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

Wakefield Safeguarding Children Partnership

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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.

Wakefield Safeguarding Children Partnership

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	What impact has this made?
1 Considered four serious incidents concerning children and undertook reviews to identify multi-agency learning, alongside progressing actions on the Suicide Cluster Review Action Plan.	1.1 System and practice development has been achieved in relation to responding to a suicide. Agencies are now joined up through a Suicide Cluster Pathway led by Public Health. 1.2 The pathway coordinates agencies to provide postvention support to those bereaved by a suicide including family, friends, education settings and the wider community. Since the development of this pathway there have been no suicide cluster deaths amongst children. 1.3 Majority of the four reviews (3) have concerned the tragic deaths of young babies and unsafe sleep practices. System wide development has taken place to support the workforce's understanding and ability to deliver safe sleep information to families. This has included the development of a Wakefield Multi-Agency Safer Sleep Standard and the commissioning of The Lullaby Trust to deliver safer sleep training. Since these developments there have been no sudden unexpected deaths amongst young babies concerning unsafe sleep.
2 Initiated a new referral process, where agencies can identify incidents to the CSPRG which do not meet the serious incident criteria but consist of multi-agency learning.	2.1 CSPRG is now able to consider incidents based on multi-agency learning rather than exclusively based on severity where those incidents are notified to the Department of Education (DfE) National Panel. 2.2 The ability for agencies to refer incidents to the group enabled a multi-agency review to be undertaken in February concerning a near miss. Learning which was otherwise unknown in respect of the need to strengthen the children and families workforce understanding of Fabricated Induced Illness was identified.
3 Developed an overarching review action log, providing the CSPRG with greater oversight across all open reviews to monitor how the learning generated is being implemented across safeguarding systems and practice.	3.1 This has provided a greater understanding as to the thematic learning needs for the children and families workforce. This has resulted in learning opportunities being aligned with safeguarding practice needs across the district. 3.2 Learning from individual reviews can now be addressed collectively, making learning more impactful and the processes in implementing learning more efficient.
4 Updated the Rapid Review template to enable good practice and areas for development to be identified more effectively to inform actions for agencies to consider which are SMART.	4.1 The new template has resulted in deeper analysis of incidents being achieved, leading to clearer learning for agencies being identified at a quicker rate than previously. 4.2 The learning identified at a Rapid Review has negated the need for further Local Child Safeguarding Practice Reviews to be undertaken due to the level of detail captured. This has been highlighted within the three Rapid Reviews carried out in this period where the DfE National Panel have fedback positively on the learning detailed and agreed with WSCP's decision a further review would not identify additional learning.

NEXT STEPS for 2021-22

- 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 Sub-Group to implement
- Demonstrate the impact reviews make on system and practice development more consistently

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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.

NEXT STEPS for 2021-22

- Develop and deliver an integrated learning and development offer which is closer aligned with the needs of children and families workforce as identified within practice reviews and audit activity
- 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 the children and families workforce to access

Key Areas of Development		What impact has this made?	
1	Development of a wide range of Wakefield specific virtual safeguarding learning opportunities	1.1	Services have been able to access training on demand and incorporate this into staffing briefings and inductions.
		1.2	Due to the extensive the virtual learning, the previous generic e-learning bought in by WSCP has been ceased. This has resulted in a significant cost saving which is being reinvested to enhance and further develop additional learning and development in Wakefield.
2	Development of the Wakefield Safe Sleeping Standard and safe sleep training	2.1	Children and families workforce now has a range of guidance in relation to safe sleep practice in a single toolkit. The guidance helps to equip practitioners with an understanding on sudden infant death, co-sleeping, bed sharing and overlaying, what best practice looks like, how to engage parents, key messages, resources for parents and practitioners.
		2.2	The safe sleep training, complementing the standard, equips practitioners with the knowledge and approaches to identify unsafe sleep and the confidence in how to engage parents to support them with safe sleep practices.
		2.3	Wakefield has experienced a number of sudden deaths of babies since WSCP was established in 2019. Since the development of the standard and training there have been no sudden deaths of babies concerning unsafe sleep.
3	Creation of One Minute Guides providing bite-sized information across a variety of safeguarding topics	3.1	Information is now more accessible and for many services makes safeguarding more proportionate to their area. One Minutes Guides have been developed on intelligence 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 local policy..

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Areas of Focus for 2021-22

Function of the SEG Sub-Group

Oversees the multi-agency effectiveness of services work in relation to safeguarding children through data analysis and assurance activity.

Key Areas of Development

What impact has this made?

1 Overseen multi-agency audits in relation to Safeguarding Young Babies during Covid-19 and Private Fostering

1.1 Throughout Covid-19 restrictions, nationally young babies (< 1 year olds) and new families were identified as a vulnerable cohort with serious incidents rising. The audit carried out sought assurance locally as to how young babies and their families were being supported by services.

1.2 Learning identified from the audit which services have implemented consisted of:

- improving information sharing process;
- GPs being invited to multi-agency meetings;
- the use of the neglect toolkit;
- updating the needs of families within assessment when intervention makes impact

1.3 Learning from the Private Fostering audit which services have begun to implement consists of the following:

- improve staff understanding of what Private Fostering is and how to respond should they identify a child who may be being privately fostered;
- GPs are notified a child is being privately fostered and included in multi-agency meetings and planning;
- consider how Private Fostering as an area can be overseen across the district;
- develop Private Fostering resources and training for the children and families workforce

2 Refined the focuses within the WSCP Performance and Data Report

2.1 The multi-agency data is aligned to WSCP priorities which have enabled great focus on specific areas where improvement in systems and practice has been required. Highlights have included:

- health provider attendance at strategy meetings has remained consistently high across this period, demonstrating significant improvement in comparison to previous periods
- police data is now amalgamated into the Multi-Agency Performance & Data Report, enabling WSCP to view this data in the wider context of other indicators

3 Wakefield CCG and Wakefield Council Children's Social Care (CSC) have worked jointly to improve arrangements to enable GP practices to be engaged with and included within multi-agency safeguarding meetings

3.1 Following a range of developments partnership working between GPs and CSC has improved. This has led to improvements in GPs being engaged with and involved in multi-agency working more consistently.

3.2 The developments have included:

- new form for gathering GP health information;
- secure email systems for sharing and receiving safeguarding information and minutes;
- family history included as part of information sharing requests;
- updated guidance for GPs preparing reports for CPC

NEXT STEPS for 2021-22

- 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 established process

Wakefield Safeguarding Children Partnership

Function of the MACE Sub-Group

Oversees the multi-agency effectiveness of services work in relation to safeguarding children through data analysis and assurance activity.

Key Areas of Development

What impact has this made?

1 Development of a MACE Action Plan and update of sub-groups Terms of Reference outlining key areas of focus for the district in preventing, identifying and disrupting child exploitation

1.1 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.

1.2 Three strategic priorities have been introduced

- Identification and Prevention
- Protect and Support
- 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 these priorities

2 Multi-agency approach in identifying all services responsibility and capability in delivering disruption work

2.1 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 agencies such as the police and CSC.

2.2 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.

3 Creation of the Partnership Intelligence Sharing Toolkit

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

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

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

NEXT STEPS for 2021-22

- Develop a MACE Strategy to provide an strategic overview of the priority areas in respect of child exploitation for the district
- Enhance services ability to identify child exploitation

Wakefield Safeguarding Children Partnership

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.

Key Areas of Development

What impact has this made?

1 Improved CDOP monitoring systems and processes

1.1 WSCP Business unit has revisited each child death and developed a monitoring system to identify steps needed to progress to the CDOP. CDOP as a result now has oversight as to the status of each child death.

1.2 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 from September.

1.3 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 sleep developments across the district.

2 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.

2.1 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.

NEXT STEPS for 2021-22

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

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

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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.

NEXT STEPS for 2021-22

- To collate feedback of safeguarding audit for 100% of education establishments in the district
- To reintroduce the impact evaluation of advanced Designated Safeguarding Lead (DSL) courses

Key Areas of Development	What impact has this made?
1 Production of updated covid/lockdown compliant safeguarding policy template and full audit for the new academic year for education establishments in the district.	1.1 Ensured consistency and provided clarity on lots of safeguarding information issued by Department for Education (DfE) to ensure ongoing safeguarding of students in schools in Wakefield.
2 Provision of recorded versions of basic training, safer working practice training and managing allegations against staff training.Continuous update of resources and training links on the education page of the WSCP website including one minute guide of children missing education.	2.1 Allowed staff to continue to access high quality training during restricted covid lockdown measures. Impact evaluations show staffs knowledge and confidence levels increased following training.Updated webpage with search function allowed easily accessible information.
3 Provision of operation encompass training regarding children not present. 100% schools trained.	3.1 Confirmation of training to be assessed in annual audit.

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Review and Assurance Activity

Areas of Focus for 2021-22

What has been carried out during this period?

During this period WSCP has undertaken four practice reviews:

- 2 x concerning young babies (< 6 months)
- 1 x 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-Ill 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