Annual Report
(FINAL DRAFT)

Staffordshire Safeguarding Children Board
2022/23

Contents

Foreword

This year has seen our safeguarding partnership achieve an incredible amount. We are proud of our renewed emphasis being placed on our children and their families. We want them to be at the centre of our system and working with us, having developed our co-production promise we want this to redefine our relationship so that we recognise, respond and realise better outcomes for our children.

We have seen first-hand the impact of doing this through the development of the Early Help Strategy. As we now develop our approach to performance this will illustrate how this approach leads to better outcomes. As a partnership we know that we still have challenges to face, but we continue to do this together in the best interests of children and remain persistent in seeking to continue to improve and develop.

Our commitment to prioritise the safeguarding of children within Staffordshire and Stoke-on-Trent, has remained a top priority for the NHS and its partners throughout 2022 and 2023. Following the closing down of the Clinical Commissioning Groups on July 1, 2022, Integrated Care Systems (ICS) were legally established through the Health and Care Act 2022. The core principles of the ICS are to strengthen collaboration and integration of services to deliver high-quality care.

Our partnerships and Boards have continued to focus upon safeguarding and promoting the welfare of our most vulnerable children through continuous improvement and learning. Within the Integrated Care Board, we have taken significant steps to strengthen safeguarding through the appointment of an Associate Director of Safeguarding and Deputy Designated Nurse for Safeguarding Children. Plans are also underway to develop a Provider Collaborative approach to safeguarding, further enhancing and strengthening our commitment to deliver a system that protects children, especially the most vulnerable.

In March 2023 His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) re-inspected Staffordshire Police and found that the force had improved the service to children and commented that: *"the force has made several positive changes to improve the ways it protects vulnerable children, including better clarity in its senior leadership and governance arrangements."*

The force understands that further improvements are required. The quality of investigations and the response to missing children needs to improve further and the risk assessment and allocation of response by the force Contact Centre also needs to be better.

The force continues to build both capacity and capability within the Public Protection Teams and works closely with safeguarding partners to improve multi-agency working. The force has also introduced enhanced vulnerability training days to frontline staff. To date, over 1,200 frontline officers and staff have been trained to capture the voice of the child, recognise, and respond to child protection concerns.

The force is investing £5 million into a new Public Protection Unit (PPU), ensuring an extra 100 officers to work in public protection. Recruitment is underway to bring in experienced Detectives as well as to train new officers to be able to work in this vital area of policing. Extra resources will ensure dedicated child protection specialists for criminal investigations and safeguarding for missing exploited children.

Neelam Bhardwaja, Director for Children and Families Staffordshire County Council

Heather Johnstone, Chief Nursing and Therapies Officer, Staffordshire and Stoke-on-Trent Integrated Care Board

Becky Riggs, Assistant Chief Constable, Staffordshire Police

Ian Vinall, Independent Chair and Scrutineer, SSCB

1 Introduction

Welcome to the 2022/23 annual report for Staffordshire Children Safeguarding Board (SSCB). Our Board is made up of the three statutory partners: health (Integrated Care Board, ICB), local authority and police and headed up by an Independent Chair and Scrutineer. We work with other relevant partners such as the Children and Family Court Advisory Service (CAFCASS), education (represented by the Local Authority Education Safeguarding Advice Service, ESAS), health providers, His Majesty's Young Offenders Institution (HMYOI) Werrington, Probation, Staffordshire Council of Voluntary Youth Services and Youth Offending Services who sit on our various sub-groups.

In order to bring transparency for children, families and all practitioners about the activity undertaken, Working Together 2018 requires the three safeguarding partners to publish a yearly report at least once in every 12-month period which sets out what they have done as result of the arrangements including on child safeguarding practice reviews and how effective these arrangements have been in practice.

The report should 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 as well as ways in which partners have sought and utilised feedback from children and families to inform their work and influence service provision. Yearly reports should also include observations from independent scrutiny.

During 2022/23 we developed a three-year business plan in response to feedback from partners about having a longer-term plan. The areas chosen were related to evidence from performance information, learning from the system as well as feedback from relevant partners and key stakeholders. Our main priority is to focus on neglect as well as four quality assurance priorities; child exploitation; domestic abuse; early help and the legacy impact of coronavirus (COVID-19) with the voice of children, families and practitioners running throughout as cross-cutting themes.

This report provides a level of assurance and accountability about the progress we have started to make against some of these objectives.

2 Observations from the independent chair and scrutineer

This is my first opportunity to contribute to the annual report and having been in role now for 18 months, I have had the privilege to meet with many safeguarding professionals from across Staffordshire. Children and young people's stories have helped me focus on the current and future areas of scrutiny and then to provide feedback and assurance to the safeguarding partners (Staffordshire Police, Staffordshire and Stoke on Trent ICB and Staffordshire County Council). We need to continue to hear more of children's stories which reflect their experiences of the safeguarding system, both positive and negative. I did have the opportunity to meet with the young people from HMYOI Werrington in September 2022 and this provided an opportunity to plan for a future Board meeting to be held at the YOI and for safeguarding partners to meet the young people.

True engagement with children and young people remains a challenge for the partnership. Whilst there is effective engagement activity being undertaken in each agency, there remain more opportunities to consider this through a safeguarding partnership lens. The Board's Team is busy making plans for meetings in 2024 to be held in partnership organisations where safeguarding leads can interact with children and families.

Section 11 of the Children Act 2004 places duties on a range of organisations, agencies, and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children. The Section 11 Peer Audit held in July 2022, highlighted the challenges of maintaining a consistent and trained workforce owing to the ongoing challenges of staff recruitment and retention and the ability to evidence the collective impact of multi-agency safeguarding practice on outcomes for children and young people. The Scrutiny and Assurance Group is tasked with developing more focused assurance on the frontline of multi-agency safeguarding practice and will go some way to consider this.

The safeguarding partners have a developing group of leaders working alongside each other at the Scrutiny and Assurance Group. This group is working to refocus on the emerging issues in keeping children and young people safe in Staffordshire and following a joint session with the safeguarding partners in November 2022, set out on developing the Scrutiny and Assurance Group into focusing on frontline safeguarding practice. This has included the development of the Learning Hub, mirroring practice in the London Borough of Bexley which will really focus the safeguarding partnership on practice issues that require additional scrutiny. This is a very positive development if all partners commit to it.

The Safeguarding Board continues to meet monthly, and dates set for the meetings are set a year in advance and full attendance allows for decisions to be made and positive reflection to take place. Delegated authority by the safeguarding leads requires ongoing clarity as decisions made at the Board level need to have a level of seniority. I have highlighted to the safeguarding partners that they need the opportunity to develop their own priorities rather than inheriting the priorities of previous senior leaders and work in the new year should go some way to address this.

The safeguarding partners are all struggling with a challenging financial envelope and there needs to be clear and open discussion of how the safeguarding partners want the arrangements to look in the future within the context of a challenging financial picture. Working Together 2023 may not address the issue of equity and equality of partnership contributions.

It is positive to report that the chairs of the safeguarding children board, the adult safeguarding board, the community safety partnership, the ICB and the health and wellbeing board are now meeting quarterly to ensure alignment and identify opportunities to enhance shared priorities. This has been particularly relevant for concerns around domestic abuse.

In December 2022, I had the opportunity to scrutinise the work of the Multi-Agency Safeguarding Hub (MASH) and am pleased to note that my recommendations were incorporated into the ongoing MASH strategic plan. I have asked safeguarding partners to provide a clear timeline for the implementation of any new MASH arrangements as it is key to ensure this key multi-agency partnership continues to keep children and young people safe and is designed with the child's journey in mind. I was also clear that the safeguarding partners need clear assurance regarding the developments in the MASH.

I have continued to ask the question of safeguarding partners how they evidence the impact the safeguarding arrangements are having on children and young people. Whilst we can assess training effectiveness for example, which has received very positive feedback from colleagues, we need to develop mechanisms to ensure we measure impact and effectiveness of the arrangements. I have been encouraging more multi-agency audit work, a greater understanding of how learning from local child safeguarding practice reviews is being embedded into practice and how we seek feedback from children and young people and professionals. The partnership continues to focus on its key priorities and now it is developing the multi-agency dataset needed to refocus on frontline safeguarding practice so assurance can be given that practice is effective. This must be progressed more quickly, but I am encouraged by the willingness of the safeguarding partners data officers meeting together to consider this.

Neglect remains the Board's priority and over 1,500 practitioners have been trained in the GCP2 assessment tool. Whilst this has not reflected in the number of assessments undertaken, there is no doubt that the training has raised awareness and there is some evidence to indicate practice has shifted. The partnership does need to review the effectiveness of GCP2 and how it is impacting on children and young people's outcomes.

My engagement with local early years, schools, pupil referral units (PRUs), colleges and local authority education colleagues has reinforced the need to engage school leaders and designated safeguarding leads in a regular working group that could support my scrutiny function. These establishments play a key role in safeguarding children and young people, and they have significant knowledge of children's needs and the communities they serve. There is a real opportunity to develop this relationship between the safeguarding partners and educational establishments, particularly considering the refreshed statutory guidance: Working Together to Safeguard Children, due for publication in late 2023.

Colleagues from health continue to be engaged in the arrangements and the development of a safeguarding provider collaborative is an excellent development. I am keen to engage health providers in the safeguarding arrangements and have had the chance to meet with health visitors and school nurses and understand safeguarding practice from their perspective. Health colleagues continue to update and assure the safeguarding partners of specific areas of concern.

Staffordshire Police were reinspected by His Majesty's Inspectorate of Constabulary and Fire and Rescue and there were some positive developments highlighted. The safeguarding leads are regularly updated on the development of the Public Protection Unit and the response to the inspection.

I will be providing the safeguarding partners with a draft report on the effectiveness of the safeguarding arrangements with a series of recommendations in late 2023. One of those is recommendations is ensuring future engagement and accountability considerations with the chief executive of the county council, the chief constable of Staffordshire Police and the chief executive of the ICB.

Learning from reviews has highlighted the challenges of embedding learning across the workforce and there have been some consistent themes arising from reviews that require safeguarding partners to analyse why they become recurring themes. There are methods of communicating the learning, yet each agency needs to identify how this learning is being embedded and more importantly how this is impacting on children and young people.

The subgroups continue to progress the priorities of the Board through their workplans and there are opportunities to enhance their role and functions refocusing on their impact on children and young people.

In my visits to safeguarding partners in this reporting period I have been impressed by the compassion, commitment and professionalism of all staff working with children and young people in Staffordshire. There are some fabulous examples of how children's lives have been impacted by multi-agency practice. I am keen to ensure the safeguarding partners hear these stories. I am equally keen to develop a practitioners' forum which will build on the opportunities to understand how practitioners are experiencing the safeguarding system.

Finally, I must mention the skill, professionalism and commitment of the Staffordshire Safeguarding Children Board Team led by Lynne Milligan. The team behind the Board arrangements can often be forgotten in the maelstrom of safeguarding work, yet they go about their work with compassion and focus. Their support to the safeguarding arrangements should be congratulated and recognised and I cannot thank them enough for the support they provide across the system.

3 Neglect

National research indicates that around 10% of children suffer from neglect.[1] Neglect featured in almost 65% of child protection plans in Staffordshire during 2022/23 and remains higher than both statistical comparators and the national average (circa. 50%). Neglect continues to be a priority for the Board with a particular focus on infants under one based on local and national intelligence and learning from reviews including a local thematic review of under ones undertaken in 2020/21.[2]

3.1 Our strategic approach

One of the key objectives in the Board's business plan is to ensure we have a clear strategic approach in reducing the impact of parental risk factors by working with Strategic Partnerships who play a key role in helping us deliver our desired outcomes.

- There is a close connection between translating the learning from reviews such as perinatal mental health and more recently concerns on pre-birth plans feeding directly into the **Maternity Transformation Programme** (MTP) through the ICB's statutory partner on the Board. The long-term improvement plan for perinatal mental health provides assurance to the Board on the early diagnosis and response to poor mental health of parents, including maternal and paternal wellbeing pre and postnatally.

- As part of our strategic approach to tacking neglect in under ones, the **Early Years Advisory Board** (EYAB) have worked as a multi-agency group to develop a delivery plan which was developed using the evidence-base including the Early Intervention Foundation (EIF) and What Works Centre for Children and Families as well as feedback from practitioners. This plan has three sub-group leads to drive forward the three priority areas: happy and healthy; enjoy and achieve; and safe and belong. Although the safe and belong strand is more focused on the Board's priority area, all aspects of the delivery plan will have a positive impact on neglect under ones. The EYAB has reflected on the learning from local Child Safeguarding Practice Review's (CSPRs) they have determined that the actions being taken will ensure that learning is embedded throughout the partnership. The partnership has generally been well attended, but there has recently been some loss of traction due to changes in personnel across the system resulting in lack of regular attendance which has impacted on the pace and continued impact of the work. The long-term delivery plan therefore requires continued support to achieve the outcomes identified including through better intelligence, attendance, and contribution from key partners.

[1] https://learning.nspcc.org.uk/media/2621/statistics-briefing-neglect.pdf

[2] Note: this thematic review was undertaken by the former Staffordshire and Stoke-on-Trent Safeguarding Children Board

- Development and implementation of a **local protocol** to strengthen our relationship with other key strategic partnerships and organisations in Staffordshire. We reported that the protocol had been endorsed last year demonstrating our joint commitment to working together to keeping children and adults safe from harm and improving their health and wellbeing. A partnership chairs and operational leads group has now been established and meets on a quarterly basis to share, align and agree priorities across the various partnerships. Some of the early decisions from these meetings include agreement to:
    - support the Health and Wellbeing Board to conduct a thorough Joint Strategic Needs Assessment (JSNA). This is their statutory responsibility but often partners have conducted separate needs analysis. The JSNA will support the partnerships to determine and agree priority areas
    - continue to share good practice to facilitate better integration of the way the partnership works.

What difference have we made?

Whilst it is too early to tell if this work has led to sustained improvements in outcomes there are several key impacts which help us to know that there has been changes in the system which will reduce neglect under ones including:

- Planned improvements to community perinatal mental health (PMH) teams across the County with increased capacity for women to access a range of evidence-based psychological interventions, support and therapy. Demographic, health inequality and service data have also helped identify the changes and improvements required to address health inequities.

- Practitioners having access to help and support including through the **Early Years Safeguarding Forum** which was established in collaboration with the sector. The forum helps build positive relationships, share lessons learnt, and discusses innovation and future topics of understanding and learning as well as listening to the voice of those practitioners to co-produce solutions.

- Practitioners have accessed free training provided by the Board regarding how to hear the voice of the child, '**with or without words**' with positive feedback from those who have attended training. Feedback captured three months after training has evidenced the impact of how some practitioners who attended training have used their training to evidence concerns for referrals into Children Social Care.

'With or without words' - post training feedback

"….use information given by caregivers but make sure that you put yourself in the child's shoes - what does their lived experience of day-to-day life look like?"

"Ensure I always hear the child and put the child first and ensure the child's safety always remains precedent"

- Staffordshire County Council launched the **Early Help Strategy** (2022-2027) in October 2022 to bring together partner organisations in building a common understanding of where we are trying to get to with children and families and how we will work with them, and each other to achieve this. As a subgroup of the Health and Wellbeing Board, the Family Strategic Partnership Board will bring the strategy to life with the support of the Early Help and Placed Based Approach Partnership. Plans are in place to develop a Staffordshire Family Hub model which brings together a range of early help provision into a coherent, connected, and accessible offer to families around a local place, supporting them to achieve and maintain positive outcomes and seek to prevent needs from escalating. The Board will continue to seek assurance on the impact of early help provision.

- Themes from recent Ofsted inspections and SSCB learning has been used to inform the focus of themes for the termly County Council Funded Early Years Sector Workshops with recent topics including safeguarding themes from inspection; neglect; and learning from child safeguarding practice reviews.

- Good take-up of entitlements and health visiting services.

Barriers and challenges

- Lack of consistent engagement from key personnel: attendance trackers are in place to ensure those who consistently do not attend are held accountable or alternative members can be identified
- Overwhelming partnership governance: a session has been planned to develop a shared understanding of accountability, responsibility and improvements to create a leaner structure
- Clearer understanding of the learning from child safeguarding practice reviews so that the system can improve

Focus for 2023/24

- Our connection to the learning is not as well developed as it could be, we need more specific examples of learning from reviews so that we can start to improve practice

- Partners are still reporting a high number of under ones coming into the care of the local authority. We need better intelligence, attendance and contribution from key partners who can provide this link with the partnership work

3.2 Improved skills and knowledge in the workforce

Evidence from local learning found practitioners often failed to recognise and respond to low levels of neglect and understand the cumulative impact of neglect. As a result of a recommendation from a local review in September 2020 we commissioned the use of Graded Care Profile (GCP2)[3] to improve our response to neglect with our neighbours Stoke-on-Trent Safeguarding Children Partnership through a joint delivery group set up to oversee implementation across the two areas. The GCP2 assessment tool came into service wide operation in April 2021.

At the end of March 2023, across Staffordshire and Stoke-on-Trent we have trained over 1,500 practitioners to become licensed to use the GCP2 tool across a range of settings including education, health and children social care. The numbers of assessments that have been recorded as being completed during 2022/23 has increased significantly compared to the previous year (207 in 2022/23 compared with 71 the previous year).

We have also done work with practitioners to understand the barriers and come up with joint solutions. As a result, we have developed and launched the new 'Supporting GCP2' training package for those not working directly with children to enable them to contribute to an assessment or signpost to a licensed practitioner, having gained valuable understanding and confidence in recognising low level neglect, as well as a screening tool for practitioners to use alongside GCP2.

The NSPCC undertook a review of our GCP2 implementation in March 2023 with our score being 51% (target is 60% for full implementation). They found that we were performing particularly well in providing quality training, supporting trainers, and gathering data around attitudes, training and GCP2 use. The key challenges they identified were: senior management engagement; practitioner use of GCP2; and monitoring the quality and impact of GCP2.

What difference have we made?

Data from the training evaluation continues to evidence an increase in both knowledge and confidence in using the GCP2 assessment tool. Post-training evaluation also demonstrates a commitment from attendees to use their acquired skills and knowledge to improve outcomes for children and families. This data also shows that trained practitioners have a better understanding of neglect in terms of the impact on the child outcomes. We have also had positive feedback from practitioners on how they have used GCP2 to improve outcomes for children and families.

[3] Graded Care Profile 2 - Staffordshire Safeguarding Children Board (staffsscb.org.uk)

Feedback from practitioners

"Worked in partnership with the Home-School-Links Worker to discuss parental supervision and safety around use of on-line devices and what children are being exposed to in the home. Parents have now put strategies in place and are managing access to devices more securely"

"The training which is being implemented with my families has worked well and had a positive impact on the children because concerns have been addressed and improvements have been made"

"I have been able to help some young girls whose mom struggled anyway. She has now had twin boys, so I have been supporting that family and helping get some help in place as there were already concerns about neglect"

Whilst it is difficult to attribute impact directly to the work we have done around neglect and GCP2, during 2022/23 we continued to see a reduced number of re-referrals and children subject to a Child Protection Plan (CPP) for a second or subsequent time where neglect is the main category of concern from previous years.

Barriers and challenges

The progress made by the joint implementation group stalled during the year leading to significant drift and delay. Therefore, a decision has been made to split our arrangements for implementation from Stoke-on-Trent from next year. There has also been a noted lack of commitment and buy-in from senior managers in understanding the benefits of using GCP2 with anecdotal evidence suggesting some feel that GCP2 has been a barrier to working with children with neglect. Further work needs to be done to reinvigorate the commitment from senior and middle management as well as practitioner engagement through feedback and mentoring through the existing NSPCC evidence base and network.

Focus for 2023/24

- Review the GCP2 programme with a focus on demonstrating whether GCP2 has had an impact on our desired outcomes

4 Quality assurance priorities

This section reports on the quality assurance priority areas that were identified in the Business Plan for 2022-25.

4.1 Child exploitation

Between May 2022 and April 2023, a total of 610 children were discussed at Multi-Agency Child Exploitation Panels (MACE) panels equating to a 20% increase from the previous year. There is an even split between criminal and sexual exploitation. The data also highlights children with multiple risks with the most common being missing episodes, exclusion from school; being open to youth offending services and/or having an education health and care plan (EHCP).

During 2022/23 the Board agreed to split governance arrangements from our neighbouring Stoke-on-Trent Safeguarding Children Partnership to enable singular focus on the needs of Staffordshire's children and communities which can be delivered in a more bespoke localised response. The revised structure supports the amalgamation of the child exploitation and missing responsibilities through a single strategic group jointly chaired between the local authority and Police.

Key deliverables during the year included:

- An in-depth needs analysis of the current need and demand to support the development of a revised draft strategy and the commissioning of services
- The appointment of additional child exploitation coordinators by the local authority to act as a single point of contact for professionals across the eight districts within the County. The coordinators will support the management of risks inclusive of the MACE panels and wider response to children who are at risk of or are exposed to exploitation.
- Improvements to the strategic monitoring and understanding of missing children in Staffordshire cementing further links with our exploitation response.

What difference have we made?

A good individual example is a child who has been supported by a lived experience mentor through the commissioned service, Catch-22; they were supported into training and community activities and the adults have been disrupted. This has led to a reduction in the risk of exploitation and the child feeling safe and supported.

- Our MACE panels are well attended by partners and continue to deliver risk reduction interventions to victims of child exploitation. Data demonstrates that child exploitation continues to be identified by a range of partners and children are being appropriately referred into services. In terms of outcomes, the data evidences that for the majority of children the risks are reducing, they are engaging with partners when referred and supporting disruption of those causing them harm. Only around 7% of children show no reduction in risk over three consecutive panels.

- There is a more localised footprint and specialist support and advice within a district model which means that the MACE objectives and principles including disruption can be embedded in communities.

- There is evidence that safety plans are being developed with children and parents but further assurance is required to ensure that we are truly capturing their voices.

- The introduction of weekly missing meetings has helped make necessary connections for children at risk of exploitation, identifying further disruption opportunities at an earlier stage.

- Utilising audits and feedback have helped to ensure that the response to child exploitation remains fluid and appropriate in order to address the changing landscape of risk and vulnerability.

Barriers and challenges

- Staffordshire Police are undergoing an operational transformation to increase resources to investigate crimes involving victims of child exploitation with maximum resource to be in place by 2026. Staffordshire Police have reviewed their capability and capacity to respond to all public protection matters. The review was carried out by independent consultants and resulted in a recommendation to significantly increase the number of staff working within the child protection area of policing. The delivery of the Public Protection Unit project will see the development of a new team solely focused on the response to child exploitation. The team will take a public health approach to tackling this issue but will also relentlessly pursue those who pose a risk to children, using all tools and opportunities at their disposal to seek perpetrators out and disrupt their harmful behaviour.

- Whilst safety plans are developed with children and their families, there remains the challenge in capturing the voice of the child. Further work next year will seek to understand why these barriers exist and how we can overcome them in order to understand the lived experience of children.

- Utilising audits and feedback to ensure that the response to child exploitation remains fluid and appropriate in order to address the changing landscape of risk and vulnerability.

Focus for 2023/24

- A full review of the local MACE process, including the Risk Factor Matrix tool, through consultation with key stakeholders including children and practitioners

- Embedding the specialist single point of contact coordinators for child exploitation within the Districts

- Developing and refining the partnership's performance framework to ensure that we can monitor impact

- The Joint commissioning arrangements that had been in place will come to an end on 31st March 2024. This will require a review of the pathways and processes to ensure that the seamless support is in place.

4.2 Domestic abuse

During 2022/23 there were around 19,700 domestic crimes and incidents recorded in the County by Staffordshire Police which was a 6% increase compared to the previous year with around 6,000 children living in these households (30%). Estimates suggest that around two-thirds of domestic abuse victims remain hidden to the system. Domestic abuse is also one of the most prevalent issues noted in Children Social Care assessments.

Oversight of domestic abuse sits with the Staffordshire and Stoke-on-Trent Domestic Abuse Commissioning and Development Board (DACDB) who are responsible for ensuring delivery of the domestic abuse strategy and accompanying action plan for 2021-24 which was informed by a strategic needs assessment and consultation with key stakeholders.

The domestic abuse action plan has four priority areas:

- Prevention of violence and abuse
- Provision of services
- Perpetrators
- Safe accommodation

There are separate working groups who lead these priority areas and report progress to the DACDB with representatives from professionals who work to safeguard children to ensure that the needs and voices of children are represented. There are several representatives from the DACDB who sit within the SSCB sub-group structure although this relationship needs to be strengthened.

What difference have we made?

- Development and implementation of a domestic abuse performance framework has been undertaken by the DACDB, which monitors the impact of the strategy

- Re-commissioning of domestic abuse support services for those affected by domestic abuse has been undertaken by DA Commissioners, whilst also recognising that support for children affected by DHRs has been conducted by the County DHR Lead

- Early discussions on the identification and support for children affected by domestic homicide reviews (DHRs) and how learning from DHRs where children are involved is disseminated through safeguarding communication and engagement channels

Barriers and challenges

One of the significant changes in the Domestic Abuse Act 2021 was that children witnessing domestic abuse should be treated as victims in their own right, which is included in the action plan. There is some ambiguity however in relation to this element which defines that children affected by domestic abuse should be treated as victims in their own right.

Interpreted to the letter, this could effectively mean that children identified at an incident should be independently directed into domestic abuse services, as opposed to being identified along with the parent/carer victim as is currently the case both locally and across the Country.

If this approach was adopted, there could be a potential increase in the number of victims identified by the Police in Staffordshire and Stoke-on-Trent of 10,000 per annum. Clearly there are a number of implications of interpretation of the Act in this way including: determination of the parent with care able to provide consent for the child to be directed into domestic abuse services; whether the child is able to give consent themselves (Gillick principles relating to age appropriateness apply); process pathway development; and resources within policing and commissioned services to meet the increased demand.

Policing colleagues across the County have been advised to retain current arrangements whilst awaiting clarification from the Government on this element of the Domestic Abuse Act 2021.

This matter was raised with the national Domestic Abuse Commissioners Office initially in Autumn 2022, who have affirmed the ambiguity and confirmed their intention to take this issue forward with central government. The national Domestic Abuse Commissioner's Office will be holding a series of events across the Country to discuss this further during 2023/24. The DACDB will refine and review the action plan depending on the outcomes of discussions with the Government.

Focus for 2023/24

- Develop through partnership engagement and participation, a refreshed 3 year DA Strategy and Action Plan and ensure delivery of same

- Refresh the Domestic Abuse Needs Assessment and Safe Accommodation Needs Assessment

- Strengthen the relationship between the DACDB and SSCB to ensure there is a child-centred lens and that learning from safeguarding system are translated into improvement

- Continue to develop and strengthen partnership relations between existing governance arrangements and pathways between DA services and other support

4.3 Early help

Early help was identified as a quality assurance priority for the Board in 2022/23. Early help is governed by an Early Help Partnership Board who report to the Family Strategic Partnership / Health and Wellbeing Board who this year developed a new early help strategy which was heavily informed by the views of children, young people and families as well as local data and intelligence and national developed evidence base and frameworks. The Early Help Partnership Board will continue to implement and monitor the success of the Early Help Delivery Plan and Strategy and are linked to SSCB through representation on various sub-groups of the Board as well as through the local protocol.

Key deliverables during the year included:

- Early Help Launch Event undertaken and local sessions delivered in each district/borough to bring commitment and partnership action
- Development of a delivery plan for early help to accompany the strategy
- Completion of a self-assessment for early help
- Being selected as one of two local authorities to promote system maturity of early help supporting ten other Local Authorities.
- Overachieved targets for number and outcomes of families worked with in 2022/23
- Learning from the system through a 5% sample of families we work. The outcomes are used to inform the training plans for our eight districts
- Feedback from children, young people and families evidences the impact of our support (large majority say it is positive)
- Information Sharing Agreement between the County Council and health has been agreed and signed which will mean we will get real-time data on children, young people and families accessing early help

What difference have we made?

During the year we saw:

- Over 1,000 children and families supported by voluntary sector providers
- A 58% conversion rate for families worked with to successful and sustained outcomes which is higher than the national average
- More families in work, children attending school and not committing crime
- Reduction in the need for children and families needing support later
- Children and families telling us that whole family working supports them in a better way

Case study: A young man was regularly missing school and getting into trouble when he did attend.

His situation worsened when he connected with a peer group engaging in anti-social behaviour within the local community. A local youth charity reached out to the young man and got him involved in their after-school football club, which he attended regularly. His attitude and behaviour improved and in recognition of this, he was given coaching responsibility. This coaching role improved his confidence and self-esteem. After three years, this young man is a part time coach and working full time. He is kind, respectful and a great role model to other young people

Source: Early Help Strategy

Barriers and challenges

- Capacity of the partner agencies to embed the work into all aspects of support. Partnership performance information reports that over 90% of Early Help is completed by Staffordshire County council or people acting on their behalf.
- Reduced funding for partners outside of the County council for early help
- Recruitment and retention of staff
- The quality of assessment, plan and outcomes varies across the partnership

Focus for 2023/24

- Embed learning across a wider range of support
- Sharing the learning and way of working to scale up
- Thinking about Family Help and Stable Homes Built on Love to ensure sustained impact of outcomes
- Better demonstration of whole family working
- Better use of data and information sharing to inform learning

5 Ensuring effective multi-agency safeguarding practice

As part of our core business, the focus of this overarching priority continues to demonstrate that there is a multi-agency approach to our safeguarding practice which is effective. We will ensure that learning is identified, its improvements embedded at both individual and multi-agency level, be alert to emerging risks and understand systemic issues which policy and practice changes will address. These continue to be implemented and/or monitored through our structure and sub-groups.

5.1 Listening to children and families

A key objective is to seek assurance that the voices of children and families are being heard and considered when developing safeguarding practice and priority areas. The voice of the child has also been a recurrent theme in local and national child safeguarding practice reviews and also featured in some of our independent inspections.

Some examples of the work we have done this year include:

- Findings from the **Section 11 peer assessment** found that most agencies met this standard. There was evidence of good practice from all agencies at a strategic level of consulting with children and young people when commissioning and/or designing/redesigning services and visible signs of improvement at operational level, for example in quality of child protection reports where the voice of the child was now included and increasing proportions of contacts where the child was seen alone. A number of agencies identified a need to improve how they capture the voices of children and use this during decision-making.

- During 2022/23, Staffordshire Council of Voluntary Youth Services (SCVYS led the work on a **Staffordshire Co-production Promise** with a launch date scheduled for September 2023. Once launched, the aim is that the Promise will result in a better experience for families who need to access support, but often must fight every step of the way to get any kind of help which will result in better outcomes for children. It will also help improve practice and drive a much-needed culture change where those receiving the support are continually placed at the heart of all decision making. The work has three main strands:

    - Communicate and align with all other co-production work streams across the system to ensure consistency of approach
    - Co-produce with children, young people, parents/carers and professionals a visually appealing one page easy to read co-production promise which includes a local definition and locally identified principles to inform our approach
    - Creation of a toolkit for local professionals to support them to choose when co-production is the best tool available and how to do co-production well, and to use a local co-production kitemark for any piece of work meeting the criteria

- From January to April 2023, SCVYS undertook an engagement exercise to gather the voices of young people in relation to their concerns around violence in their local community and online. Over 1,600 young people from Staffordshire and Stoke-on-Trent completed the survey or were involved in qualitative conversations around the subject (facilitated by SCVYS). The final report has now been compiled with the findings and recommendations informing the new priorities within the local **Violence Reduction Strategy** due to be signed off by partners during 2023/24.

During 2023/24, partners are committed to undertaking the self-assessment quality assurance tool developed by Staffordshire Council of Voluntary Youth Services (SCVYS) which will assess how well we listen and engage with children.

5.2 Listening to practitioners

In light of national challenges relating to workforce issues, and as an action from a child safeguarding practice review, the Board is working together to ensure practitioner's voice is solicited across the partnership, and improvements made in a planned manner and services for children and families in Staffordshire remain of a high standard.

There are also some forums and drop-ins for designated safeguarding leads. Partners at the Section 11 peer assessment day provided examples of how they collect and use practitioner feedback to improve their part of the system. Opportunities to collect feedback included supervision, team meetings, regular practitioner forums and drop-ins. Examples included feedback with Police Officers to shape their new operating model; changes to the missing person procedure; 'Was Not Brought' policy/template within primary care and change to the Section 175/157 audit survey tool in response to feedback from schools. Following learning from the peer assessment day, we also initiated the Early Year Safeguarding Forum as previously described in the Neglect section.

However, this is an area where we have collectively not made as much progress as we would have liked during the year and we have recently developed an action plan to progress this. Therefore during 2023/24 we will be:

- undertaking a stakeholder analysis for their own organisation to understand the mechanisms that exist to engage practitioners and seek their views
- holding practitioner events
- launch our practitioner survey to see how embedded safeguarding is across the wider workforce

The independent chair and scrutineer also has a planned roadshow programme with practitioners.

We are also planning to pilot a 'Learning Hub' model based on the Bexley model. This will build on existing work done by safeguarding partners in their individual organisations and our approach to child safeguarding practice reviews. The model will improve our line of sight to front-line practice and allow learning and improvements to be practitioner-led and provide opportunities to learn, share and reflect as a multi-agency group.

We are committed to developing internal mechanisms whereby practitioner feedback is consistently included within improvement plans which are clearly communicated and progressed with transparency and impact.

5.3 Statutory Partner transformation

Staffordshire County Council

During 2021/22 the local authority went through a transformation process to align their resources by district, bringing together Early Help, social care, education inclusion and special educational needs and disabilities (SEND) together in place-based teams to join up services. These district teams are supported by central functions that work across the county and support consistent ways of working. The overarching principle for the district model is to deliver services to children and families and support permanence for children at the earliest possible opportunity. Embarking on a transformation of this size has been challenging, so the Council are pleased to report that they are now starting to realise the benefits and have seen some positive feedback from our workforce.

The performance and quality assurance information from the local authority continues to evidence strengths in partnership working across the board:

- Partnership working leading to effective support plans for children being supported within early help, children in need and child protection plans processes.
- Our low re-referral rates demonstrates that support provided is enabling families to achieve independence within community settings.
- For our most vulnerable children and families such as children subject to education, health and care (EHC) plans and those who are cared for by the Local Authority, through co-production with all partners including parents/families, we are able to support the majority of children and young people through local resources and/or within their local area. When required, support from independent settings, or out of county resources are deployed, with a strong partnership focus to ensure services remain consistent and effective.

We are aware of the challenges that exist, and we work together to identify solutions such as the need to improve our offer of support for children with complex emotional wellbeing needs.

Staffordshire and Stoke-on-Trent Integrated Care System (ICS)

The ICS are developing a Safeguarding Provider Collaborative between key health agencies in Staffordshire, namely:

- Staffordshire and Stoke-on-Trent Integrated Care Board (ICB)
- Midlands Partnership University NHS Foundation Trust (MPFT)
- North Staffordshire Combined Healthcare NHS Trust (NSCHT)
- University Hospitals of North Midlands NHS Trust (UHNM)
- University Hospitals of Derby and Burton NHS Foundation Trust (UHDB) (as a partner)

The Safeguarding Provider Collaborative are committed to fulfilling their statutory and regulatory duties and responsibilities in relation to safeguarding by promoting the welfare of children, young people, adults and their families or carers within our communities who encounter our services. Acting as one health voice allows us to have a shared set of standards and outcomes across the system to provide consistency and improve quality whilst working collaboratively towards the safeguarding agenda across the Staffordshire and Stoke on Trent Integrated Care System.

What the provider collaborative will mean:

- One voice for health (authority to speak for all organisations)
- Improved prevention through shared learning and sharing of best practice
- Reduced duplication
- Consistent set of standards in safeguarding practice

Each organisation will maintain their individual organisational accountability in relation to safeguarding that in turn reports into the Health Safeguarding Forum, Quality & Safety Committee and then into the Integrated Care Board through the Senior Responsible Officer of the ICB. It is important we ensure collaboration, quality, safety, efficiency, and personalisation, with value, benefit, and success.

Staffordshire Police

During 2022/23 Staffordshire Police have carried out significant improvements in their approach to Child Protection. His Majesty's Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS) carried out a thematic Child Protection inspection of Staffordshire Police in the autumn of 2021. The outcome of this inspection led to the force receiving 15 recommendations for areas of improvement.

The Board has received regular updates from the force on its plans for improvement, along with the progress being made.

The force was re-inspected in April 2023 and was pleased to have achieved sign off on 6 of the recommendations, these being in the following areas:

- The way the force uses Information Technology (IT)
- The strategic governance and access to performance information
- The training of its workforce
- Attendance at Initial Child Protection Case Conferences
- The use of the Child Abuse Identification Database and the appointment and utilisation of a Victim Identification Officer.
- The effectiveness of the Sex Offender Management Unit (SOMU)

The force continues on its journey of improvement in the outstanding areas, and the Board will continue to interrogate progress against the plans going into 2023/24.

During 2023/24 Staffordshire Police has undergone a full review of its Public Protection function by independent consultants. This has led to the distinct alignment and ownership of Child Protection work under the leadership of one Detective Superintendent. The Chief Constable has committed to a significant increase in police officer numbers into the Public Protection Unit. This increase will see the implementation of a brand new Child Exploitation Team in early 2024. The new team will be closely aligned to partners seeking every opportunity to respond to child exploitation concerns in a co-ordinated multi-agency approach reducing risk and bringing to justice those who seek to cause harm to children for their own gain. The team will work closely with the Violence Reduction Team and the Youth Offending Service.

5.4 Safeguarding in education

The County Council's Education Safeguarding Advice Service (ESAS) continues to be key in providing a voice for educational settings to the safeguarding partners. They work in partnership to provide effective support and challenge to early years and education settings in their decision-making. As well as representation on all the Board's sub-groups, ESAS colleagues attend multi-agency meetings/groups to act as a voice for school practitioners. This also means that ESAS can disseminate learning back to schools based on local needs and ensure schools are routinely invited to relevant multi-agency meetings such as MARAC. The ESAS team are also responsible for ensuring that the Section 175/157 safeguarding audit is completed and provides appropriate qualitative and quantitative information to safeguarding partners and schools with a robust self-evaluation of policy and practice.

During the 2022/23 academic year ESAS have handled over 4,200 calls as well as almost 50 individual safeguarding reviews to those schools that are identified as vulnerable. School visits and safeguarding reviews allow for continual improvements to safeguarding arrangements, highlight good practice which can be disseminated to other settings and identify areas of focus for drop-ins. This also ensures settings are Ofsted-ready and support the mental health and wellbeing of Designated Safeguarding Leads (DSLs).

ESAS also deliver Level 3 training and refresher courses to large numbers of DSLs. They also hold termly safeguarding briefings to DSLs and provide bespoke training and/or support to new DSLs. DSL drop-in sessions continue to be popular and provide additional support and guidance on a variety of current topics such as listening to the voice of children; neglect; sexual abuse; domestic abuse and mental health) and allow for both sharing of good practice and learning. As a result of findings from last year's Section 175/157 audit which identified a development need for PREVENT, over 170 practitioners from schools attended three Synergy events with West Midlands Counter Terrorism Police colleagues which has had positive impact.

Following the Synergy Events, the West Midlands Counter Terrorism Police stated:

"I've had numerous referrals of excellent quality come in after the events, so I think it was very much a success"

The education safeguarding page of the Staffordshire Learning Net (SLN) has been reviewed and updated and now provides educational settings with a live central bank of resources of training materials; PSHE resources; information on referral pathways and newsletters as well as signposting to relevant local tools and resources for example on the SSCB website. It also allows for one of the means of timely dissemination of learning from local child safeguarding practice reviews. During the year ESAS also published a template for safeguarding and child-on-child abuse policies based on KCSiE (2022) and Working Together (2018).

Barriers and challenges

- IT issues which have prevented access to the SLN to some staff
- School engagement, for example not all identified vulnerable schools accepted the offer of a safeguarding review; academies choosing to complete their own S175/157 assessment rather than the ESAS team's S175/157 audit template which allows for consistent assessment across the County
- ESAS capacity, during the year team vacancies were recruited to. However, the size of the team still provides a challenge to support over 400 education settings as well as early years settings and childminders

Focus for 2023/24

- Improving ESAS systems so they are more efficient and effective in order for us to analyse and share and analyse this information more easily through development of an education safeguarding dashboard
- Developing wider mental health support for DSLs
- Developing an education risk register of schools
- Continuing to improve the quality of safeguarding resources available to schools

5.5 Multi-Agency Safeguarding Hub (MASH)

Our MASH arrangements remain safe, strong and contribute to timely information sharing to achieve robust decision making for children particularly at the statutory level. We are however, committed to making MASH arrangements more robust, engaging partnership information sharing and decisions at the earliest opportunity including through family hubs.

The finding of a joint peer assessment review in November 2022 highlighted a number of areas to ensure we have the best possible outcomes for children and families including:

- A MASH structure with clear governance and leadership. Purposeful strategic and operational meetings that are continually striving to progress, strengthen, and unite partnership safeguarding arrangements
- A new performance framework with input from all partners to demonstrate how effective the MASH is and the difference it makes. Provision of clarity to all partners 'what good looks like'
- Branding and vision, a new dynamic MASH. A clear and easily recognisable logo with a key mission statement that states the prime purpose of the MASH
- Co-location of MASH partners and building a wider network of partners across the County to build and strengthen relationships; enhance information sharing and intelligence gathering
- Appropriate representation from all agencies and equal status in leadership
- A thematic multi-agency audit programme that results in training and refreshing skills base of all staff
- New technology, replacement, or upgrade of current Information Sharing Log (ISL) that incorporates a performance dashboard including demand
- Retention and recruitment of staff across all partnerships, making the MASH a desirable location to work within
- Shared documents and processes that are produced through a MASH threshold document; adapt a more critical/problem solving approach

Following last year's review of our joint MASH arrangements with Stoke-on-Trent, the main priorities for this year were to explore a Staffordshire MASH for children, independent from previous MASH all-age safeguarding arrangements.

Barriers and challenges

- Technology - need to ensure we have an IT system that allows us to share information effectively and efficiently that is fit for purpose
- Police Public Protection Unit (PPU) transformation - ongoing process, models and staff reorganisation taking place
- Workforce - staffing levels and turnover seen across the partnership
- Finance - need to ensure that agreement is made though a revised service level agreement across all statutory partners to ensure equity
- Confusion on information sharing agreements which had delayed progress with our planned multi-agency audit programme

Focus for 2023/24

Our expected impact of our proposed arrangements will lead to a more efficient information exchange process which will reduce demand on staff within the current MASH and more early conversations and information exchange through existing structures at a district level such as early help and Family Hubs model and harm reduction hubs. As part of this a number of priorities for 2023/24 have been identified:

- Developing and agreeing a future vision for local MASH arrangements
- Developing and monitoring the implementation of the transition plan through the MASH Project Board
- Agreeing a robust and effective project plan with clear timescales for implementation which will be delivered through an operational group with the Board having overall oversight
- Exploring and agreeing on a new system that will facilitate meaningful performance data
- Implementing our performance and multi-agency audit programme
- Reviewing and updating our existing Information sharing agreement (ISA)
- Engagement with wider range of non-statutory partners to join the proposed new arrangements to provide richer picture of safeguarding arrangements and true multi-agency working

5.6 Scrutiny and Assurance

The Scrutiny and Assurance (S&A) group oversees the delivery of the Board's business plan and ensures there is multi-agency oversight of service and programme areas delivered to children across the partnership landscape. Whilst the S&A group has maintained a focus on the priorities as set out in the 2022-25 business plan, it has also reacted dynamically where there have been areas of concern identified through inspection outcomes.

The S&A group meets monthly and therefore provides regular oversight of the board's priorities. The group regularly invite members of the wider partnership to present on service or programme areas for children. Over the last 12 months the group have tried to focus their work on the desired outcomes for children. We want to ensure that whilst capacity is a challenge in the public sector, that all efforts are going into making certain that we are making a difference to children and their families. The group recognise that oversight is sometimes too wide and therefore doesn't provide the opportunity to delve deeper into specific agreed quality assurance priorities such as child exploitation and domestic abuse. The group also agree there needs to be a far greater understanding of the services and programmes from the perspective of children and practitioners. This needs to be understood as a whole system approach so that agencies do not seek to solely understand the impact of the service they are providing.

Plans are in place to develop and pilot a learning hub model based on good practice from Bexley. This will provide more clarity on what good outcomes look like for children and use performance and multi-agency audit activity and feedback from children, families and practitioners more effectively to gather tangible evidence as part of our learning and improvement and provide us with an improved line of sight to front line practice.

Section 11 assurance

During 2022/23 we held a Section 11 peer assessment focussing on four key areas: listening to children and young people; professional challenge and escalation; information sharing and staff training and development. Our findings were generally positive with most partners able to evidence how they were meeting the Section 11 requirements that were assessed on the day with some organisations partially meeting some standards. This was particularly apparent for agencies within the criminal justice sector which may have reflected their respective inspection outcomes. Whilst partners were able to demonstrate their individual organisations impact one of the key challenges was our collective ability to evidence the impact of multi-agency working.

Most partners also evidenced how their organisations had aligned their strategic and operational plans to the Board's priorities as well as learning from the system. They provided evidence of how key messages from learning had been disseminated to practitioners through a variety of methods. Organisations were able to evidence how they had made changes to policies, procedures and practice in respond to learning with the impact of these monitored through audits as well as feedback from children, families and practitioners. However, the overall impact on child and family outcomes, particularly at a multi-agency level were more difficult to evidence.

The peer assessment approach was mostly welcomed by partners. Having a face-to-face event, following the pandemic, gave colleagues an opportunity to get together and network as well as collaboratively come together to share good practice and come up with solutions.

The key challenges for the partnership identified throughout the day were:

- Maintaining a consistent and trained workforce due to ongoing challenges with staff recruitment and retention
- Ability to evidence the collective impact of multi-agency working

Inspections

During 2022/23 we have had a number of inspections: Children Social Care focussed visit (May 2022); Probation (June 2022); HMYOI Werrington revisit (November 2022) and Staffordshire Police revisit for child protection (January 2023).

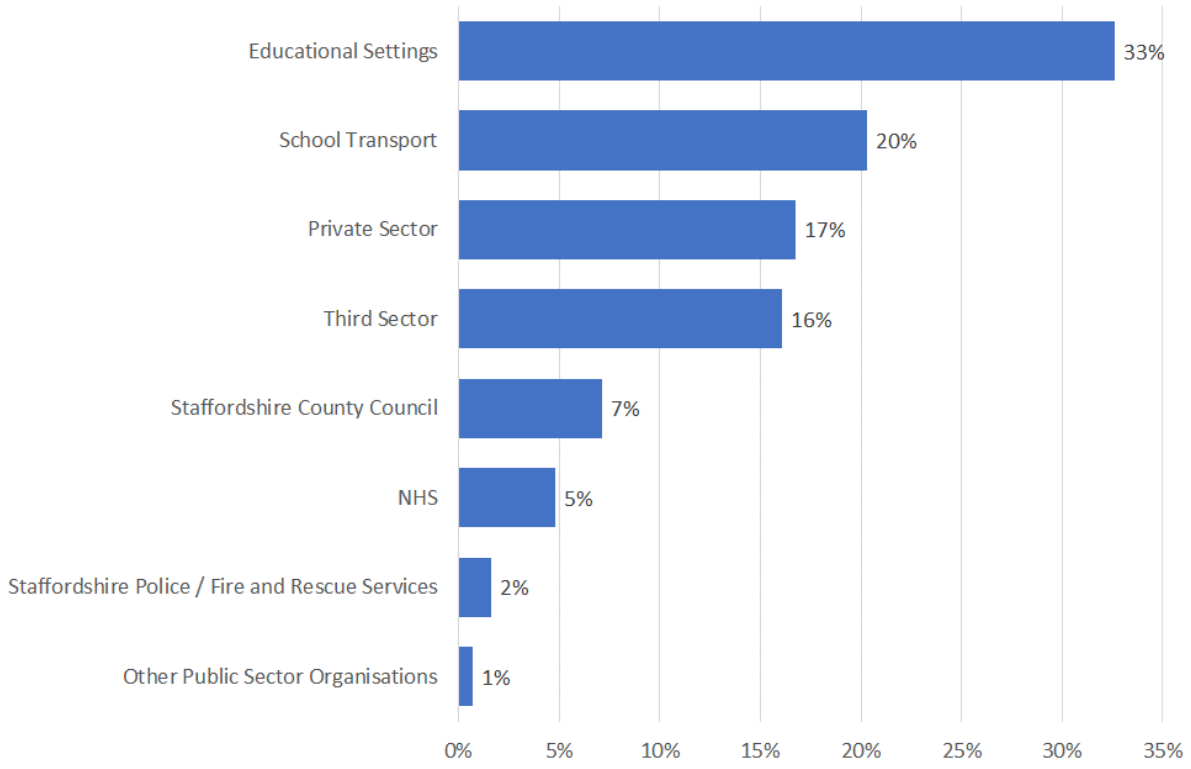
The findings from these inspections identified a number of improvement areas for either individual or across a number of organisations: staffing capacity and pressures; listening to children, young people and practitioners; leadership, management and governance; professional challenge and escalation; effective assessment of risk and need; quality of contact time; management oversight and supervision; staff training and development; record management and information sharing; and performance and quality assurance processes. Many of these improvement areas were not a surprise to safeguarding partners and are recurring themes seen from Child Safeguarding Practice Reviews.

Staff training and development

The Section 11 peer assessment day provided assurance that workforce training and development programmes, including induction, for safeguarding were in place across the County.

During 2022/23, the Board commissioned and delivered multi-agency training to complement single agency training to almost 8,000 colleagues from a range of agencies (Figure 1). The Board's training programme is based on a combination of mandatory and thematic training based on evidence from performance and quality assurance as well as learning arising from local reviews. The Board also offer a number of additional learning resources to the workforce.

Figure 1: Attendance at SSCB training and e-learning courses by organisation type



Following a move to online training during the pandemic, the Board have continued to offer the benefits of flexibility, reach and scale of online training and e-learning courses but also offer some face-to-face training in response to colleagues valuing this approach and in particular the opportunity to share expertise and network.

Feedback post training

"I will be more confident now, knowing that what we are doing is grounded by the information gathered on the course as well as previous experience in a different authority. It will give me the confidence to professionally challenge any circumstance in which children, young people and their families may be needing support"

"The knowledge accrued yesterday will ensure I have the tools to look out for signs to ensure children are safe and supported in education"

"I think that I will be even more mindful of the restorative approach, in order to maintain, create or improve relationships with those parents and children that I am dealing with"

Some of the challenges and barriers identified for partaking in training and development include: staff capacity and training costs.

6 Learning from the system

6.1 Child safeguarding practice reviews

The Child Safeguarding Practice Review (CSPR) sub-group is a multi-agency group, comprising of the statutory partners as well as education, probation, youth offending service and representatives from other agencies on a case-by-case basis, that has delegated responsibility from the Board to oversee reviews and to report to the national Child Safeguarding Practice Review Panel on learning and progress made in line with Working Together 2018.

Involvement with statutory processes including rapid reviews, child safeguarding practice reviews (CSPRs) and domestic homicide reviews continues, constituting a significant volume of reactive workload. As a result of the review process the learning trends and themes shape the proactive work and form the basis for the Board's business plan. We also share best practice and learning from national reviews and annual reports published by the National Panel including Child Protection in England (the national CSPR into the murders of Arthur Labinjo-Hughes and Star Hobson).

During 2022/23 Staffordshire have completed six Rapid Reviews of which four have resulted in the commissioning of local CSPRs. Three of those CSPRs are in the final draft stage whilst one is due to commence. In addition, there are four CSPRs that have been completed and awaiting publication due to ongoing criminal proceedings. Children and family members involved are given the opportunity to meet with the lead reviewer to discuss their views.

Neglect and associated non-accidental injuries in babies under one year remain thematic and there have been three cases of inter-generational and intra-familial child sexual abuse. CSPRs awaiting publication involve children subjected to potential forced marriage, non-accidental injury in babies under one and intra-familial child sexual abuse.

In partnership with Stoke-on-Trent Safeguarding Children Partnership the thematic review of under ones executive summary was published this year. Learning from this review has been embedded and the action plan continues to have assurance oversight from both Safeguarding Boards/Partnerships.

Learning identified include some recurrent themes as well as some new findings: professional curiosity (critical thinking and good risk assessment); professional challenge and escalation; multi-agency approach to managing risk (significant men); recognition and response to intra-familial child sexual abuse where the threshold for criminal intervention is not reached; exploration of historical offences, voice of babies and children and understanding their lived experience; cultural bias; understanding and responding to potential forced marriage; Whole Family; information sharing; family norms accepted and overruled with little challenge or enquiry; cross border working; and the impact of the coronavirus (COVID-19) lockdown for families. Many of these themes are similar to recurrent themes/ learning within the National Panel's annual report. There are plans to provide assurance through the Board's sub-group structure and the learning hub approach to ensure that the activity identified are leading to positive improvements in the system.

Key messages from learning are disseminated to the workforce through a system-wide approach, for example, directly from the Review Team; 7-minute briefings; single agency / Board newsletters, social media, organisation and/or Board's website and intranet; team meetings; staff or member briefings; mandatory training; development sessions or learning events such as the local authority and ICS's lunch and learn events or reiteration through learning and development events during national safeguarding awareness week. Many of the messages are also reiterated during individual or group supervision.

The SSCB's Business Team support partners in their duty to disseminate learning. Some creative and innovative work has commenced with the development of a learning from reviews video (under development) and through a refreshed website hosting a variety of media opportunities to learning from reviews, including links to newsletters, webinars, guidance, training and 7-point briefings. Learning from reviews are also fed into relevant strategic partnership groups such as the MTB, EYAB and DACDB through members of the CSPR sub- group who sit on these groups/sub-groups although there is recognition that this area needs further strengthening.

Following rapid reviews and CSPR processes, practitioner events are facilitated by the SSCB supporting additional learning and an opportunity to discuss and debate outcomes from applying changes to systems and processes across the partnership. Individual agencies also support frontline staff through training programmes, workshops and forums enabling ongoing learning and discussion, required for continuous reflection. The weaknesses of the processes/functions is having the capacity to reflect and being able to monitor and collate the difference we have made to improve practice and children outcomes at a multi-agency level.

What difference have we made?

The SSCB have clear principles for learning and improvement and the CSPR sub-group monitors the progress of actions and requires evidence of embedded learning. It is the expectation that safeguarding partners will put in place arrangements to monitor and challenge the quality of their own and other agencies' work in relation to children's safety and welfare. By doing this the SSCB can be assured that partners have been enabled to identify and understand the reasons for systemic strengths and weaknesses that relate to safeguarding practice. **The focus remains on the 'so what' factor and how do we know things are improving for the children and young people of Staffordshire.**

- Updated the local guidance and flowchart for bruising in non-mobile babies' which is held, on the Board's website as well as key points accessible to practitioners, at a glance, through a seven-minute briefing
- Improved the training uptake and application of neglect and the GCP2 assessment tool, in particular with GPs ensuring think family is well embedded
- Improved the content of local domestic abuse training according to the Domestic Abuse Act 2021, as such, the child is a victim; coercion and control being criminal offences and increasing recognition of the impact on the unborn, baby and child

- Set up a task and finish group to review and improve our process for Domestic Homicide Reviews so that they clearly include the impact on the child, when involved, ensuring the child's lived experience, wishes and feelings are captured and recorded
- Improved child protection medical processes which now also include family history information
- Improved the response rate, timeliness and quality of GP conference reports and virtual attendance
- Revised the strategy discussions protocol to invite key partners to enable an expert health voice and provide opportunity for professional challenge
- Implemented an alert on the child's, parents / carers and significant family members records (e.g. Health, Children Social Care and Police) when there has been a serious incident notification submitted to the National Panel. There is also ongoing work continuing to improve the information attached to the Integrated Care Record.
- Developed a multi -agency audit panel and tool to evidence the quality and impact of multi-agency working and learning
- Increased focus on postnatal period contacts and ICON (programme to reduce abusive head trauma) which has been rolled out across Staffordshire. Early recognition of adverse behaviour in infants and its distress meaning.
- Raised awareness of the National Forced Marriage Unit and its ability to support investigations in an advisory capacity
- Improved understanding of the need to information share when managing a person who poses risk to children (PPRC)
- Implemented a robust governance structure within policing to ensure that lessons are learned
- Delivered comprehensive training to understand the need to capture the child's voice
- Provided training for all child protection staff on the Child Safeguarding Review Process and the need for them to engage
- Improved staff understanding how to escalate when disagreements between partner agencies occur
- Shared briefings explaining the risk of domestic abuse and parental neglect to unborn babies

Barriers and challenges

During the Section 11 peer assessment day there were discussions that learning from both local and national reviews have remained consistent for many years and the challenge was to assess whether we are identifying the right themes, root causes and actions to embed learning at a local level.

One of the key barriers to embedding learning identified during the peer assessment day was staffing pressures. Sickness, turnover, unfilled vacancies and redeployment (during the pandemic) meant there were time and work constraints to complete and keep up-to-date with training. Staffing pressures was also thought to reduce the likelihood of staff having time to read and digest relevant learning. It has been recognised locally that organisational transformation has also had an impact on staff morale leading to difficulties with staff retention and productivity and therefore safeguarding practice could be affected. The CSPR sub-group welcomes the opportunity to raise these macro level issues with the National Panel that are beyond the control of the partnership and whilst present in some recommendations, are less likely to lead to positive impact.

In terms of monitoring and measuring impact, this has proven the most challenging to robustly obtain, especially long-term sustained change and measuring cultural change. Findings from single-agency/multi-agency audits, surveys, compliments and complaints, feedback from children, families or practitioners and self/peer assessments are often cited by partners as evidence to demonstrate the impact of embedding of learning. However, there remains a challenge in our collective ability to evidence that learning is being embedded to improve outcomes particularly at a multi-agency level.

Focus for 2023/24

- Further work to understand better the recurrent themes and how systemic they are within Staffordshire

- Ensure that our connections with strategic groups is developed further so that learning is communicated and understood more clearly so that it can be embedded into respective delivery plans

- Improve the way we monitor and measure impact of our embedded learning across the partnership

6.2 Learning form child deaths

The Child Death Overview Panel (CDOP) reviews deaths of all children and young people under 18 years resident in a specified area to learn what happened and why, whether there were any modifiable factors whereby local activity could prevent or reduce similar child deaths in the future. The local CDOP is made up from a range of partner agencies across Staffordshire and Stoke-on-Trent and an update is distributed to partners giving an overview of recent notifications and reviews with recommendations, learning points and any emerging themes. The CDOP also sends data to the National Child Mortality Database (NCMD) so that learning can be identified and shared at a national level.

During 2022/23 we saw a small reduction in the number of notifications of child deaths (79 compared with 93 notified the previous year) with neonatal deaths (deaths within 28 days of life) continuing to account for the largest proportion. Children from a white background had the highest proportion of deaths, reflective of the population. Of these notifications, 17 (22%) were categorised as unexpected requiring a joint agency response (JAR).

During the year 107 child deaths were reviewed in Staffordshire and Stoke-on-Trent. Of these 28 were considered to have modifiable factors with the most frequent themes being smoking and maternal obesity.

Our priorities for the year were to:

- Ensure that learning from child deaths is communicated to the workforce through a range of channels and used to inform training events
- Increase voice of parental feedback to inform learning
- Ensure reoccurring modifiable factors highlighted in reviewed deaths are raised and targeted locally
- Ensure there is a consistent death review process in place for low gestation babies.
- Ensure that recommendations from the suicide thematic review that was completed last year are embedded into relevant mental health workstreams.
- Seek assurance that the care and treatment of asthma for children and young people are compliant with NICE recommendations as a respond to local asthma child deaths.
- Ensure consistency across the hospital trusts in relation to the obtaining of the Kennedy samples as part of the rapid review process.

Owing to the regional and national trend following the relaxation of the clinical rules regarding “pills by post” this presents a significant safeguarding concern for the board due to the increasing impact on our communities. Staffordshire recently saw the first criminal conviction for such an offence which has been high-profile and heightened the political awareness of the issue. The Board are monitoring the impact of this national trend, raising awareness seeking to ensure professionals understand the shifting landscape, upskilling the workforce and ensuring fast time learning is shared timely as these incidents are reported and ideally prevented due to positive partnership engagement and increased awareness.

What difference have we made?

Some of the service improvements we have seen from recent learning includes:

- Use of an interpreter (e.g. language line) during booking or antenatal care. Awareness around language barriers and need for specialist services have also been promoted with staff
- Earlier intervention and recognition and response to a ‘grey’ baby . Learning has been shared with emergency services such as NHSEI (who are responsible for 111) and WMAS as well as the National Child Mortality Team in order to review pathways and processes
- Relaying of resuscitation status to family highlighted for service improvement

- Bereavement midwives are now informed and involved in implementation of the Advance Care Plan (ACP)
- Mothers for a subsequent pregnancy referred to the pre-term birth prevention clinic; advised for high dose folic acid pre-conception and monitoring of high BMI. They are also given advice on weight loss before pregnancy to improve outcomes for both mother and baby
- Discussion with the palliative care team whether it is possible for ventilator dependent children in PICU to be managed at home after discharge

Barriers and challenges

- CDOP identifies learning and improvement areas. However, as implementation often falls to another partner/partnership this poses challenges and risks to achieving desired outcome
- Some risk / procedural barriers to support out of area suicides
- Understanding the health inequalities and health disparities of those with individual characteristics and societal factors such as vulnerable or inclusion[4] health groups or those with protected characteristics[5]

Focus for 2023/24

- There is a healthy desire across CDOP for innovation, development, and learning. The CDOP co-ordinator is designing the Panel's first immersive child death training course that seeks to give all key CDOP members (and beyond) the opportunity to learn in a controlled immersive hydra experience. This will strengthen our response to child death. This will be the first course of its kind designed around the child death themes identified in the annual data to ensure relevance.

6.3 Review of Restraint

The **Review of Restraint Group** was established under the previous Local Safeguarding Children Board arrangements and have continued under the new safeguarding partnership arrangements to ensure compliance with Working Together 2018 in providing scrutiny of restraint. The group reviews whether staff in HMYOI Werrington are trained in behaviour and de-escalation techniques and ensure that appropriate monitoring arrangements are in place to oversee restraints of children, which ultimately provide assurance to the safeguarding partners that children are safe.

[4] for example, vulnerable migrants, Gypsy, Roma, Irish Traveller and Boater communities, people experiencing homelessness, offenders or former offenders, and sex workers

[5] under the Equality Act 2010 – the 9 protected characteristics are: age, sex, race, sexual orientation, marriage or civil partnership, pregnancy and maternity, gender reassignment, religion or belief, and disability

Most incidents of restraint are in a response to violence. All incidents of restraint are reviewed by the social work staff seconded from the local authority into the establishment and a selection are chosen for review by the Review of Restraint Group. Over the last 12 months the Review of Restraint Group has selected 20 incidents of restraint for scrutiny focussing on three types of restraint: pain-inducing, group assaults and passive non-compliance. All of those incidents demonstrated a sound knowledge of applying restraint appropriately and within the expected standards. The viewing of footage evidence that staff are competent and confident in their knowledge and skills in these types of restraint with no concerns raised by techniques or excessive force used in any restraints viewed.

The viewing of this footage has however raised some questions around staffing levels as it is evident that in some cases there has not been the facility to swap staff during extended restraints. Furthermore, it has been noted that a lack time out of their rooms may be a factor in many cases where restraints are used. These issues have been noted and form part of HMYOI Werrington's feedback to the Safeguarding Board's Scrutiny and Assurance group.

The Review of Restraint Group are also keen to invite representatives from local authorities whose children are involved in restraints to meetings in the future. The logistics of this are currently being devised. As a minimum the chair of the task group will contact the identified manager within the home local authority to inform them a restraint on a child from their area has been viewed by the task group and any factors/issues identified by the group will be shared.

What difference have we made?

In addition to the independent review of restraint, HMYOI Werrington have a number of other ways in which they provide assurance and learning opportunities to promote the safety of children. This includes:

- Daily triage of all uses of Minimising and Managing Physical Restraint (MMPR) and within 36 hours by a multi-disciplinary team. 40% of MMPR paperwork requires improvement to be of a reasonable or good standard. The MMPR team offer support and guidance to staff when completing use of force paperwork.
- Weekly risk management meetings (RMMs) where all uses of force are screened with good practice and/or learning identified and shared with staff to drive improvement. There is video evidence of instances where MMPR de-escalation techniques have been used to avoid the use of force, and the MMPR team have begun to compile and share examples of good practice.
- Monthly Use of Force meeting where trends and themes from data analysis of force data is shared. The number and rates of incidents have reduced significantly since the His Majesty's Inspectorate of Prisons' (HMIP) visit in September 2022. A new process to improve timescales for receipt of use of force paperwork is due to be introduced from June 2023.
- Weekly MMPR training with 78% of staff up to date
- Safeguarding Masterclasses
- Introduction of safety meetings

- Introduction of a Weapons Reduction Strategy in October 2022, which has proved to be effective and is understood by staff and children
- Training in personal protection techniques which delivered to all staff (operational and non-operational)

Staffordshire County Council and HMYOI Werrington have also developed a document that outlines responsibilities and practice guidelines for keeping children safe in custody which has been approved and published by SSCB.

The new Youth Custody Service (YCS) Safeguarding Policy is in the final stages of being ratified and from HMYOI Werrington, alongside all establishments will be required to produce their own Safeguarding Local Operating Procedure (LOP) during 2023/24.

Barriers and challenges

- Dedicated Social Workers (DSWs) - long-term absences and provision of cover has affected workload including delays in processing child protection referrals

Focus for 2023/24

- Children will be invited to become members of the core group so that their voices can be heard to inform learning and improvement

- Undertaking a training needs assessment, produced by the YCS and piloted at HMYOI Wetherby, to understand where staff are in terms of their safeguarding knowledge and confidence in undertaking their safeguarding duties. HMYOI Werrington staff have previously reported a lack of confidence in knowing these duties, including understanding of processes in making a referral and in what circumstances.

7 Summary

The Board's structure provides an effective mechanism for partners to raise constructive challenge, seek suitable assurances and work on agreed plans. We will continue to learn improve our safeguarding system and reflect any changes to our arrangements in line with Working Together 2023.

Despite the challenges of being a large and diverse County, partners have continued to work hard to deliver aspects of the business plan to improve outcomes for children and families. The greatest challenge that all agencies are facing is workforce capacity and therefore during 2023/24 the business plan will be reviewed and simplified to ensure all professionals engaged in the delivery of it are clear around the expectation and believe and own the content. As a partnership we will ensure the content of the plan is focusing us in on the parts of the system that we know are under the most pressure in relation to need for service and capacity to deliver and ensure there is a balance between the current issues with delivering against long-term priorities.

We have seen a number of improvements in areas identified through independent inspections of which some were similar to our CSPR findings across the system. However, we recognise that there are some areas which still require further improvement.

We also recognise that there is more work to improve how we use and share wider performance data within the partnership with a need to strengthen our multi-agency performance scorecard to ensure that it helps us monitor the progress we are making towards achieving our outcomes.

We also need to further increase our understanding of the child's journey and experience across the multi-agency system and how we assess and addressing inequalities. Further works is also needed to improve how we evidence impact and outcomes.