What Works *for* Children's Social Care

THE CHILD **SAFEGUARDING** PRACTICE REVIEW PANEL

ANALYSIS OF SAFEGUARDING PARTNERS' YEARLY REPORTS 2019-20

Overview report

May 2021

What Works for Children's Social Care

THE CHILD SAFEGUARDING PRACTICE REVIEW PANEL

Authors

Eleanor Briggs
What Works for Children's Social Care

John Harris
Pool of Reviewers: Child Safeguarding Practice Review Panel

About What Works for Children's Social Care

What Works for Children's Social Care seeks better outcomes for children, young people and families by bringing the best available evidence to practitioners and other decision makers across the children's social care sector.

Our research looks at the point of referral through to permanence, including adoption, care-leaver support and targeted early help. We focus on children's social care practice in England and draw on and share learning at the international level.

Engagement and co-design are central to our approach and we are working in close consultation with leaders, practitioners, children and young people, families and researchers across the sector to:

- Identify gaps in the evidence, and create new evidence through trials and evaluations
- Collate, synthesise and review existing evidence
- Develop, test and publish tools and services that support the greater use of evidence and inform the design of the future Centre
- Champion the application of robust standards of evidence in children's social care research.

To find out more visit the Centre at: whatworks-csc.org.uk

About the Child Safeguarding Practice Review Panel

The Child Safeguarding Practice Review Panel is responsible at a national level for identifying and overseeing the review of serious child safeguarding cases which, in its view, raise issues that are complex or of national importance.

The Children and Social Work Act 2017 provided for the creation of a new Child Safeguarding Practice Review Panel and statutory guidance on 'Working together to safeguard children 2018' sets out how the Panel operates and works with safeguarding partnerships. The Panel is appointed by the Secretary of State for Education but is independent of Government.

We have a shared aim with safeguarding partners in identifying improvements to practice and protecting children from harm. We share concerns, highlight commonly recurring areas that may need further investigation (whether by local or national review), and share learning, including from success, that could lead to improvements elsewhere. We want national and local reviews to focus on improving learning, professional practice and outcomes for children.

Local authorities should notify the Panel:

- If a child dies or is seriously harmed and abuse or neglect is known or suspected:
  - in their area
  - outside of England, but they're normally resident in their area
- To report the death of children looked after by a local authority whether or not abuse or neglect is known or suspected

To find out more visit: www.gov.uk/government/organisations/child-safeguarding-practice-review-panel

ANALYSIS OF SAFEGUARDING PARTNERS' YEARLY REPORTS 2019-20

Overview report

1. INTRODUCTION

1

This report sets out the key findings from a compliance audit and 'deep dive' analysis of safeguarding partnerships' yearly reports. This analysis was undertaken for the Child Safeguarding Practice Review Panel ('the Panel') by What Works for Children's Social Care (WWCSC) and John Harris, one of the Panel's Pool of Reviewers (who also coordinated the development and delivery of the Panel's Annual Report 2019-20).

2

The analysis addresses three key questions:

i. To what extent do safeguarding partnerships' yearly reports meet the requirements set out in Working Together to Safeguard Children 2018 (WT 2018)?[1]

ii. What can we learn about the priorities and practice issues safeguarding partnerships have been focussing on? (prioritisation, progress, use of evidence and impact)

iii. What can we learn about how safeguarding partnerships' are undertaking, sharing, disseminating and embedding learning from rapid reviews and local child safeguarding practice reviews? (Dissemination and embedding of learning)

Further details of the research scope are provided at Appendix 2.

3

WT 2018 requires that copies of all published yearly reports by safeguarding partnerships should be sent to the Panel and WWCSC within seven working days of publication. These reports are an important source of learning. The findings from our analysis will inform the work taken forward by the Panel in response to common challenges in child safeguarding highlighted by these reports. It is also expected that the learning from this analysis will complement Sir Alan Wood's Sector Expert Review of Multi-Agency Arrangements for Protecting Children and inform further development work with safeguarding partnerships.

Safeguarding Partnerships

Local organisations and agencies that work with children and families play a significant role when it comes to safeguarding children. There is a shared responsibility to safeguard and promote the welfare of all children in a local area. The responsibility for this join-up locally rests with the three safeguarding partners who have a shared and equal duty to make arrangements to work together to safeguard and promote the welfare of all children in a local area. These partners are defined under the Children Act 2004 (as amended by the Children and Social Work Act, 2017) as: the local authority, the clinical commissioning group for an area and the chief officer of police for the area. These partners must publish a yearly report setting out what they have done (see Appendix one).

1. The reporting requirements for safeguarding partnerships are set out in *Working Together to Safeguard Children 2018*, Chapter 3 paragraphs 41-46. See Appendix 1 of this report.

Methodology

4

The analysis is based on desktop audits of the 68 yearly reports submitted to the Panel and WWCSC by 8th January 2021. All of the 68 yearly reports have been audited for compliance with WT 2018 requirements by the team at WWCSC. The audits provide an overall assessment as to whether compliance with WT 2018 requirements is evidenced; partly evidenced; or not evidenced.

5

A 'deep dive' audit of a sample of 19 yearly reports was completed, using an integrated audit tool that incorporated evaluations of:

- compliance with WT 2018 requirements;
- prioritisation, progress, use of evidence and impact;
- dissemination and embedding of learning.

6

The sample of safeguarding partnerships for the 'deep dive' audit includes two partnerships from each of the nine regions, comprising counties, unitary authorities, metropolitan areas, and sub-regional partnerships. Our selection also took into account indices of deprivation to ensure a range of socio-economic contexts.

Context

7

It is important to set this first cycle of yearly reports in context. The reports were produced at the end of a twelve-month period of transition to new multi-agency arrangements to protect children. Most of the reports cover six months of activity relating to the previous Local Safeguarding Children Boards (including completion and publication of Serious Case Reviews) and the first six months under new partnership structures and roles. The reports suggest increasing commitment by the safeguarding partners to tri-partite leadership of a learning system.

8

The COVID-19 pandemic has had a very significant impact on the work and priorities of the safeguarding partners. Partnerships reported that key areas of their work programmes were delayed or deferred. These delays particularly affected training and learning events. Partnerships focused on maintaining effective support for vulnerable children and families. Timely and appropriate arrangements for Serious Incident Notification and rapid reviews appear to have been maintained. A number of the reports noted that the challenge of maintaining effective support for vulnerable children and families during the pandemic had a galvanising effect in strengthening partnership working. Their reports have sought to draw out the learning from approaches to risk assessment and adaptations for COVID-safe practice. This learning needs to be considered alongside the findings from the Panel's **thematic analysis of the impact of COVID-19** in serious safeguarding incidents.

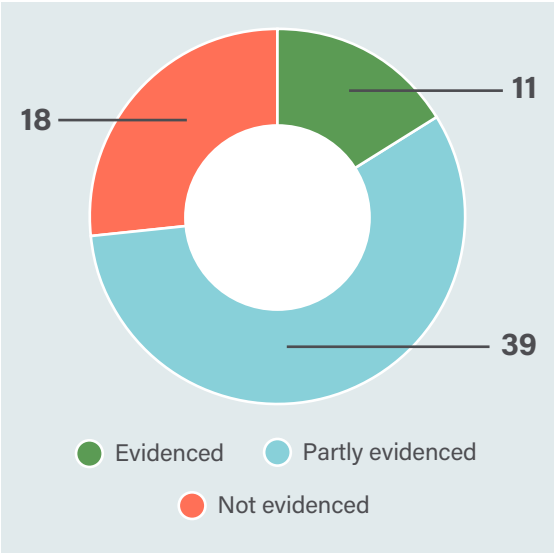
2. KEY FINDINGS

Meeting *Working Together 2018* requirements

9

At the cut off point for this analysis (8th January 2021), 68 of the 132 safeguarding partnerships had published a yearly report and submitted it to the Panel and WWCSC. Our analysis has found that WT 2018 requirements were evidenced in 11 yearly reports. These requirements were partly evidenced in the majority of reports: 39. We concluded that 18 had not evidenced WT2018 requirements (see figure 1). Reports that were not evidenced provided little or no evidence in the areas outlined in WT2018, for example in relation to the impact of safeguarding partners on outcomes for children and families in relation to early help, looked-after children and care leavers. Appendix three provides further details of the compliance audit for the full sample of 68 reports.

Figure 1: Yearly reports meeting WT 2018 requirements



10

Of the sample of 19 reports where a 'deep dive' was conducted, four reports were found to be 'evidenced'. These made use of a range of evidence sources (data, inspection, multi-agency audit, workforce feedback, and the views of children and families) to identify priorities and evaluate their impact. A critical overview of the effectiveness of local arrangements was provided, including details of those aspects where limited or no progress had been made. Reports outlined how the learning from reviews informed improvements in terms of strategy, procedures, models of practice and workforce development. As well as describing new partnership governance arrangements, there was evidence of steps to look at their impact, particularly through leadership forums focusing on 'stubborn challenges', formal sub-regional working, and independent scrutiny.

11

Partly evidenced reports demonstrated some, but not all, of the above characteristics. The 'deep-dive' audit found 13 reports in this category. Typically, these were descriptive rather than evaluative, with a focus on actions completed in relation to partnership priorities. A number of the required elements in the report were not covered: most frequently these concerned early help, looked after children, and care leavers. Information about multi-agency training and levels of participation was provided, but with limited or no analysis of impact. Similarly, evidence of learning from multi-agency audits and case reviews was outlined, and methods to disseminate learning highlighted, but with limited or no evidence of the impact of that learning. In some cases, independent scrutiny arrangements had only recently been developed, with limited or no independent scrutiny of the evidence cited in the report.

12

In the small number of not evidenced reports in the 'deep dive' audit (two reports), there was insufficient detail or evidence to demonstrate that WT 2018 requirements were met.

13

Very few reports reflected openly on challenges and difficulties faced and where there has been a lack of progress. No reports reported on challenges between partners. A more open style of report that focuses less on a list of completed actions and more on 'stubborn challenges' and evidence based approaches to their resolution would aid learning between partnerships and would help the Panel in identifying common challenges and areas for further support.

> *"A more open style of report that focuses on 'stubborn challenges' and evidence based approaches to their resolution would aid learning between partnerships"*

14

The new multi-agency arrangements for protecting children provide more flexibility and encourage a localised approach. That flexibility is reflected in the reporting requirements for safeguarding partners set out in WT 2018. Unlike the LSCB Annual Reports (in which prescriptive national requirements about content were considered to have encouraged lengthy and largely descriptive reports), yearly reports for partnerships are intended to be shorter, more focused on impact, with more scope for local variation in terms of structure and publication format. We found considerable variation in the length of report and the detail provided; the sample in the 'deep dive' audit ranged from 11 pages to 124, with most in the range 30-40 pages. The length of the report was not an indicator of quality, with some reports focussing on reporting activity rather than setting out the evidence base behind these actions or their impact. There were differing interpretations of the content required and depth of information needed to cover the areas specified in WT 2018. Some reports focused primarily on the work of the statutory partners, with technical appendices providing performance data. An alternative approach was to provide hyperlinks to other related documents. Given the degree of variation in approach, there would be benefit in the three national advisers for the safeguarding partners working with safeguarding partnerships, the Panel, and What Works Children's Social Care to consider the areas for development in our report, so that future yearly reports better inform learning and evidence-based improvement.

3. DETAILED FINDINGS

A sense of new working arrangements

15

All reports set out an overview of partnership governance and provided a rationale for key changes. Local areas have taken the opportunity to realign safeguarding partnership working with other partnerships, notably Health and Well-Being Boards, Community Safety Partnerships, Adult Safeguarding Boards, and Children and Young People's Strategic Partnerships. As a result, safeguarding partnerships have a sharper focus on a smaller number of priorities and practice themes, with the aim to have a greater emphasis on quality assurance and learning. In most cases, partnership reports described the governance arrangements. In only a few reports was there analysis of the way in which new arrangements have been working in practice to affect change and improvement.

16

Reports provided interesting examples of tripartite leadership. Typically, partnerships have established a pattern of high-level strategic meetings involving the safeguarding partners, along with some form of wider forum involving relevant partners. Although not named as statutory partners, local partnerships were keen to include schools as a strong influence in multi-agency safeguarding arrangements. Some leaders of the safeguarding partners have sought to model shared leadership and promote discussions that focus on problem solving 'wicked issues'.

17

Sub-regional arrangements are a key feature of a number of partnerships in our sample. These have the potential to provide a more coordinated response to cross-cutting safeguarding risks such as criminal exploitation and enabling more effective and efficient multi-agency working. It will be important in future reports for partnerships to evidence the impact of sub-regional arrangements.

Areas for development

- As new arrangements bed in, safeguarding partners' reports need to provide evidence of the added value and impact of these arrangements rather than purely describing governance structures.
- There is a need for a more systematic approach to the evidencing of impact, drawing on a balanced scorecard of evidence: high quality evaluation of interventions and practice; data; audit; workforce; children and families feedback.
- As well as reporting on impact, it would be beneficial for partners to set out the evidence base behind their actions and decision making as well as how they will evaluate activity.

> *"Safeguarding partners' reports need to provide evidence of the added value and impact of the new arrangements rather than purely describing governance structures"*

Progress, prioritisation, use of evidence and impact

18

Some partnerships had undertaken an exercise with stakeholders to agree a revised set of priorities for the safeguarding partners, to be addressed over a two or three-year period. In some cases, the priorities were linked to sub-regional arrangements. More usually, priorities had been carried forward from the previous LSCB Business Plan. It was not always clear about the evidence used by partnerships to determine priorities.

19

We found a high degree of commonality in the priorities identified by safeguarding partners. These were: neglect, criminal exploitation/contextual safeguarding, mental health/well-being and domestic abuse. Partners also identified a broader range of practice themes such as Signs of Safety practice model, early intervention and prevention, voice of the child, knowledgeable workforce, co-production to engage families. The development of a partnership's capacity and impact was a priority for some partnerships.

20

In evaluating progress against priorities, partnership reports tended to concentrate on actions completed rather than the evaluation of impact. Reports provided little information on adopting an evidence-based approach and few stated why they had taken particular actions or adopted specific practice models.

21

However, a number of partnerships recognised the importance of moving beyond traditional performance metrics to developing a wider range of data and intelligence, with enhanced analytical capacity. In addition, a few partnerships made explicit connections to research and evidence in determining their response to safeguarding priorities and changes in multi-agency practice.

Dissemination and embedding of learning

22

All yearly reports emphasised the key functions of the partnership in relation to quality assurance, learning and improvement, with these functions undertaken by one or more sub-groups. Sub-group structures varied: in some partnerships there were separate groups for quality and audit, and case reviews. In others a more integrated approach was adopted (for example, a Quality Group with separate workstreams for data and intelligence; multi-agency audit; section 11 audit; section 175 audit). Learning and improvement was also being developed within a sub-regional framework in a number of areas. Reports tended to detail structures rather than provide examples of impact at this early stage.

23

Reports varied in the level of detail that was provided about: the number and nature of Serious Safeguarding Incidents reported to the Panel; undertaking rapid reviews (RR); the number of RRs completed and their timeliness; and decisions to commission local child safeguarding practice reviews (LCSPR). Details of the learning from RRs and LCPSRs were not always provided. Reports mentioned specific multi-agency audit exercises and findings. Robust multi-agency audit processes and the analysis of key issues from performance data were particularly important in local areas that had not undertaken RRs or LCSPRs. There was some variation in the scale of multi-agency audit work and the detail provided in reports. Partnerships were establishing more innovative approaches to learning, often linked to independent scrutiny processes.

24

In some reports a learning and improvement cycle was set out, showing how the learning from case reviews, audits, and inspections was brought together in an overall commentary to inform the improvement of practice. It was more often the case, however, that the learning was incorporated into reports from individual sub-groups, with significant variation in the level of detail provided. There was very little reference to the use of research or evidence-based practice to respond to issues highlighted in case reviews or audits.

25

Dissemination typically involved one or more of: briefing papers; case study material; training modules; bespoke learning events for practitioners; information on the partnership website; cascade via 'train the trainers' or team briefings. Partnerships were seeking to establish more systematic approaches through scheduled programmes of quarterly learning events or a practitioners' forum. Reports do not look at the impact of dissemination or measure its effectiveness – a gap which a number of partnerships have recognised and sought to address through innovative developments such as learning hubs. Evaluation of these models would help to identify if there is value in others adopting this practice.

Training

26

Reports typically listed courses of multi-agency training, sometimes with projected and actual attendance figures. A few reports showed how commissioned training had been influenced by learning from case reviews. Evaluation of the impact of training was limited, usually involving end of course feedback. We found a few examples of the use of multi-agency audit to assess the impact of training.

Areas for development

- Future reports should set out more clearly the partnership's learning and improvement cycle and evaluate its overall impact.
- There is a need for support for partnerships to develop approaches to measuring the impact of training and the dissemination of learning.

Seeking and using feedback from children, young people and families

27

Consultation activity with young people was a significant strength in many local areas. However, some partnerships did not include any information about their arrangements for seeking feedback from children, young people and families. There were some examples of the strategic use of feedback from families, more usually incorporated into progress reports about particular priorities or in response to learning from audit or case reviews. There were more limited examples to show how feedback from children , young people had informed overall partnership strategy and learning.

Independent scrutiny

28

Partnerships have identified independent scrutiny as a defining feature of the new multi-agency arrangements for protecting children. We found a range of innovative approaches to this function that were in place or proposed. Going forward, evaluation of the effectiveness of these approaches would help other partnerships learn from their experience. A number of reports included helpful examples of the impact of scrutiny itself in promoting learning and development, and in providing an independent critical evaluation of the findings in the yearly report. In some cases, reports provided an account of independent scrutiny activities during the year, but it was not clear whether the reports themselves had been subject to independent scrutiny. In a few cases, partnerships had combined the independent scrutiny function with the role of Independent Chair. In some regions, independent scrutiny was being taken forward through a developing sub-regional peer review model. There remained some reports where there was very little detail about independent scrutiny and how the arrangements were being developed.

> *"Future reports should set out more clearly the partnership's learning and improvement cycle and evaluate its overall impact"*

Meeting other specific reporting requirements of *Working Together 2018*

29

Partnership reports included in the deep dive audit were extremely variable in their evaluation of the effectiveness of early help, care and support for looked after children, and provision for care leavers. Appendix three sets out in more detail how the 68 reports overall met the specific reporting requirements set out in WT2018.

30

Reports from local areas where there was a secure establishment did include review of the use of restraint. It was not always clear, however, that the findings had been reported to the Youth Justice Board.

31

Reports routinely included the details of any changes to published arrangements. The changes generally involved changes to sub-group structures rather than wider partnership structures or governance.

4. CONCLUSION

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Overall the yearly reports from safeguarding partners included in the 'deep dive' audit suggest resilience, creativity, and adaptability as partners took forward the new partnership arrangements during the unprecedented challenges of the COVID-19 pandemic. However, there was disparity in the quality of reports, with a need to move away from descriptive accounts that focus on detailing actions taken to focus instead on setting out the evidence behind approaches and their impact. **Our analysis suggests the need for Yearly Reports to have a sharper focus on impact, evidence, assurance and learning.**

5. NEXT STEPS

33

The Panel, WWCSC, and the national advisers for multi-agency safeguarding arrangements, will seek to work with safeguarding partners to consider and take forward the areas for development in this report. The Panel is offering detailed feedback to all those areas with a report that was subject to 'deep dive'.

> *"Our analysis suggests the need for Yearly Reports to have a sharper focus on impact, evidence, assurance and learning"*

6. APPENDICES

APPENDIX 1:
Working Together to Safeguard Children 2018

Reporting

In order to bring transparency for children, families and all practitioners about the activity undertaken, the safeguarding partners must publish a report at least once in every 12 month period. The report must set out what they have done as a result of the arrangements, including on child safeguarding practice reviews, and how effective these arrangements have been in practice.

In addition, the report should also include:

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

Safeguarding partners should make sure the report is widely availabe, and the published safeguarding arrangements should be set out where the reports will be published.

A copy of all published reports should be sent to the Child Safeguarding Practice Review Panel and the What Works Centre for Children's Social Care within seven days of being published.

Where there is a secure establishment in a local area, safeguarding partners should include a review of the use of restraint within that establishment in their report, and the findings of the review should be reported to the Youth Justice Board.

The three safeguarding partners should report any updates to the published arrangements in their yearly report and the proposed timescale for implementation.

Source: Department for Education (2018) Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children (PDF). London: HM Government.

APPENDIX 2:
Analysis of safeguarding partners' yearly reports – scope

What can we learn about the priorities and practice issues that safeguarding partners have been focussing on?

This should include:

- What themes and patterns are there in the priorities and practice issues safeguarding partners are focussing on? Are there correlations between areas with a similar demographic and the focus they are taking?
- How have safeguarding partners made their decisions on what to prioritise, how have they used evidence?
- How have safeguarding partners developed their priorities in taking action to make improvements? OR What actions have safeguarding partners taken to take forward these priorities?
- What evidence is being used to determine the actions safeguarding partners are taking/How evidence based are the recommendations safeguarding partners are making for future practice? What themes and patterns are there in the areas they have identified where they have made little of no progress on agreed priorities, or where there are conflicting views across partners on what the best course of action is? In what ways are the safeguarding partners measuring the impact of the changes they are implementing? How robust are these approaches?
- What are the observations of the Independent Scrutineer?

What can we learn about how safeguarding partners are undertaking, sharing, disseminating and embedding learning from rapid reviews and local child safeguarding practice reviews?

This should include:

- What can be learnt from examples of practice and innovation?
- How effective are safeguarding partners at sharing learning? What methods are safeguarding partners using to disseminate learning and to what timescale? How are safeguarding partners measuring the impact of learning? Does this lead to a change in practice?
- What evaluation is taking place, and what are the barriers to better evaluation?
- What barriers are there which prevent learning being shared, disseminated and embedded?
- For safeguarding partners who have not undertaken any rapid reviews or local child safeguarding practice reviews in their first year, how are they demonstrating learning?
- What recommendations can be made to support improvement?

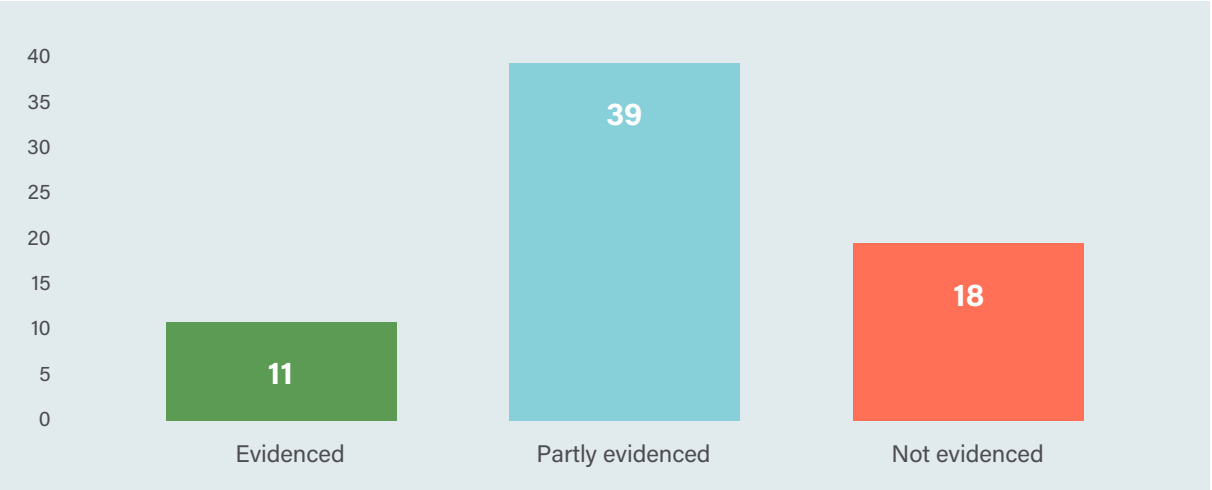
Source: NCPRSP Project Scoping Document October 2020

APPENDIX 3:
Findings from Working Together to Safeguard Children compliance audit of 68 Safeguarding Partners' reports

The analysis within the main body of the report is based on the 'deep dive' audits of 19 yearly reports. In addition, all 68 yearly reports received by WWCSC by 8th January 2021 were audited for compliance with the Working Together to Safeguard Children 2018 (WT 2018) requirements. Here we summarise how the 68 yearly reports for 2019/20 sent to WWCSC meet these stated requirements.

The compliance audit looked at the areas set out in Appendix 1, and also rated each report on how well evidenced it was overall using defined criteria (evidenced, partly evidenced, not evidenced). We found that the majority of reports were partly evidenced (39) with 11 evidenced and 18 not evidenced (see Graph 1).

Graph 1: Yearly reports meeting WT 2018 requirements



Analysis of the types of evidence included in reports found that safeguarding partners referred to a range of sources including audits, user feedback, surveys, evaluations, various forms of performance/impact/quality sub groups, inspection outcomes and case reviews.

Reviews

WT 2018 asks for reports to "set out what they have done as a result of the arrangements, including on child safeguarding practice reviews, and how effective these arrangements have been in practice." Our analysis found that just over half of reports (35) contained content on child safeguarding practice reviews, with 33 not including this (though this was often because no relevant review had taken place during the time period of the report). The level of detail provided varied. For example, one report set out how learning from the reviews had been disseminated and provided examples of case studies and changes made to guidance as a result of the process. In other cases, little or no detail was provided.

There was a similar picture for rapid reviews, where 33 had included details about the partnerships' work on rapid reviews, with this content absent in 35 of the reports. This may have been because no rapid reviews took place during this period.

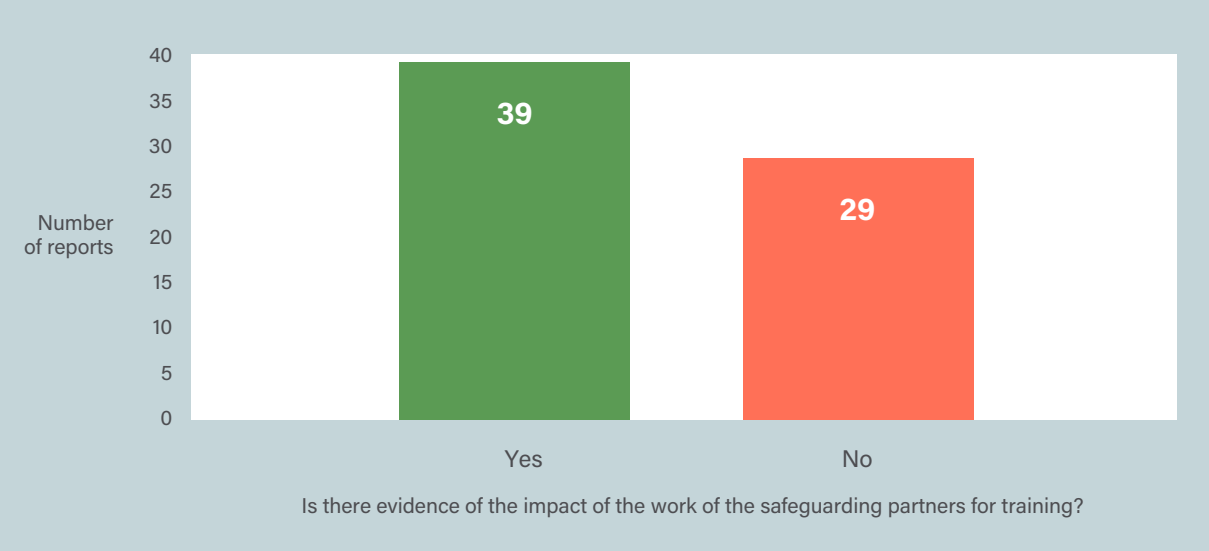
Only 11 reports made specific mention of the Panel's national thematic reviews and steps they were taking to implement the Reviews' recommendations. However, some partnerships did provide examples. In one report, following the Panel's report on child criminal exploitation, they had tasked Community Safety with setting up a new scheme to help businesses recognise factors of exploitation.

Training and outcomes for children (from early help to care leavers)

Partnerships are also asked to include "evidence of the impact of the work of the safeguarding partners and relevant agencies, including training, on outcomes for children and families from early help to looked-after children and care leavers." WWCSC reviewed each report to look at content on training, early help, looked-after children and care leavers.

More than half (39) of reports had included relevant content on the impact of training (see Graph 2). This ranged from a brief sentence on activities to detailed sections highlighting the variety of courses provided, numbers attending (including breakdown of participants from the different partner agencies) and follow up activities. However, as with the 'deep dive' audit, very few reports provided detailed evidence on the impact of training. The analysis also looked at dissemination of learning. The majority (59 of the 68 reports reviewed) of Safeguarding Partnerships disseminated learning locally. Mechanisms for disseminating learning including conferences, newsletters, briefings, websites, regional and local learning forums, social media and specific tailored campaigns.

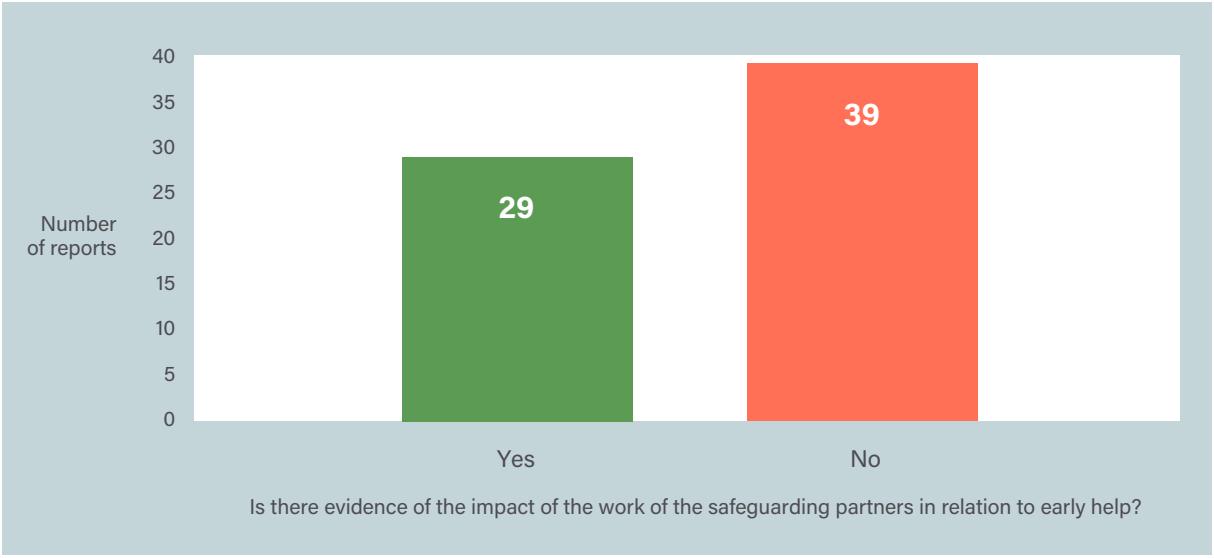
Graph 2: Training



This is in contrast to early help (see Graph 3). The majority of reports did not include evidence of the impact of the work of the safeguarding partners in relation to early help. This was only included in 29 of the 68 reports. Thirty-nine included no evidence.

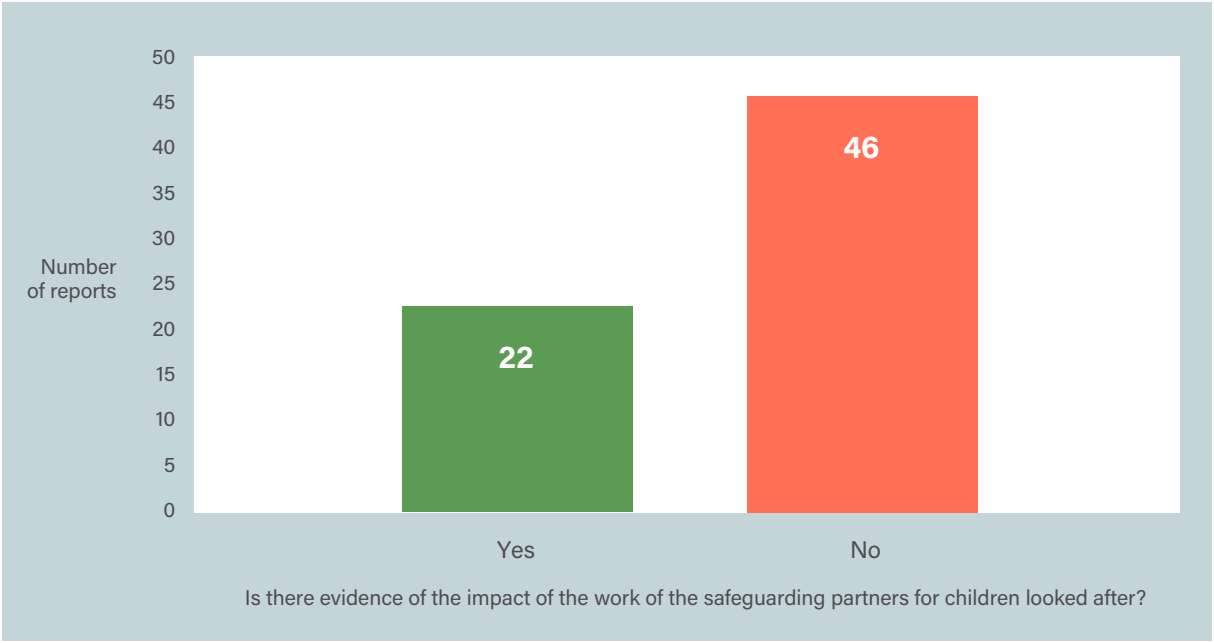
Where the impact of early help was mentioned, with a few exceptions, most reports included a brief summary of services available and actions taken in this sphere, rather than detailed evidence.

Graph 3: Early help



Evidence of the impact of work around looked after children was less likely to be included than information on early help. Of the 68 reports analysed, 46 did not include this information (see Graph 4). Reports that did have this content, generally included information on the number of looked after children with some details on outcomes (including health outcomes). A few reports had more extensive content, for example, one report detailed peer reviews of services which have been found to be effective, along with the positive outcomes for children.

Graph 4: Children looked after



Care leavers were the group of young people specified in WT2018 least likely to be mentioned. Only 11 reports including evidence of the impact of the work of partnerships in relation to this group. This information was missing from 57 reports (see Graph 5). Where information was included, it was mostly in the form of data on the number of care leavers, though a few reports did highlight the changes and effect of their work for these young people.

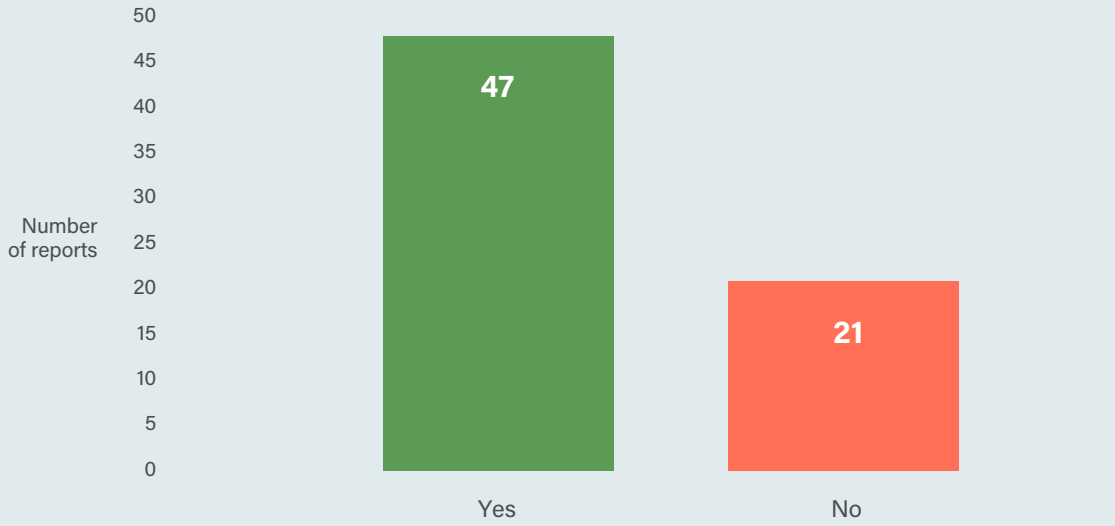
Graph 5: Care leavers

Feedback from children and families

WT2018 also asks partnerships to specify how they have sought and utilised feedback from children and families to inform their work and influence service provision. This content was included in more than two thirds of reports (47) (see Graph 6).

Some reports provided a brief statement, whilst others gave in-depth detail on the range of engagement activities (from conferences, young people's forums/panels, meetings in schools and young people's inspections of services).

Graph 6: Feedback from children and families



Have partners sought and utilised feedback from children and families to inform their work?

Secure establishments

WT2018 asks partnerships where there is a secure establishment within their local area to report on the use of restraint (the review on the use of restraint should also be reported to the Youth Justice Board). The analysis found that nine reports included information on a secure establishment in their local area, of which seven included detail about the use of restraint.

Independent scrutiny

Finally, WT2018 notes that, "Safeguarding partners should also agree arrangements for independent scrutiny of the report they must publish at least once a year." Analysis found that the majority of reports (58) did include reference to independent scrutiny. This was absent from 10 of the 68 reports. The level of detail included varied, with some providing detailed information or embedding comments throughout, and others only providing a brief mention of the role of independent scrutiny. Partnerships are also asked to report on any updates to published arrangements during the year. Of the reports received, 27 contained information on changes to arrangements.

As noted in the main report, these findings must be seen in the context of a year where Safeguarding Partnerships have been both establishing and adjusting to new arrangements and dealing with the consequences of the current global pandemic. The findings from the compliance analysis echo those from the 'deep dive' audit. Whilst there were some examples of evidenced reports including detail about the impact of Safeguarding Partnerships activities as set out in WT2018, the quality of reports was very varied. Overall, there is a need to move away from descriptive accounts that focus on detailing actions rather than impact. It is hoped that the Areas for Development set out in the main report will help Safeguarding Partnerships to ensure future reports set out clearly the evidence behind approaches and their impact for children and families.

What Works *for* Children's Social Care

THE CHILD **SAFEGUARDING** PRACTICE REVIEW PANEL

info@whatworks-csc.org.uk
@whatworksCSC
whatworks-csc.org.uk

The Evidence Quarter
Albany House
Petty France
London SW1H 9EA