WSCP Annual Report 2022-23

01 April 22 - 31 March 23

Wakefield Safeguarding Children Partnership

Annual Report 2022-23

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Introduction

This report summarises, reflects on, and presents the work of the Wakefield Safeguarding Children Partnership (WSCP) between 01 April 2022 and 31 March 2023. This covers the third full financial year of operation by the WSCP since it replaced the previous Local Safeguarding Children Board (LSCB) in September 2019. All details about the work of the partnership and the materials it presents to those who work or volunteer with children and families, children and young people, parents, carers and communities, and the comprehensive network of services that work with them, are available on the WSCP website at www.wakefieldscp.org.uk.

The partnership is a statutory body, led by an Executive and supported by an Independent Scrutineer. The Executive is led by Wakefield District Metropolitan Council (WMDC), NHS West Yorkshire Integrated Care Board and West Yorkshire Police, each represented by staff sufficiently senior as to be able speak with authority for and approve decisions on behalf of their organisations. It is also contributed to by a small number of representatives: lead officers from key services in all three statutory partners, headteachers from primary, secondary, and special educational needs schools, the voluntary sector, and Public Health.

This report focuses largely on the impact the partnership has achieved, documenting the work undertaken by the partnership's Executive and 5 sub-groups, highlighting areas of strength and areas the partnership needs to focus on developing within the next year.

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Corporate Director
Children and Young People's Services
Wakefield Metropolitan District Council

Richard Close

Chief Superintendent
Wakefield District Commander
West Yorkshire Police

Penny Woodhead

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Partnership Structure and Governance

The partnership has an established a structure which comprises of an Executive and 5 sub-groups. The sub-groups are the Child Safeguarding Practice Review Group (CSPRG), Child Death Overview Panel (CDOP), Multi-Agency Child Exploitation (MACE) Group, Learning and Development (L&D) Group, and the Safeguarding Effectiveness Group (SEG). The function of the Executive is to provide strategic oversight, scrutiny, and assurance of the work the partnership undertakes to ensure multi-agency safeguarding arrangements in Wakefield are effective. Each sub-group has specific responsibilities and identifies, discusses, develops, and delivers a range of multi-agency safeguarding information, resources, assurance, and learning opportunities which are as described within Figure 1 – Structure of WSCP. Of note this year, the Integrated Learning and Development Group was split into a Strategic and Delivery group as part of efforts to strengthen how the partnership develops a bespoke learning and development offer for the workforce which is aligned to need as identified from safeguarding practice review and quality assurance activity.

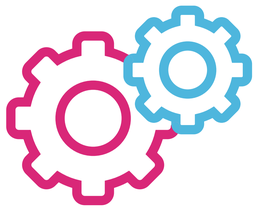
Wakefield Safeguarding Children Partnership

Members: All partners, including voluntary, private and community sector.

Safeguarding Partnership Executive
Members: 3 partners (Council, ICB, Police) with support from Public Health, the VCSE, primary and secondary head teacher representatives.

Child Safeguarding Practice Review Group	Child Death Overview Panel	Multi-Agency Child Exploitation Group	Integrated Learning & Development Groups		Safeguarding Effectiveness Group
			Strategic Group	Delivery Group	
Responsible for rapid reviews following the death or serious injury to children or young people where abuse or neglect are suspected. The Safeguarding Partnership Executive decides whether a full or local review is warranted on this review and evidence.	Considers all child deaths in the Wakefield area to identify any learning and themes.	Develop, monitor and challenge the work of the partnership in respect of contextual safeguarding including child sexual exploitation (CSE), child criminal exploitation (CCE) and children missing from home or care.	Strategic Group seeks to identify, make decisions, find agreement and report upon any appropriate examples of local, regional, and national learning concerning safeguarding children and generate these into learning outcomes.	Taking steer from the Strategic Group, the Delivery Group seeks to plan, co-ordinate and deliver learning identified on the WSCP Learning and Development (L&D) Action Log to the children and families workforce in Wakefield.	Carries out audit and assurance activity to examine the process and impact of practice and systems, performance data and analyse information from services to ascertain effectiveness and early identification of emerging issues and risk to children.

Figure 1 – Structure of WSCP



WSCP is aligned to the wider system in Wakefield and continues to contribute to the strategies and priorities from other strategic partnership and boards such as:

- Wakefield District Safeguarding Adult Board
- Wakefield District Safer Together Partnership
- Health and Well-being Board
- Children and Young People's Partnership Board

In November 2022, WSCP launched a new delivery plan, aligning itself to the district wide Children and Young People's Plan, 2022-25. The delivery plan contains 13 overarching priorities which the partnership has adopted and will focus on through to March 2025, whilst being reviewed annually and accommodating any emerging areas of development. The 13 priorities are as follows:

1. Ensure enhanced recognition and response to neglect across the partnership is in place
2. Babies and infants are protected from sudden death due to unsafe sleep
3. Children are protected from non-accidental injury
4. Children who are at risk from self-harm including thoughts of suicide can be identified and offered timely support
5. WSCP has robust scrupulous arrangements in place
6. Services who work with children have a proactive approach in identifying, preventing, disrupting, and stopping child exploitation
7. Children experiencing and/or displaying harmful sexual behaviour are supported by services who have the knowledge and expertise to provide support
8. Children have a lead role in shaping and contributing to a safeguarding agenda
9. Children who experience bullying feel able to report it and are supported by services
10. Safeguarding thresholds are well understood across the partnership workforce
11. High quality safeguarding learning and development offer is in place for frontline workforce across the partnership
12. Safeguarding information, resources and guidance is accessible for all services who work with children and families
13. Develop shared understanding and culture of trauma awareness across the partnership

The progress made this year against the 'Key Areas of Focus for 22-23' as laid out in the partnership's previous Annual Report is summarised on page 4. Throughout the report further detail is provided on the overall work the partnership has undertaken during 2022-23.

Key Areas of Development identified in 2021-22	Progress made since 2021-22
Ensure enhanced recognition and response to neglect across the partnership is in place	WSCP has made significant progress in developing resources to support the workforce across the partnership in recognising and identifying neglect at an early stage. This has included the launch of a new multi-agency neglect training and updated neglect toolkit which has moved online as part of the WSCP website. Further detail on the progress made in respect of neglect is captured under the Learning and Development (L&D) Sub-Group section on page 14.
Babies and infants are protected from sudden death due to unsafe sleep and non-accidental injury	The existing offers in strengthening the workforce understanding on what unsafe sleep practice looks like and what support families need has become well established, along with increased awareness of ICON – babies cry you can cope programme, which includes: • Lullaby Trust commissioned training on sudden infant death and unsafe sleep • Wakefield Safer Sleep Standard, providing clear guidance on what is required in terms of ensuring parents and carers are provided with effective safer sleep advice • Guidance on viewing where a baby sleeps during health visiting and community midwifery home visits is now embedded as standard practice. This has coincided with their being no sudden deaths concerning unsafe sleep since this has come into force • Specific page on safeguarding babies and infants on the WSCP website, providing a 'one stop shop' on all key information and resources on safer sleep and the ICON programme • Improved awareness of ICON by promoting infant crying messages to a parent audience reach of 20,000, which equates to 50% of the number of families identified in the 2011 census and child benefit 2019 data. The overall reach was over 123,500 exceeding the yearly target by 500% Throughout the year, the work undertaken in respect of safe sleep continues to be appearing to have a demonstrable impact. There has been no death of a child suspected to have been caused by unsafe sleep practice since February 2022. Prior to this period in 2022, the previous death was in 2020. Since ICON commenced roll out across the district, there have been no reported incidents of shaken babies since 2020.
High quality safeguarding learning and development offer is in place for frontline workforce across the partnership	Progress has continued in developing a safeguarding learning and development offer which is needs led and of high quality for the workforce to access across the partnership. The highlights include two key learning offers being rolled out on neglect and professional curiosity and challenge respectively. These two areas have been prominent features in previous safeguarding practice reviews as areas for development. A recent safeguarding practice review highlighted improvements in identifying neglect and the appropriate professional challenge practitioners displayed. Further detail on the learning and development offer is captured under the Learning and Development (L&D) Sub-Group section on pages 14 and 15.
Children who are at risk from self-harm including thoughts of suicide can be identified and offered timely support	The partnership has continued to contribute to the district wide developments in relation to suicide prevention via the Multi-Agency Suicide Prevention Group which is led by Public Health. Developments this year have included: • Partnering up with Papyrus, a national charity in preventing death of suicide amongst children) to deliver training to those who work or volunteer with children outside of mental health services • Further established links with West Yorkshire Health & Care Partnership Suicide Prevention group • Promotion across the district of the Managing Difficult Feelings Booklet
WSCP has robust scrupulous arrangements in place	WSCP has introduced a quarterly scrutiny and assurance meeting into its Executive schedule. This meeting acts as a function for reporting against the 13 priorities detailed within the partnership's delivery plan, where appropriate challenge on progress of the plan is undertaken and impact evidenced. Further detail on the progress of the scrutiny arrangements in place can be found under the Executive section on page 8.
Services who work with children have a proactive approach in identifying, preventing, disrupting, and stopping child exploitation	Developments have included: • Initiating a multi-agency working group to strengthen arrangements in identifying children at risk of child exploitation at the earliest stage possible • Partnering up with the National Working Group (NWG) to deliver a Transitional Safeguarding Workshop as part of Safeguarding Week 2022 • Roll out of regular training on how to use the Partnership Intelligence Portal Further detail on the work undertaken in respect of child exploitation is captured within the Multi-Agency Child Exploitation (MACE) Sub-Group section on page 13.

The partnership has experienced some significant changes of key personnel during this period. Both at Executive level and amongst some of those senior leadership roles which included chairing key partnership sub-groups. I have attended the majority of Executive meetings and sub-groups and am able to confirm that the smooth and effective operation of the partnership has not been adversely impacted by this period of change. In addition, the Executive's rotating chair arrangement has passed smoothly from Council-NHS-Police in a seamless transition with the support of the partnership's Business Unit. These changes have included my taking the chair role at the Safeguarding Effectiveness Group, while CCG has during this period also become an Integrated Care Board, and this significant change too did not interfere with the smooth operation of the partnership. Subgroups continue to meet regularly and to be well attended by all appropriate agencies.

Across all of the partnership subgroups there has been an increased effort to ensure that all actions and workstreams that arise at each of the groups' meetings are carefully logged and tracked. Any workstream that is 'slipping' is quickly identified and followed up. This enables me to confidently say that the partnership in the district is not a 'Safeguarding Talking Shop' in that in almost every case actions agreed are followed up and completed before being removed from the 'Open Action Log.' Clearly, there are some areas of activity and actions that relate to long term cultural change, and these are more difficult to show as 'complete' and provide evidence of impact, these remain open and on occasion may require escalating back to the Executive committee.

The partnership remains cognisant of the national perspective and system wide issues and consultations. The Executive has received reports, summaries and synopses of national consultations and central government proposals relating to safeguarding practice, Special Educational Needs, Social Work approaches etc. on a regular basis. The partners are enabled with the support of the Business Unit to respond appropriately to such consultations and to integrate changes within the delivery plan when required. A "Delivery Plan Highlight Report" is presented to alternate Executive meetings. This details 13 priorities and 42 actions agreed by the Executive and reports the progress in each action. Currently there are no actions flagged for concern and all actions show a trajectory of progress the overall status of the programme is recorded at the period end (March 2023) as 'L2' –"In Development." Although some of the actions are straightforward areas of practical improvement some are ambitious cultural changes involving all agencies, for example, "Develop a shared understanding of Trauma Informed Practice across the partnership".

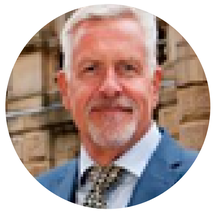
It is clear that as the partnership has matured the key area for development, in the first year this was a focus on collecting the right data to inform the Executive appropriately. This then shifted towards rigorous assurance activity (which is now securely embedded) and now during this reporting period the priority has become effective 'Learning and Development.' All learning and development activity can be traced back to actions arising from one of the assurance processes, such as multi-agency case audit, section 11 review questionnaire or case review. The learning and development subgroup has worked hard to deliver the most appropriate learning experiences ranging from formal training events, a series of briefings and one-minute guides. The highlight of this work culminates in Safeguarding Week which has again offered a wide range of multimedia learning experiences, well attended across the partnership.

There have been serious incidents during the reporting period and the National Safeguarding Panel agreed with the partnership's Executive on each occasion that the resulting Rapid Review reports were appropriate and sufficient, full Child Safeguarding Reviews were not required. With the support of the Business Unit Rapid Reviews were completed within the challenging timescales required and each report detailed individual agency and multi-agency actions. These multi-agency and single service improvement actions have been assiduously tracked and continue to be so. I was particularly impressed by the extent to which each of the agencies participated openly throughout the review process, open to challenge and accepting criticism alongside the appropriate areas for development. For example, in one case up to 17 agencies were involved in a critical analysis of their involvement, sharing their case files and evaluation openly.

The partnership has worked hard to fully engage all GP Practices and schools, the dispersed nature of these agencies makes this a challenge in any partnership. The section 11 monitoring process with schools and single agency audit with NHS/ICB has shown an increasing involvement of these partners. In addition, when required to contribute to formal case reviews key schools and GP Practices have engaged appropriately.

Also similar in all partnerships is the prevalence of neglect as the single biggest category of concern in terms of the number of cases. After being concerned with the engagement of partners and the limited use of the neglect related materials the Business Unit with the support of the Executive reviewed and redeveloped the approach. Thus far there has been an increased engagement and increased usage of the Neglect Toolkit. Neglect Champions are becoming increasingly common across a range of services. I am hopeful that this will bring positive outcomes. More work will need to be done to assess the full impact of these developments over time and the overall data as it relates to neglect will need to be analysed.

As an organisation the partnership now operates with a very clear 'Golden Thread.' From analysing the extent of safeguarding issues and priorities, to delivery of improvement actions via an agreed programme of work followed by implementation of actions leading to a focus on evidence of impact. As a result, the partnership ambitiously tackles some challenging areas seeking to bring about cultural change amongst services. Preparing and expecting front line staff and their managers to exhibit 'professional curiosity,' increased data sharing, identifying lead professionals on complex cases and triangulating information when faced with possible disguised compliance. The Executive must continue to lead, promote and support staff through these approaches to practice.



Stuart Smith

Independent Scrutineer

Function of the Executive

Has strategic oversight for all the work WSCP undertakes, having responsibility for driving the business and the development of the partnership forward through a delivery plan, ensuring compliance in having effective multi-agency safeguarding arrangements in place.

Key Areas of Development	What impact has this made?
1 Development and launch of a new partnership delivery plan	1.1 Provided the partnership with a clear focus on the priority areas to develop, aligning the business of the partnership with the district wide Children and Young People's Plan, 2022-25.
	1.2 Increased the accountability and transparency of the partnership's work, enabling progress of work to be reported against agreed success measures to demonstrate the impact being achieved.
	1.3 Reporting into the Children and Young People's Plan has enabled the partnership to have a greater platform to demonstrate the impact of its work and its value.
2 Introduction of quarterly scrutiny and assurance meetings	2.1 Enabled the partnership to develop a culture of supportive challenge of services through a clear scrutiny process.
	2.2 Provided a function to scrutinise the progress of the partnership's delivery plan through receiving updates to all actions detailed within the priorities and scheduled deep dive reports of priorities on a rotational basis.
	2.3 Enabled the partnership to maintain momentum of the previous Improvement Board in continuing to apply rigour in being self-scrupulous on the journey towards excellence post-inspection.
3 Updated the partnership's safeguarding threshold document, Continuum of Need: A Framework to Support Decision Making	3.1 The update provided a more easily accessible document to help those who work or volunteer with children and families across the Wakefield District make decisions about how to best provide support.
	3.2 The update brought the Continuum of Need in line with the Wakefield Families Together approach where a child and their family receive the right help, at the right time from the right service, and importantly, from the right person, whilst always acting in the best interest of a child.

KEY STEPS for 2023-24

- Maintain recently developed scrutiny and assurance arrangements
- Continue to oversee the implementation of the partnership's delivery plan
- Consider any required changes to the partnership upon the anticipated publication of Working Together to Safeguard Children 2023

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

1 Implemented the recommendations of 3 action plans generated from previous safeguarding practice reviews

2 Undertook three reviews pertaining to serious incidents concerning children to identify multi-agency learning

What impact has this made?

1.1 System and practice development has been achieved as a result, across a range of areas including:

- Rationale when considering a Domestic Violence (Abuse) Protection Notice (DVPN) is clear within records
- Strengthened policy and guidance in respect of the link between school absence and potential wider safeguarding implications for a child
- Ensured cross border communication processes are in place between services to share information appropriately with external district counterparts
- Guidance reaffirmed for the workforce in maintaining routine enquiry to consider the impact of adult mental ill-health on a child
- Improved service's procedure to ensure where disclosures of contact with children are made from somebody who is known to services to have no contact, this is shared appropriately with partner services to take necessary action
- Partner services of Turning Point are aware of the professional referral pathway to refer into the service
- 0-19 Service and Community Midwifery view where a baby sleeps as part of routine enquiry
- Schools involved in the reviews improved several of their safeguarding processes such as:
  - Using extended Designated Safeguarding Lead (DSL) team to delegate safeguarding responsibilities so not one role is responsible for all concerns
  - Set meetings to discuss cases
  - Implemented electronic information management system
  - Closer working between attendance and safeguarding staff
  - Monitoring processes in place for sibling absences
- Business Continuity plan in place within the police to mitigate unforeseen outages to enable manual Operation Encompass notifications to be shared
- Robust assurance provided by the ICB through undertaking an audit to ensure systems to follow up on missed health appointments are effective in cases of neglect

2.1 Identified areas of development which specific agencies have been tasked to progress and implement, in summary this included:

- Review and strengthen the step up: step down process between statutory and non-statutory support of cases where multi-faceted safeguarding issues (domestic abuse, substance misuse, parent / carer mental-ill health) are present
- Consider how reflective safety plans are of the lived experience and history of a family to be effective in mitigating risk
- Probation Service to be better embedded within child safeguarding systems and processes
- Ensure rationale is clear within a child's records as to why a routine enquiry in respect of domestic abuse is not undertaken

Identified areas of development which the partnership needs to develop and implement, in summary this included:

- Review and update the Neglect Toolkit and develop a new multi-agency neglect training
- Consider if there can be further development of systems, protocols, and guidance in relation to concealed pregnancy
- In complex cases with multiple children and multiple agency involvement, consider the requirement to have a lead professional appointed to the family whose role it is to triangulate all information received and discuss concerns in supervision
- Ensure there is a consistent and effective approach in how professional curiosity and challenge is undertaken by the workforce across the partnership

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

3 Introduced safeguarding practice review assurance events

What impact has this made?

3.1 In line with the wider partnership arrangements in increasing the robustness of its scrutiny, these events have been introduced to provide further opportunity to evidence the impact safeguarding practice reviews have generated in making positive developments to safeguarding systems and practice.

3.2 The event is to be trialled in June (outside of this reporting period, findings will be included in the 23-24 annual report) on two reviews undertaken in late 2022. Services who were attributed actions from the reviews are being invited to present how actions have been implemented and what impact changes have made to their safeguarding systems and practices.

KEY STEPS for 2023-24

- Undertake safeguarding practice review assurance event with a view to adopting this as standard process
- Maintain the oversight of learning identified from safeguarding practice reviews and ensure recommendations are implemented across safeguarding systems and practices

Function of the CDOP

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

Key Areas of Development

What impact has this made?

1 Maintained a well-established CDOP meeting

1.1 Wakefield reviewed 17 historical deaths of children (deaths occurred between 2020 – 22) at CDOP.

Of the 17 cases reviewed (deaths occurred in 2020 – 22), 7 (41%) had one or more modifiable factors identified (cases can have multiple modifiable factors). These were:

- Smoking (6)
- Parental substance use (2)
- Unsafe sleeping (1)
- Room temperature & infants clothing/bedding (1)
- Access to medication (1)
- Parental alcohol use (1)
- Obesity (child) – High BMI (1)

1.2 Of the 17 deaths reviewed, 6 were unexpected and all the categories were:

- Sudden, Unexpected, unexplained death (2)
- Perinatal / neonatal event (3)
- Chromosomal, genetic, and congenital anomalies (5)
- Chronic Medical Condition (2)
- Malignancy (3)
- Trauma and other external factors including medical/surgical (1)
- Acute medical or surgical condition (1)
- Infection (1)
- Suicide/deliberate self-harm (1)

1.3 Identifying modifiable factors from a breadth of cases has enabled work to be undertaken which is informed by need. Across 22/23 CDOP undertook specific developments, which included a recurring Safer Sleep Campaign and new Water Safety resources

2 Using findings from CDOP to inform key campaigns and awareness

2.1 The partnership has invested significant effort into reducing deaths of young babies due to unsafe sleep. This has included:

- Commissioning specific training on safer sleep for anybody who works or volunteers with children and families via the Lullaby Trust
- Embedding of the Wakefield Safer Sleep Standard
- Promotion of the safeguarding babies and infants on the WSCP website
- Health Visitors and Community Midwives seeing where a baby sleep as part of routine enquiry

This investment appears to be demonstrating impact with there being no death of a baby suspected to have been caused by unsafe sleep since February 2022. Prior to this period in 2022, the previous death was in 2020.

2.2 Since 2019 there has been three deaths in the district suspected to have been due to drowning in open water. CDOP members considered what action could be taken to educate on the dangers of open water. The work of CDOP led to the creation of a dedicated WSCP Water Safety Page, containing key safety messages about how to stay safe in and around water and also what to do if somebody is in difficulty.

This development has also helped direct the partnership's involvement with the Wakefield District Water Safety Working Group, and three safety videos are due to be launched in June 2023, to help raise awareness surrounding water safety as part of district wide Be Water Wise campaign.

Wakefield Safeguarding Children Partnership

Function of the CDOP

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

Key Areas of Development

3 Maintained a well-established CDOP meeting

What impact has this made?

3.1 Launched a Wakefield District Child Death Arrangements document to provide an overview what the district's arrangements are, the importance as to why a child death requires to be reviewed, what the process covers, and what happens with the information collated

3.2 Hosted a CDOP Development Day, which was attended by colleagues from Kirklees and Calderdale. This was an informative event with inputs on key topics such as:

- Safer sleep, the use of vaping/e-cigarettes during pregnancy
- Consanguinity
- Modifiable factors

Along with guest speakers from the Foreign Commonwealth and Development Office (FCDO) and The Lullaby Trust.

KEY STEPS for 2023-24

- Multi-agency learning from child deaths to continue to be adopted on actions plans and where appropriate stepped across to the WSCP Learning & Development sub-group to progress and to action
- Continue to monitor the work CDOP has driven in respect of safer sleep and water safety to ascertain the impact achieved
- Continue to establish engagement with GPs and achieve 100% sign up to the eCDOP system so they can share any relevant information in relation to a child and family
- CDOP meetings to continue to have a focus on sharing good practice and advice, complementing the process in review cases
- Develop a bereavement page on the WSCP website detailing where parents and families can access support

Function of the MACE Group

Develops, implements, and monitors the Wakefield MACE Action Plan to ensure there is a co-ordinated multi-agency response to child exploitation and assessment of risk posed outside the home.

Key Areas of Development

What impact has this made?

1 Continued to embed the Wakefield District Multi-Agency Child Exploitation (MACE) strategy

1.1 The Wakefield MACE Strategy has driven a range of activity which included:

- Ensuring good multi-agency attendance at the Risk Assessment Meeting (RAM) with a recent addition in respect of 0-19 Service
- Training and practice learning briefings delivered by members of the Vulnerable and Exploited Group with a focus on early identification of exploitation
- Wider dissemination of the Wakefield district Police Exploitation Profile to enhance partner and community knowledge of perpetrators, victims and locations where exploitation may be occurring
- Increased use of and regular training provided on the Partnership Intelligence Portal
- Further embedding the perpetrator RAM within the partnership and established closer working and new processes with the Probation Service
- Increased disruption activity, for example hotel booking test operations, use of disruption notices such as Child Abduction Warning Notices (CAWN) and the National Referral Mechanism (NRM)
- Joint working and coordination between the police and the Children Vulnerable to Exploitation (CVE) Team when a child comes into custody
- Range of resources on different types of exploitation on the Child Exploitation Page on the WSCP website.

2 Rates of submissions to the Partnership Intelligence Portal (PIP)

2.1 The Partnership Intelligence Sharing Toolkit has continued to support stable submission rates of intelligence from partner services into the police's Partnership Intelligence Portal. The PIP continues to be key mechanism for partner services to submit concerns, including those in relation to criminal activity where child exploitation is suspected. The toolkit includes a host of resources such as key messages and graphics to raise practitioner's awareness, a one-minute guide on intelligence sharing, a video and presentation on the PIP.

2.2 Wakefield has remained one of the highest districts in submitting intelligence to West Yorkshire Police in relation to child exploitation, seeing an increase of 85 submission on the previous year.

3 Implmentation of a Child Exploitation Working Group focusing on early identification

3.1 A working group and action plan has been established by the MACE Group to review the arrangements across the partnership in respect of early identification of children at risk of exploitation. This includes:

- Develop a core learning offer for practitioners
- Create a Child Exploitation Knowledge Hub on the WSCP website, providing resources and guidance across all aspects of exploitation from a central place
- Promote the function of the Children Vulnerable to Exploitation Service and develop a risk assessment to enable early identification of exploitation
- Create a series of one minute guides on child exploitation

KEY STEPS for 2023-24

- Implement the developments in progress being overseen by the Child Exploitation Early Identification Working Group:
  - Develop a core learning offer for practitioners
  - Create a Child Exploitation Knowledge Hub on the WSCP website, providing resources and guidance across all aspects of exploitation from a central place
  - Promote the function of the Children Vulnerable to Exploitation Service and develop a risk assessment
- Review and refresh the MACE strategy to align with current research and practice principles for responding to child exploitation and extra-familial harm

Function of the Strategic and Delivery L&D Group

Responsible for responding to the multi-agency safeguarding 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

What impact has this made?

1 Delivered a wide range of multi-agency learning and development for the workforce across the partnership

1.1 Across the year, over 900 practitioners from the children and families workforce across the partnership accessed a range of learning which included:

- Perplexing Presentations (PP) / Fabricated or Induced Illness (FII) masterclass
- Working Together to Safeguarding Children – A Shared Responsibility training
- Managing Allegations Against Those Who Work or Volunteer with Children training
- Safer Recruitment training
- Impact of Parental Mental Ill-Health training
- Barnardo's Safeguarding a Child's Perspective training
- Safer Sleep and Sudden Infant Death training
- Reducing Parental Conflict training
- Various workshops as part of Safeguarding Week 2022

Evaluation feedback drew parallels with the previous year in reporting most learners highly rated the quality and relevance of learning with over 90% of saying their skills and knowledge had improved as a result of the training they received.

Some of the more specific evaluation reports can be found on the links below:

- SGW 2022 evaluation
- FII / PP Masterclass

2 Development and launch of multi-agency neglect training, online neglect toolkit and neglect champion programme

2.1 Last year's annual report referred to the stepping across of recommendations generated from safeguarding practice reviews and audit activity to the L&D Sub-Groups to in order to develop a needs led training offer for the workforce. The development and launch of the multi-agency neglect training and online neglect toolkit has been a significant step in progressing and achieving this, given previous safeguarding practice reviews highlighted early identification of neglect as an area to develop.

This work was launched in February 2023 via a neglect campaign and initial signs have been positive in terms of take up of the training, access of the toolkit and sign up of neglect champions.

2.2 Updating and moving the neglect toolkit online has increased usability, with practitioners being able to view applicable sections in a more bite-sized and clearer manner along with using a streamlined assessment to help inform decision making.

3 Development and launch of Professional Curiosity and Challenge Learning Briefing

3.1 Similarly, to the early identification of neglect, professional curiosity and challenge was an area in previous safeguarding practice reviews requiring development. In response, a multi-purpose learning briefing was developed by the partnership and launched in March 2023.

3.2 The briefing provides easy read guidance for those working or volunteering with children and families on what professional curiosity and challenge is, what it means to be curious and challenging, why it is important, approaches to take when looking, listening, asking, and checking out, along with four cases studies based on safeguarding reviews which have occurred in the Wakefield District. The case studies provide an activity where professional curiosity and challenge is applied in different safeguarding contexts including child exploitation, domestic abuse, unsafe sleep, neglect, and harmful sexual behaviour

Function of the Strategic and Delivery L&D Group

Responsible for responding to the multi-agency safeguarding 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

4 Continued to publish a range of safeguarding resources including One Minute Guides and 7-Point Briefings, providing easy to access information across a variety of safeguarding topics

What impact has this made?

4.1 Across the year, activity regarding the partnership's learning resources has progressed strongly. There is now a well-established out-ward facing approach in place from identifying what needs to be developed e.g., a guide, webpage, learning briefing, how and who will develop the work with the aim to make resources easy to understand and making safeguarding inclusive.

4.2 One Minutes Guides have been developed on child protection conferences, children not engaging with school, multi-agency case audit, domestic homicide and Domestic Homicide Reviews, Sexual Assault Referral Centre (SARC), supporting Ukrainian children and families, Continuum of Need, Children In Care (CIC) initial health assessments and extreme ideologies: incels.

4.3 7-Point Briefings have provided key headlines on educational neglect, and safeguarding reviews concerning a baby, teenager, and infant child respectively. The key information detailed within the briefings enables findings in relation to learning to be disseminated to frontline practitioners in a more concise and proportionate manner as opposed to lengthy reports.

KEY STEPS for 2023-24

- Develop a professional curiosity and challenge short explanation video to further enhance the recently launched learning briefing
- Continue to develop offers and resources of bite sized learning
- Progress the Learning and Development Action Log, focusing on developing further learning opportunities in respect of professional curiosity and challenge, harmful sexual behaviour and engaging with fathers and male care givers

Function of the SEG

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

Key Areas of Development

What impact has this made?

1 Continued to produce a multi-agency safeguarding data set which provides an overview of the vital signs of the child safeguarding system, generating analysis, and informing action for system and practice development

1.1 To help enable the Safeguarding Partnership Executive to determine if the safeguarding system is working well and to identify any issues at an early stage, the Partnership receives a performance report with a range of key performance of indicators (KPIs) some of which have targets linked to them. An analysis from each report is presented highlighting where targets have been achieved evidencing good performance, where there has been a change in data compared with previous months and any targets that have not been achieved against KPIs. Following discussion of performance, the Safeguarding Effectiveness Group is tasked to look in more detail at this. Below is a summary of performance seen in 2022 -2023.

A high level of performance was sustained or improved across a range of KPIs:

- Rate of referrals to Children's Social Care
- Referral decision making timeliness by Integrated Front Door
- Attendance at Strategy Discussion meetings by partners
- Initial Child Protection Conferences held in timescale
- LADO allegation meetings and discussions held in timescale

A fluctuating trend in data was seen across the following KPIs:

- Re-referrals to Children's Social Care
- Initial Child Protection Conferences held in timescale
- Engagement of children and young people in return home interviews

Development is still required across the following KPIs:

- Percentage of contacts reaching threshold for Children's Social Care remained below target
- Completion of Section 47 Investigations within timescale
- During the period an increasing trend was seen in the number of children on a Child Protection Plan

2 Undertook a range of multi-agency assurance activity in relation to Domestic Abuse, Harmful Sexual Behaviour, and individual safeguarding arrangements (Section 11) respectively

2.1 Learning identified as a result of multi-agency audit which is overseen by the Safeguarding Effectiveness Group includes:

- Reviewing Harmful Sexual Behaviour (HSB) Panel guidance and referral pathways
- Developing a multi-agency HSB training offer for the partnership workforce
- Developing a HSB standalone page on the WSCP website and bite-sized guidance on HSB for the workforce
- Launching an awareness raising campaign on HSB targeted at the partnership workforce promoting the work developed
- Findings from the domestic audit were incorporated into the wider development of the Wakefield District Domestic Abuse Strategy, Multi-Agency Risk Assessment Conference (MARC) review and subsequent domestic abuse action plans

3 Overseen Joint Targeted Area Inspection (JTAI) preparation arrangements

3.1 Ensured the partnership has a clear multi-agency inspection process in co-ordinating three separate (local authority, health, and police) inspectorate areas into a single approach.

3.2 Provided opportunities to seek assurance and further strengthen child safeguarding systems and practice based on inspection focuses via undertaking self-assessment and multi-agency audit activity

KEY STEPS for 2023-24

- Develop a West Yorkshire faith-based settings safeguarding assessment tooi
- Implement the developments in progress being overseen by the Harmful Sexual Behaviour Working Group:
  - Update HSB guidance and referral pathways
  - Develop a HSB standalone page on the WSCP website and bite-sized guidance on HSB for the workforce
  - Launch an awareness raising campaign on HSB targeted at the partnership workforce promoting the work developed

Wakefield Safeguarding Children Partnership

Function of the Safeguarding Advisor for Education

Provides safeguarding advice, support, and training to all schools and colleges in the Wakefield district.

Key Areas of Development

1 Delivered of an extensive range of high-quality safeguarding education training in schools and colleges:

- Safeguarding Basic Awareness Refresher – 62 schools
- Safer Working Practice – 59 schools
- Strategic Governor – 21 sessions
- Designated Safeguarding Lead (DSL) – 20 sessions
- Safer Recruitment - 3 sessions
- Early Career Teachers - 2 sessions

2 Continued to delivered a wider safeguarding support offer for all schools and colleges in the districts, which includes standalone safeguarding school and college section on the WSCP website, free to access safeguarding template policy, school and college safeguarding audit and key policy updates.

What impact has this made?

1.1 Regular feedback of the training continues to be extremely positive which has included … "the knowledge of the Safeguarding Advisor for Education is excellent; the training is very useful and detailed".

1.2 There have been several requests for out of area course delivery due to the consistent high quality of the training offer.

1.3 Evaluations 3 to 6 months post training delivery demonstrated the impact the training has had. 95% of attendees stated the training was very useful to their roles. In many examples, because of the DSL training, staff were checking policies, updating procedures and adding current topics/questions to the weekly safeguarding quizzes they have in place for all staff.

2.1 Schools and colleges accessed an updated safeguarding policy and templates ensuring consistency in the quality of guidance schools and colleges follow in respect of safeguarding children and local service information for Wakefield.

2.2 All schools and colleges in the district completed the 22/23 school safeguarding audit. Schools commented on the value in being able to self-assess themselves against the audit, which draws from national and local guidance, to ensure they have all appropriate arrangements in place to safeguard children. Once submitted schools and colleges received feedback from the Safeguarding Education Advisor and appropriate guidance on how to develop areas requiring strengthening.

2.3 Reinstated half termly DSL Forums, which provided a range of safeguarding topic tops ups from local and national experts. Followed by a DSL opinion form sent to all schools every half term which collects general themes of what's working well and what can be improved.

2.4 Commencement of face to face DSL peer support meetings for DSLs in secondary schools, colleges and independent schools in the district.

2.5 Supported schools and colleges in multi-agency audit activity.

2.6 Produced a 7 Point Briefing on Educational Neglect.

KEY STEPS for 2023-24

- Continue to support schools in line with changing national and local guidance for education
- Introduce random spot checks for selected schools and colleges on their annual safeguarding audit submission
- Deliver DSL courses for Local Authority Children and Young People Service workforce to have insight and understanding of education policy and inspection requirements
- Increase Harmful Sexual Behaviour training offer for schools and colleges

Wakefield Safeguarding Children Partnership

WSCP WEBSITE

WSCP has further progressed on how it communicates the work the partnership undertakes. This year has continued to see key developments in the partnership's communication and engagement.

Overview of what has been achieved

During 2022/23 the WSCP website has continued to progress since being updated last year. It has become the primary function as to how the partnership communicates all of the work it produces and where those who work or volunteer with children and families visit to access safeguarding children resource, training and information.

A key undertaking this year has the development of the neglect toolkit moving it from being document based to online. These specific pages are now where practitioners can find an interactive and easy to use version of the Wakefield District Neglect Toolkit. This is one example where the partnership has modernised the approach to how practitioners access this large document as well as addressing the long-standing issues around the length of the document, time constraints and the assessment process. Without changing the bulk of the content, it has been reduced into bite-sized modules for practitioners to access online, either in full or in sections, giving the ability to download and save versions as supporting documents for referrals. This is linked to all resources relating to neglect into the toolkit pages whilst promoting our new Neglect for professionals page and Multi-agency Neglect training.

The added functionality of this style of page will now enable the partnership to develop a Knowledge Hub where various complex safeguarding topics can be laid out in a user friendly and informative manner.

During the year the following pages have been added:

Professionals

- JTAI
- Water Safety
- Neglect for Professionals
  - Neglect Toolkit online wiki pages

Children & Young People

- Healthy vs Unhealthy relationships

Parents & Carers

- Safeguarding in Sport

Training

- Variety of pre-recorded training was audited and updated

The impact of the website

Website engagement has continued to strengthen across the year. Feedback from those visiting is that the website is easy to use, find what you need and informative.

From the website statistics overall user engagement has improved for the new website in comparison to the previous website and those accessing it are on average spending more time on the new website. Below is a summary of the website analytics:

- 80,543 total amount of page views across the year
- 55,562 being unique views (where a page has been clicked on for the first time by a user)
- Home page (15%), training section (8.5%), worried about a child (4.5%), resources section (3%) and schools section (2.5%) were the top five pages visited
- 7,301 users visited the website, with 69% of those being returning visitors and 31% being recorded as new users

Key steps for 2023-24

- Pages within the Children and Young People and Parents & Carers section will be further developed. Currently pages on Mental Health support and advice as well as support on Bereavement are being developed
- Develop further content within the Knowledge Hub section

WSCP e-bulletin

Overview of what has been achieved

WSCP's free monthly e-bulletin continues to be a key approach in communicating all the latest local and national safeguarding resources, training, information and developments to provide anybody who subscribes (currently 1035 subscribers which is an increase of 80 since last year).

In total 15 editions were produced and disseminated during the year. These consisted of:

- 12 standard monthly editions
- 3 special editions:
  - Safeguarding Week 2022
  - Neglect Champion Launch
  - Updated Continuum of Need

Subscribers are from the following service areas:

- Education (430 increase from 350 in 21/22)
- Children and Young People Services (320 increase from 313 in 21/22)
- Early Years (136 increase from 116 in 21/22)
- Health (55 decrease from 73 in 21/22)
- Other (37 no change from 21/22)
- Public Health (17 no change from 21/22)
- Adult Services (13 no change from 21/22)
- Probation (12 no change from 21/22)
- Police (17 increase from 8 in 21/22)
- Voluntary and Community Sector (10 increase from 7 in 21/22)
- Youth Justice (5 increase from 4 in 21/22)
- Housing (5 increase from 2 in 21/22)
- Fire Service (1 no change from 21/22)

It is suspected the decrease in health subscribers has coincided with the change in 0-19 Service provider, this is being actively explored. In addition to those who subscribe, each edition is also added to the WSCP website and promoted on the WSCP Twitter page to enable non-subscribers to view.

To subscribe to the e-bulletin and view previous editions, visit the WSCP e-bulletin page on the WSCP website.

The impact of the e-Bulletin

The e-bulletin has become a key component in how WSCP directly communicates to a wide audience. The steady increase and retention of subscribers month-on-month highlights how valuable the content is that is produced. In August 2022 the partnership circulated a survey, seeking feedback on the ebulletin. Overall feedback was positive with over 80% of the respondents reporting they found the content of the e-bulletin either very useful or useful.

The e-bulletin consists of a range of information relevant to children's safeguarding. This year of note, in response to incidents of drowning of children in open water in the district in recent years, the e-bulletin has had a consistent focus on water safety in an attempt to raise awareness of the dangers. During the year, articles relating to water safety have featured in 8 editions highlighting key water safety messages specific to winter and summer, and detailing what resources are available to share with children and young people to get safety messages across.

A key feature of the e-bulletin is that as it is an online tool which enables the partnership to respond timely to any safeguarding developments and concerns in disseminating information promptly. An example of this included a safety alert of the dangers of self-feeding pillows which were deemed a significant risk to babies, was quickly shared with professionals via the ebulletin, who can then cascade the advice and information to the families they work with.

Key steps for 2023-24

- Undertake a follow up survey in 23/24 with subscribers to ensure they are receiving the e-bulletin when it is disseminated, and enquire if there are any suggestions, they can make for what they would to see included/ways to improve it
- Target service areas who have a low subscription rate to increase numbers

WSCP Social Meida

Overview of what has been achieved

WSCP's Twitter account - @Wakefield_scp provides regular safeguarding children updates on local and national developments, resources, initiatives, policy, and guidance.

The account has over 500 followers (increase of 99 followers since last year) and is steadily growing. Followers predominately consist of practitioners and services who work and volunteer with children and families. The WSCP's Twitter feed is used to provide important information such as updates to policies and procedures, promotion of learning events and links to new safeguarding information and resources.

An Instagram account was launch in November - @_keepyamatessafe_ and has steadily begun to build a presence focusing on sharing awareness raising of safeguarding topics direct to children and young people as part of the partnership's campaign.

The impact of social media activity

Continuing to grow an established presence on Twitter has enabled WSCP to extend its reach in running several safeguarding campaigns which included supporting the 16 Days of Action for Domestic Abuse, Tackling Child Exploitation Awareness Day, Safer Sleep, Children's Mental Health Week, Safer Internet Day and Safeguarding Week 2022.

These have all received good engagement on Twitter across the year and all metrics have increased when compared to last year, through new followers (99), profile visits (over 40,000), impressions (over 84,500), engagement (400), likes (63) and retweets (43).

At the end of March 2023, the Instagram account had 35 followers and has shared campaign material such as promoting Children's Mental Health Week, awareness of Home Invasion and County Lines, and a collaboration with the Young Lives Consortium on Safer Internet Day.

Key steps for 2023-24

- Further establish WSCP presence on Instagram
- Consider establish a presence on other social media platforms to extend reach to members of the public such as TikTok and Linked In

Key Areas of Focus for 2023-24

The partnership has made significant progress across a range of multi-agency safeguarding areas. Alongside the next steps already identified throughout this report under respective groups and areas, the partnership's delivery plan will continue to provide the basis for the 13 priority areas as referenced on page 3 to progress in 2023-24. These will include specific focuses on the below priorities as part of the delivery plan's deep dive report schedule:

- Children are protected from non-accidental injury
- Children experiencing and/or displaying harmful sexual behaviour are supported by services who have the knowledge and expertise to provide support
- Children have a lead role in shaping and contributing to a safeguarding agenda
- Services who work with children have a proactive approach in identifying, preventing and disrupting child exploitation
- Safeguarding information, resources and guidance is accessible for all services who work with children and families
- Develop shared understanding and culture of trauma awareness across the partnership