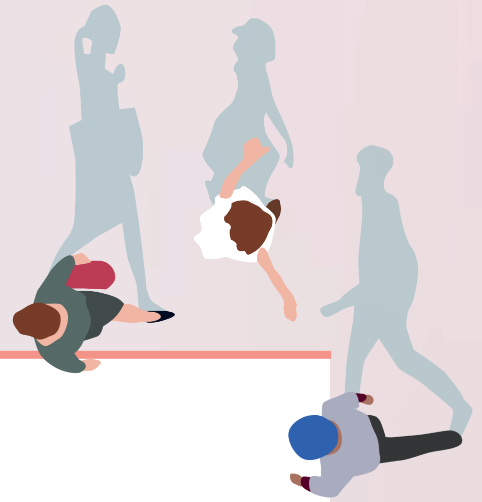
What Works *for* Children's Social Care



SAFEGUARDING PARTNERS' ANNUAL REPORTS ANALYSIS 2020-21

December 2022

What Works *for* Children's Social Care

Acknowledgements

The authors acknowledge the contribution of past and present colleagues from What Works for Children's Social Care (WWCSC), including Amar Alam, Arnaud Vaganay, Janae Goodridge-Downer and Hannah Scott. Thank you also to the Child Safeguarding Practice Review Panel for their support in developing the audit tool, reviewing the Safeguarding Partnership reports and the production of the final report.

Authors

Katherine Osthwaite,
What Works for Children's Social Care

Eleanor Briggs,
What Works for Children's Social Care

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. We generate, collate and make accessible the best evidence for practitioners, policy makers and practice leaders to improve children's social care and the outcomes it generates for children and families.

To find out more visit our website at:
www.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

If you'd like this publication in an alternative format such as Braille, large print or audio, please contact us at: info@whatworks-csc.org.uk

CONTENTS

INTRODUCTION 3

WHAT WE DID 5

WHAT WE FOUND 6

- Number of safeguarding partners' reports received 6
- Priorities, progress and impact 6
- Dissemination and embedding of learning 11
- Meeting the Working Together 2018 requirements 13

CONCLUSION AND NEXT STEPS 14

APPENDIX 1: WORKING TOGETHER TO SAFEGUARD CHILDREN 2018 15

APPENDIX 2: THE AUDIT TOOL 16

INTRODUCTION

This report sets out the key findings from an analysis of a sample of safeguarding partners' yearly reports from 2020-21.

This analysis was undertaken for the Child Safeguarding Practice Review Panel ('the Panel') by What Works for Children's Social Care (WWCSC). The analysis builds on last year's report (published here) which sought to determine the extent to which safeguarding partners' annual reports met the requirements set out in Working Together to Safeguard Children 2018 ('Working Together 2018').

The analysis looks at the following key themes:

1. Prioritisation, progress and impact

- What were the safeguarding partners' priorities and why were these selected?
- What is the evidence base for the interventions mentioned in the reports and what is their impact on families and professionals?
- Are there any areas identified in the reports where there is a lack of progress?
- What are the scrutiny and leadership arrangements?

2. Dissemination and embedding of learning

- What types of training are delivered and what is its impact?
- What actions have been taken as a result of local learning activities, Rapid Reviews, Local Child Safeguarding Practice Reviews or National Child Safeguarding Practice Reviews?
- How is the voice of children, families and professionals recognised in the safeguarding partners' work?

3. Meeting the requirements of Working Together 2018

- Are the requirements of Working Together 2018 evidenced in the report?

Under each theme, we have suggested areas for development based on our analysis of the reports.

Working Together 2018 requires that copies of all published yearly reports by safeguarding partners 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 contribute to further development work with safeguarding partners coming out of the recent recommendations in the Child Safeguarding Practice Review Panel's report Child Protection in England and the Panel's annual report. It has already informed the recent guidance developed by the Panel to help safeguarding partners include relevant information within future reports to ensure these are a useful tool for sharing learning and experience between different local areas.

Who are Safeguarding Partners?

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

1. The local authority/ies
2. The clinical commissioning group for an area
3. The chief officer of police for the area

These partners must publish a yearly report setting out the work they have undertaken that year. Working Together 2018 states:

"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.... 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."

There are 137 safeguarding partnerships across England: many are single local authority Safeguarding Partnerships, but there are several Safeguarding Partnerships which are made up of multiple local authorities.

WHAT WE DID

The analysis is based on desktop deep-dive audits of a sample of 18 yearly reports for the year 2020-21, submitted to the Panel and WWCSC by 1 June 2022. The 18 reports were reviewed using an integrated audit tool that looked at:

- Prioritisation, progress, use of evidence and impact
- Dissemination and embedding of learning
- The degree to which the report draws on evidence and data
- Compliance with Working Together 2018

An integrated audit tool was used to analyse these reports. This audit tool was first developed for the review undertaken last year by WWCSC and members of the Panel, and this year was updated and revised by WWCSC and members of the Panel to include areas of interest that emerged from the recent Child Protection in England report and key themes that have been identified by the Panel over the last year. Five researchers at WWCSC independently reviewed and coded the reports using the audit tool.

The sample of safeguarding partners was selected to include two partnerships from each of the nine regions of England, 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. Safeguarding partners whose reports were analysed last year were provided with individual feedback based on the audit process. Therefore, this year, where possible, one report from each of the nine regions was from a partnership where we analysed their report last year so that we could identify any changes or improvements from the previous year.

Context

The reports analysed were for the year 2020-21, the second year that safeguarding partners have been in place. The previous year's reports (2019-20) were produced at the end of a twelve-month period of transition to new multi agency arrangements to protect children, with many covering six months of activity relating to the previous Local Safeguarding Children Boards and the first six months under new partnership structures and roles. Therefore many of these reports are the first reports which report on a whole year of the safeguarding partnership's work.

In addition, as with the previous year, in 2020-21 the COVID-19 pandemic continued to have a significant impact on the work and priorities of the safeguarding partners. Partnerships reported that key areas of their work programmes were delayed or deferred as partnerships focused on maintaining effective support for vulnerable children and families.

WHAT WE FOUND

Number of safeguarding partners' reports received

For 2020-21, as of 1 June 2022, only 65 safeguarding partners' reports (out of 137 - less than half) had been sent to either WWCSC or the Panel. This is a similar number of reports received at the time of reporting for the previous year (68 for 2019-20). There is also inconsistency amongst those who have published a report: not all safeguarding partners who published a report in 2019-20 have published a report in 2020-21, and some of those who published a report in 2020-21 did not publish one the year before.

Areas for development:

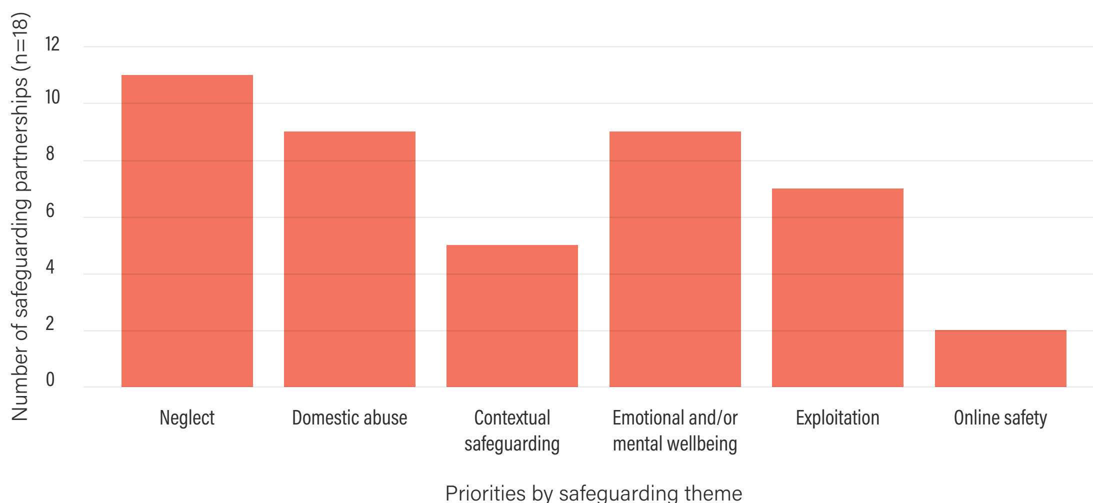
- Consideration should be given to how to improve compliance with Working Together 2018 so that all safeguarding partners are fulfilling their duty to publish a yearly report.

1. Priorities, progress and impact

Safeguarding partners' priorities

We analysed the safeguarding partners' reports to identify each partnership's priorities, looking for both safeguarding and practice themes. All of the safeguarding partners' reports provided details on their priorities by safeguarding theme and all reported more than one priority. The most common priority was neglect. This was a priority in over half (11/18) of the safeguarding partners' reports that we analysed. Other common themes were domestic abuse (9/18), emotional and/or mental wellbeing (9/18), exploitation (8/18), contextual safeguarding (5/18) and online safety (2/18). Figure 1 shows the most common themes across the sample of safeguarding partnerships.

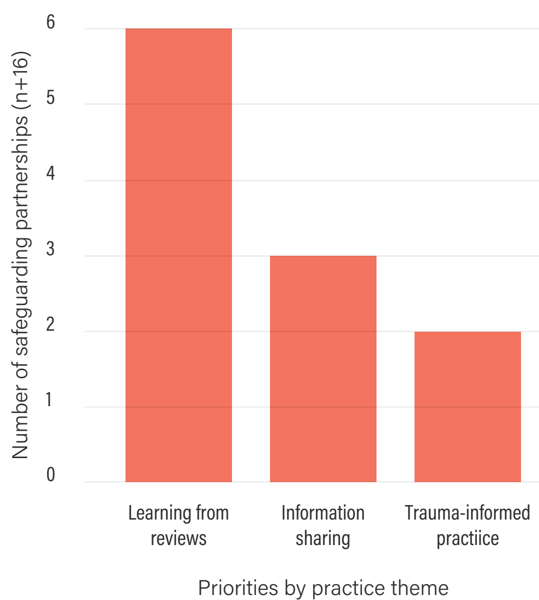
Figure 1: Most common safeguarding partners' priorities by safeguarding theme*



* Some safeguarding partners had multiple priorities

There was more variety in safeguarding partners' practice priorities compared to the priorities by safeguarding theme, with many reporting practice themes unique to them. 4/18 of the reports did not discuss priorities by practice theme. The most common safeguarding priorities by practice theme were learning from reviews (6/18), information sharing (3/18) and trauma informed practice (2/18). Figure 2 shows the most common themes across the sample by practice theme. Other unique priorities included engaging with children and young people, a knowledgeable workforce, and leadership. We were keen to understand why and how safeguarding partners had selected their priorities. However, the majority of the reports (13/18) did not provide information about the decision making process, merely stating what their priorities were.

Figure 2: Most common safeguarding partners' priorities by practice theme*



* Some safeguarding partners had multiple priorities

Five of the reports included their decision making process for determining their priorities. The selection processes included:

- Use of evidence from data, inspection findings, audits, performance analysis and case reviews and responding to emerging need
- Feedback and self-evaluation from partners
- Government department's priorities

Evidence behind safeguarding partners' activities and interventions

WWCSC and the National Panel were keen to understand why safeguarding partners had adopted certain approaches, activities, practice models and interventions. Safeguarding partners must consider many factors in deciding what activities and interventions to deliver in their area, and we were keen to understand whether evidence plays any role in that decision-making process. A third (6/18) of reports did not include any detail about the evidence behind the partners' activities. This means that, from the reports alone, it is difficult to understand why safeguarding partners chose to deliver the interventions they did. This, combined with the lack of information around selecting priorities, meant that many reports do not provide a clear rationale for partners' programmes of work.

More encouragingly, 12 reports did include some information on why activities and interventions had been selected. A third (6/18) used audits to inform their decisions, a third (6/18) used case reviews, four of 18 used local authority data and three of 18 used feedback from professionals and/or children and families. Figure 3 shows the common data sources reported to be used to inform safeguarding partners' activities.

Figure 3: Common evidence bases to inform safeguarding partners' activities

Whilst there was some indication that some partnerships were moving beyond traditional performance metrics to developing a wider range of data and intelligence, with enhanced analytical capacity, reports provided very limited information on adopting an evidence-based approach and few stated why they had adopted specific practice models.

Impact on children and families

Working Together 2018 states that the reports should include "evidence of the impact of the work of the safeguarding partners and relevant agencies, including training, on outcomes for children and families". Whilst all reports described their activities and interventions for children and families in their area, the majority of reports (11/18) did not include any information on the impact that this work is having on children and families. This means that it is difficult to determine the effectiveness of the safeguarding partners' activities.[1]

The remaining seven (of 18) reports did seek to identify some performance measures around children and families. It is welcome that more than a third of the safeguarding partnerships are seeking to identify data measures, which in turn may be used in future years to inform their programmes of work. The data used in these seven reports were:

- Feedback from families and professionals who have accessed and delivered the interventions
- Data measures on numbers who access service
- Data measures on numbers of children who are e.g. classified as CIN, and how this compares to previous years/ neighbouring areas
- Case studies

Impact on professionals

Just over half (10/18) of the reports use data measures surrounding professionals, with the most common data measure being feedback from staff, reported either anecdotally or through staff feedback forms.

1 Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children. Department for Education (2018). Chapter 3, s42

Other data measures for professionals were:

- Number of staff accessing resources (such as online training courses) compared to previous years: three safeguarding partnerships reported an increase following activity to promote available resources
- Number of meetings held compared to previous years: one safeguarding partnership reported a decrease in meetings following activity to clarify partners roles within the safeguarding partnership, whilst keeping enough "place based" focus
- Reduction of "potential sickness" - however this safeguarding partnership did not detail how this was measured

Areas for development:

- Partners should set out clearly why they have selected their priority areas and the evidence base behind their activities in these areas
- Reports should put more focus on a systematic approach to measure impacting and evaluation, rather than describing activities.

Lack of progress in achieving objectives

We were keen to review whether reports captured areas of work where safeguarding partners had faced challenges, and where there had been a lack of progress against agreed priority areas. Working Together 2018 states that the safeguarding partners' reports should include "an analysis of any areas where there has been little or no evidence of progress on agreed priorities." [2]

More than half of reports (10/18) did not mention any areas of work where there had been difficulties. This raises questions about the value of the reports as a learning tool, as there is a missed opportunity if partners are not able to share where there have been challenges and to learn from other areas. It also raises concerns about the transparency of the work of safeguarding partners.

Of the eight reports which did discuss areas of work where there had been a lack of progress, there were no common themes around areas of difficulty. Areas where safeguarding partners highlighted challenges included transitions from child to adult services, coordination of early help, relationships with schools and with families, a better understanding of local need, and use of evidence in practice and decision-making.

It is positive to see that several of these reports also highlighted the actions they had taken to try to overcome lack of progress. For example, one report highlighted the "significant efforts" being taken to help enable front line practitioners to develop better working relationships with children and families and to fill other gaps in the system. Another report discussed how they had applied for additional funding from the Department for Education to help improve engagement. A further report highlighted that the safeguarding partner had developed a toolkit to address victim blaming language.

2 Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children. Department for Education (2018). Chapter 3, s.6-7, 11.

Leadership structure and management arrangements for safeguarding partners

Working Together 2018 states that: "The three safeguarding partners should agree on ways to co-ordinate their safeguarding services...To fulfil this role, the three safeguarding partners must set out how they will work together and with any relevant agencies...Strong leadership is critical for the new arrangements to be effective in bringing together the various organisations and agencies."[3]

The majority of reports (15/18) provided an overview of partnership governance, with some variation in how the leadership of safeguarding partnerships are managed. There were several examples of tripartite leadership arrangements where the Chief Executives (or other senior representatives) of the three statutory bodies are responsible for leadership, though some extended this out to include senior representatives of other agencies/bodies involved in child safeguarding, such as youth justice, probation and broader health groups.

Several reports set out how the leadership function also has sub-groups looking at specific themes and priorities, such as sub-groups for domestic abuse, tackling racism, and trauma-informed leadership.

In most cases, the reports simply described the governance arrangements. Only a few reports analysed how new arrangements have been working in practice to affect change and improvement. Several reports simply reported that the governance arrangements are working well, without providing the evidence for reaching this conclusion.

It is positive to see that in one report there was discussion of how the leadership manages differences of opinion between partners: following a regular case review finding that there are issues about effective escalation of cases where there is a difference of opinion in case management, the safeguarding partnership wrote additional guidance to support practitioners.

A number of reports also highlighted the role of their Independent Scrutineer in evaluating governance arrangements as they can provide an impartial view about the quality of the leadership arrangements and independent challenge (see below for further detail on independent scrutiny arrangements).

Scrutiny arrangements

Working Together 2018 notes that, "The published arrangements should set out the plans for independent scrutiny; how the arrangements will be reviewed; and how any recommendations will be taken forward... Safeguarding partners should also agree arrangements for independent scrutiny of the report they must publish at least once a year".[4]

Analysis found that the majority of reports (13/18) included reference to independent scrutiny. It is concerning that five of 18 did not mention their scrutiny arrangements or refer to independent scrutiny of the report, meaning they are not compliant with Working Together 2018.

3 Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children. Department for Education (2018). Chapter 3, s.6-7, 11.

4 Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children. Department for Education (2018). Chapter 3, s.34-35

The level of detail included in the reports varied, with some providing detailed information about an appointed Independent Scrutineer, their scope and their findings, and others only providing a brief mention of the role of independent scrutiny.

Areas for development:

- Safeguarding partners should be more open about where there is a lack of progress in their work, the barriers to progress, and what might help to improve multi-agency working, to ensure that reports are a useful tool in identifying areas where partnerships would benefit from additional support
- There is a need for the reports to move beyond simply describing governance structures to instead provide evidence of the added value of these arrangements, using a range of measures, such as data, audits, and feedback from families and professionals
- Partners should include their independent scrutiny arrangements in the annual reports and should also consider evaluating and reporting on the effectiveness of scrutiny approaches to help other partnerships learn from their experience.

2. Dissemination and embedding of learning

Training

All 18 reports included a section on training provided for staff. Most reports simply listed courses of multi-agency training, though a few reports showed how commissioned training had been influenced by learning from case reviews. Common subjects for training included:

- Multi-agency safeguarding
- Sexual abuse
- Neglect
- Domestic abuse
- Exploitation
- Mental health and self harm

Four of 18 of the reports contained no information on the impact of this training and only reported the number of staff attending training. In some reports this is used as a measure of impact, however, it does not clearly outline what impact the training has on those attending. For the remaining 14 of 18 reports, evaluation of the outcome of the training was very limited and mainly restricted to feedback from course attendees.

Positively, in one partnership, both in-course evaluations and a follow-up impact evaluation three months after the training were used. There was recognition in another report that feedback alone is not sufficient to measure impact and there is "a need to be more systematic about how we monitor this". This partnership is therefore seeking to develop a more robust measure of impact, looking at potential models to do so. It is positive to see examples of partners looking for more innovative measures of evaluating training.

It is worth noting that COVID-19 impacted on safeguarding partners' ability to provide training, with many reports highlighting the move to online courses, demonstrating their responsiveness to change and commitment to ensure training continued despite the restrictions of lockdown.

Actions taken as a result of local learning activities, Rapid Reviews, Local Child Safeguarding Practice Reviews or National Child Safeguarding Practice Reviews

It was encouraging to see that nearly all reports (17/18) included information on actions taken by the partners following local learning activities and/or local or national reviews.

Common areas where safeguarding partners had taken specific action following local learning activities or reviews include:

- Neglect
- Mental health / self harm / suicide
- Exploitation
- Race / experiences of black children
- Sudden unexpected deaths
- Information sharing

It was common for learning from reviews to drive the direction and priorities of the safeguarding partners' Subgroups or Action Plans, with many undertaking audits or assessments of current models of practice to ensure they take forward reviews' recommendations.

There was some evidence of a learning cycle within safeguarding partnerships, with details provided about methods of dissemination of learning from reviews. These included: webinars and events, staff bulletins, specific training modules, toolkits, and refreshed policies and procedures. As with broader staff training (discussed above), the reports do not look at the impact of dissemination or measure its effectiveness.

Areas for development

- Developing an understanding of how different types of dissemination of learning from reviews informs practice would help to identify if there are any particularly successful models which could be used by other safeguarding partners.

The voice of children and families

We were keen to look at whether safeguarding partners had included the voice of children and families in their work. Working Together 2018 states that the reports should include "how the [local safeguarding] arrangements will include the voice of children and families".[5] Based on our sample, this seems to be an area for improvement for some partnerships. Seven of the 18 reports did not include any information about how the voices of children and families influenced their activities. For the 11 of the 18 reports that did mention this, types of engagement with children and families included:

- Surveys
- Co-production of services
- CYP Subgroups
- Family Forums
- Conferences / events

5 Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children. Department for Education (2018). Chapter 3, s.39

The voice of professionals

As with children and families, we found that 11 out of 18 reports did not include information or evidence on how the voice of professionals is recognised in the work of safeguarding partners. For the seven out of 18 which did include this, the voice of professionals was captured through:

- Staff surveys
- Feedback collected during audits
- Staff forums
- Staff development days

Areas for development:

- There is a need for support for partners to develop approaches to measuring how training influences practice and the dissemination of learning
- Partners should consider more how to include the voices of children and families into their activities and the development of annual reports.

Overall analysis of meeting the Working Together 2018 requirements

Each of the 18 reports was assessed to determine whether the Working Together 2018 requirements drew on evidence and data. Five of the 18 (28%) were found to be "not evidenced"; 11 of the 18 (61%) were found to be "partly evidenced"; and two of the 18 (11%) were found to be "evidenced".

This is similar to last year's analysis, though it should be noted that the sample size of reports analysed was significantly larger (n=68) last year, which found 26% "not evidenced", 57% "partly evidenced" and 16% "evidenced".

Reports that were classified as not evidenced provided little or no evidence in the areas outlined in Working Together 2018, for example in relation to the impact of safeguarding partners on outcomes for children and families. They described activities and approaches without saying why they were adopted or the evidence base behind them.

Reports which were "partly evidenced" included attempts to use evidence for certain elements of the report, but the quality of evidence provided was low or purely anecdotal.

The two reports which were "evidenced" made use of a range of evidence sources, including administrative data and feedback from professionals and families, and outlined how the learning from reviews informed improvements in terms of strategy, procedures and workforce development. One of these reports highlighted that feedback from the Panel, after the audit last year, had led them to focus on the impact of their activities in their most recent report which was encouraging to see.

The reports ranged in length, detail and structure: of the 18 analysed, the reports ranged from 20 pages long to 72 pages long. The length of the report was not necessarily an indicator of the quality of the reports in terms of use of evidence, demonstrating impact, and compliance with Working Together 2018.

It is welcome that the Panel has recently published guidance for safeguarding partners on their annual reports, building on the analysis in this report and the report from 2021. This provides safeguarding partners with a series of prompts to help them include relevant information and ensure the reports are a useful tool for meeting the requirements of Working Together and sharing learning and experience between different local areas.

CONCLUSION AND NEXT STEPS

The year 2020-21 represents only the first full year of reporting for many safeguarding partners. It is therefore encouraging to see the steps taken in many areas to embed new partnership arrangements, particularly against the difficult backdrop of the COVID-19 pandemic. It is also clear that some areas have improved their approach to reporting based on the feedback from last year's analysis of reports, with a greater focus on learning and the use of evidence.

Overall however, our second review of these reports found many of the same concerns that we highlighted last year. Again, we found that reports were largely descriptive; there is still a need to move away from accounts that focus on detailing actions rather than impact. Future reports should set out clearly the rationale behind priorities, the evidence behind approaches and their impact for children and families.

We found significant variation in the content and quality of safeguarding partners' reports. It is therefore encouraging that the Panel has recently provided safeguarding partners with clear guidance to consider when drafting future yearly reports to help ensure that they include the most relevant and helpful information. More clarity on the purpose and content of reports may encourage safeguarding partners to prioritise completion and publication of reports. This is something urgently needed given that fewer than half of partnerships have published a report for the years 2019-20 and 2020-21.

The recent Child Protection in England report highlights the need for tools to strengthen and support local safeguarding partners, including the role of the Panel in driving practice improvement. The requirement for safeguarding partners to report annually on their performance has a potential role here. However, our second year of report analysis reveals that there is an urgent need for a change in approach, with a sharper focus on evidence and learning, if the reporting process is going to play a part in this.

APPENDIX 1: WORKING TOGETHER TO SAFEGUARD CHILDREN 2018

Extract on "Reporting" - paras 41-46

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, including 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 available, and the published safeguarding arrangements should 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.

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 focusing 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 and how have they used evidence?
- How have safeguarding partners developed their priorities in taking action to make improvements; and 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 or 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 role have children, families and practitioners had in planning and activities?
- 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, how are they demonstrating learning?
- What recommendations can be made to support improvement?

What Works *for* Children's Social Care

CONTACT

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