategy meetings has remained across this period, demonstrating significant omparison to previous periods
- amalgamated into the Multi-Agency Performance & ling WSCP to view this data in the wider context of

levelopments partnership working between GPs and s has led to improvements in GPs being engaged with gency working more consistently.

- ve included:
- ering GP health information;
- stems for sharing and receiving safeguarding ninutes;
- uded as part of information sharing requests;
- updated guidance for GPs preparing reports for CPC



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Areas of Focus for 2021-22

## **Function of the MACE Sub-Group**

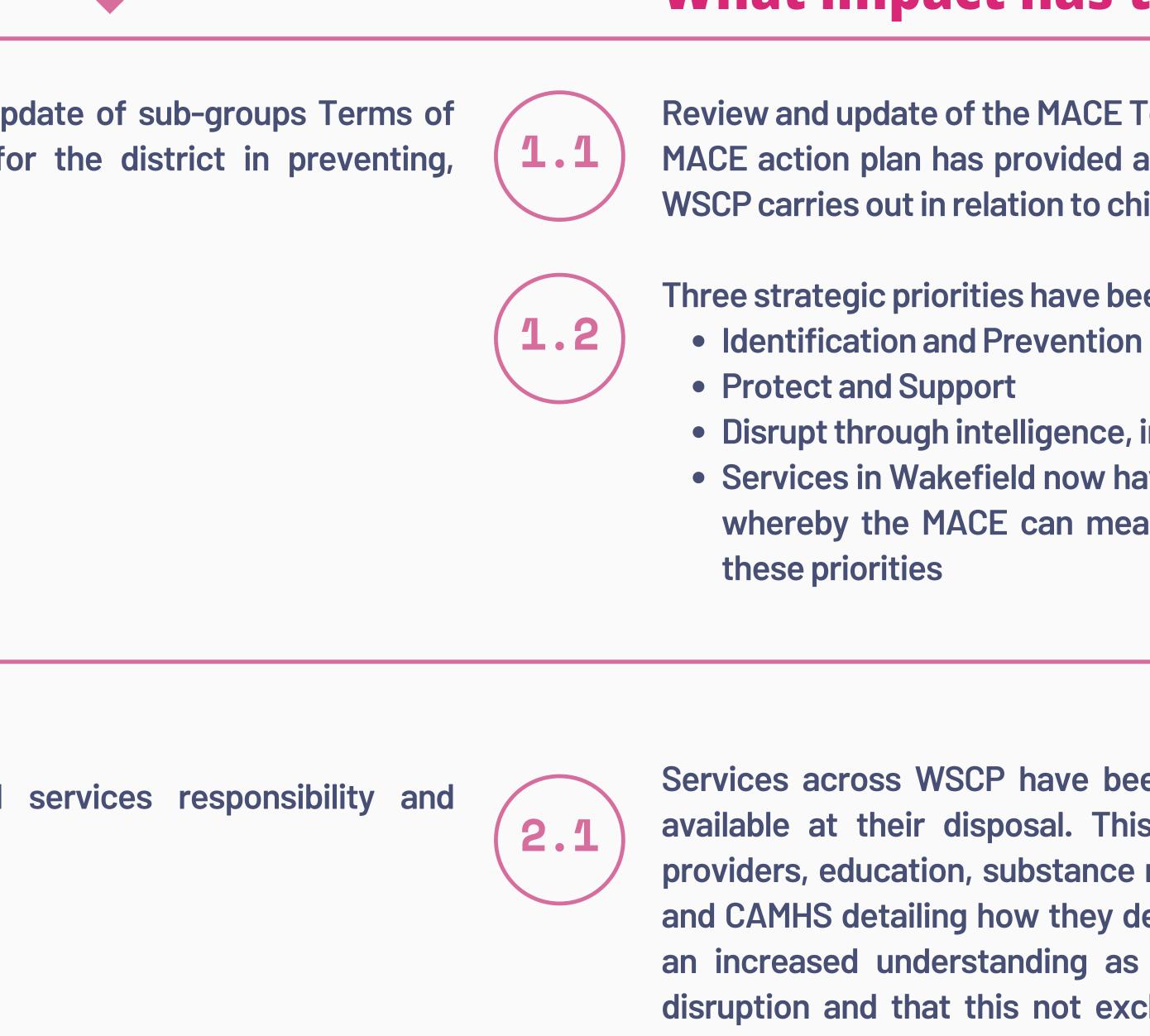
**Oversees the multi-age** effectiveness of servi work in relation to safeguarding children through data analysis assurance activity.



	Key Areas of Development
	<b>1</b> Development of a MACE Action Plan and up Reference outlining key areas of focus for identifying and disrupting child exploitation
Jency Ces	
and	
	<b>2</b> Multi-agency approach in identifying all capability in delivering disruption work
	<b>Creation of the Partnership Intelligence Sharin</b>
	<ul> <li>Develop a MACE Strategy to provide an s</li> </ul>

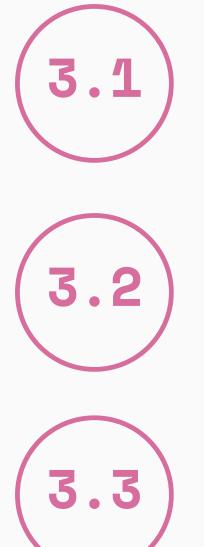
• Enhance services ability to identify child exploitation







#### ng Toolkit



The MACE Sub-Group has overseen the development of a Partnership Intelligence Sharing Toolkit to increase submissions to the Partnership Intelligence Portal (PIP).

The toolkit includes a host of resources which have raised practitioners understanding of intelligence sharing and the use of the PIP.

The toolkit will be used as part of PIP campaign in June.

strategic overview of the priority areas in respect of child exploitation for the district

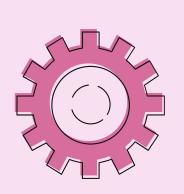


Review and update of the MACE Terms of Reference and introduction of the MACE action plan has provided a stronger framework as to how the work WSCP carries out in relation to child exploitation is delivered.

- Three strategic priorities have been introduced
- Disrupt through intelligence, investigation and prosecution
- Services in Wakefield now have a clear vision and plan to work towards
- whereby the MACE can measure effectiveness and progress against

Services across WSCP have been articulating the disruption techniques available at their disposal. This has included services such as health providers, education, substance misuse agencies, housing, youth services and CAMHS detailing how they deliver disruption work. Services now have an increased understanding as to how they are able to contribute to disruption and that this not exclusively a responsibility for enforcement

Disruption activity received from services has been collated to provide an evidence base, join up approaches, reduce duplication and to identify where there are gaps for MACE Sub-Group to address.



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#### **Function of CDOP**

Considers all child deaths in the district, reviewing information to analyse the circumstances, confirm cause of death, determine any contributing factors and to identify learning arising which may prevent future child deaths.

#### NEXT STEPS for 2021-22





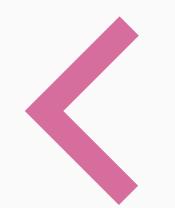




Wakefield CCG have led efforts to implement the Child Death Review Meeting (CDRM) process. Wakefield CCG have funded alongside Kirklees CCG and Mid Yorkshire Health Trust (MYHT) a Lead Nurse for Child Death role to be created and sit within MYHT.

Initiate a Child Death Arrangements Working Group to consider the following:

- child
- carried out by CDOP and priorities for the following year



## What impact has this made?





The Lead Nurse role is responsible to support families as the key worker, coordinate the CDRMs, and provide additional support across the whole child death process.

• Monitor the strengthening of existing child death process and support the implementation of the CDRM

• Create Child Death Pathway Protocol which outlines timescales to respond, at which point different processes are initiated, which professional / service is responsible for leading on a process, illustrates the whole child death process

• Develop One Minute Guides on Joint Agency Review meeting, Child Death Review Meeting, Child Death Overview Panel to support professionals in understanding the nature of the meeting, expectations, responsibilities, guidance on what they need to do

• Establish a support package for parents, carers and families to ensure there is a consistent offer to access

• Develop Child Death Review Training for professionals, covering the whole child death process to provide participants with understanding their roles and responsibilities in the process, the skills to explain to families the purpose what will happen to their child, how to collate and evaluate information for CDRM and CDOP. Along with having an increased knowledge of the nature and cause of unexpected deaths and to be able to recognise and respond appropriately to the circumstances surrounding the death of a

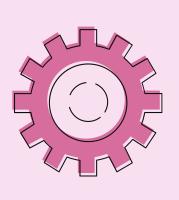
• Publish a Wakefield Child Death Arrangements Document as described within statutory guidance

• Publish CDOP Annual Reports to provide a breakdown of child deaths across the year, themes in relation to the deaths, the work

WSCP Business unit has revisited each child death and developed a monitoring system to identify steps needed to progress to the CDOP. CDOP

There are currently 36 open child deaths which requiring presenting to CDOP. WSCP has arranged a Wakefield only CDOP in May where 11 cases will be presented, this will be followed by quarterly joint panels with Kirklees

The modifiable factors identified from the child deaths presented at the October 2020 panel concerning two babies who died in relation to unsafe sleep practices in 2019 were considered and have informed the wider safe



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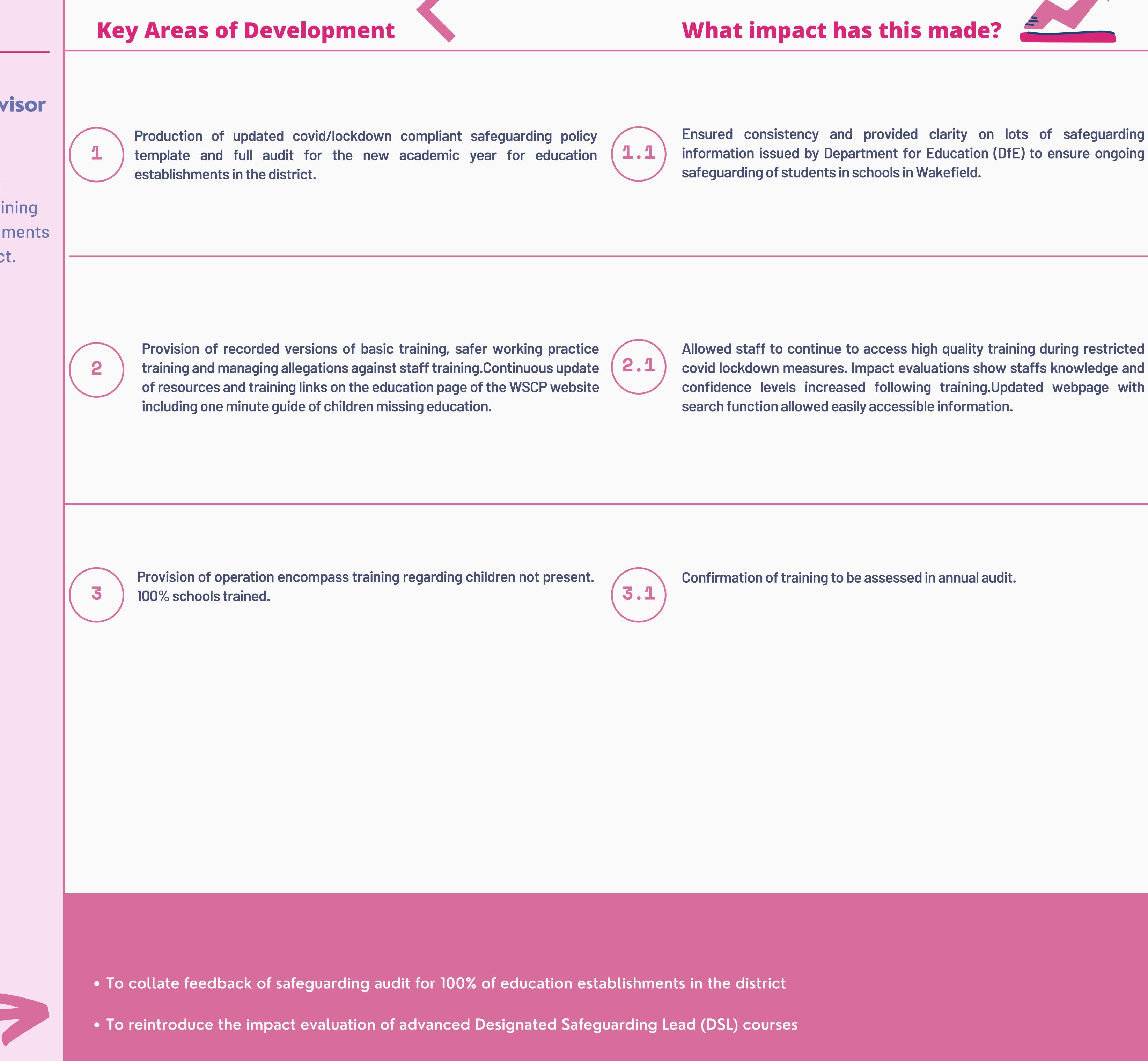
Review and Assurance Activity

Areas of Focus for 2021-22

**Function of** Safeguarding Advisor for Education

Provides safeguarding advice support and training to Education Establishments in the Wakefield district.







Ensured consistency and provided clarity on lots of safeguarding information issued by Department for Education (DfE) to ensure ongoing

covid lockdown measures. Impact evaluations show staffs knowledge and confidence levels increased following training.Updated webpage with





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What has been carried out during this period?

During this period WSCP has undertaken four practice reviews:

- 2 x concerning young babies (< 6 months)</pre>
- 1x concerning two infant siblings
- 1 x concerning a teenager

In addition, the partnership has carried out two Multi-Agency Case Audits (MACAs):

- Safeguarding Young Babies During Covid-19
- Private Fostering



#### What impact has this review and audit work achieved?

#### The activity carried out identified key learning which has been taken forward by the Learning and Development Sub-Group, Safeguarding Effectiveness Sub-Group and services to implement. The learning identified consisted of the following:

#### Professional Awareness and Knowledge

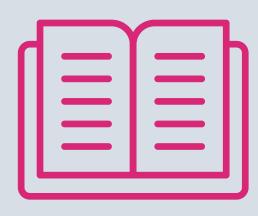
- Impact of parental adverse childhood experiences and deliver intervention which is trauma informed
- Understand what safer sleep / unsafe sleep practice is and have the confidence to provide support to families in relation to safe sleep
- The signs and how to respond to Fabricated Induced Illness
- Prescription and illicit drugs parents take and the impact on children

#### **Practice Development**

- Develop and using focussed and respectful curiosity and challenge
- Build trusting relationships with families avoiding recurring short, time limited interventions Routine use of the WSCP Neglect Toolkit
- Child voice to be captured within assessment to articulate wishes and feelings

#### System Development

- Information shared by Lay Persons to be acted upon as robustly as information received from professionals
- Information sharing across services to be consistent:
- 1. Multi-agency meetings convened within timescale
- 2. Records shared appropriately
- 3. Information triangulated within assessment 4. Meeting documentation shared and recorded on single agency-systems



## How is the learning being implemented?

Both the Learning and **Development Sub-Group and** Safeguarding Effectiveness Sub-Group are overseeing the implementation of the recommendations identified. Given the majority of the learning identified has been sourced from reviews and audit activity concerning babies and infants, WSCP is developing a Safeguarding Babies and Infants Masterclass. The masterclass will promote the key developments which WSCP overseen based on the learning identified which includes:

- Safer sleep key messages, promotion of the Wakefield Safe Sleep Standard and Safe Sleep training
- Preventing non-accidental injuries in babies
- Baby and infant mental health
- Parental Mental-III Health and the impact on babies and infants
- Learning from review and audit activity concerning babies and infants



#### Areas of Focus for 2021-22

In addition to the next steps highlighted within each sub-group, WSCP will take forward the following areas of focus in 2021-22

- Engage sports organisations and faith based settings in the district with WSCP arrangements
- Continue to progress the developments in relation to safeguarding babies and infants
- Review WSCP's Multi-Agency Learning & Development offer, aligning it with learning identified through practice reviews and audit activity
- Broaden approaches to communicate safeguarding children developments to the children and families workforce:
- 1. Launch a monthly safeguarding children e-bulletin
- 2. Increase WSCP generated activity online to highlight safeguarding developments
- 3. Update and launch the new WSCP website to enable guidance, procedures and resources to be more accessible