Annual Report

Staffordshire Safeguarding Children Partnership 2023/24 (FINAL DRAFT)

Contents

Foreword 3
1. Observations from the Independent Chair and Scrutineer 4
2. Neglect 6
3. Ensuring effective multi-agency safeguarding practice 7
Listening to children and families 7
Listening to practitioners 8
Safeguarding in education 9
Information sharing 10
Inspections 11
Training and development 12
4. Learning from the system 15
Learning from Child Safeguarding Practice Reviews 15
Learning from child deaths 17
Review of restraint 18
5. Our multi-agency safeguarding arrangements 19
Governance 19
Finance 21
Updates to arrangements 21
6. Summary 22

Foreword

Welcome to the 2023/24 annual report for Staffordshire Safeguarding Children Partnership (SSCP).

In June 2024, we have appropriately transitioned to a partnership approach as defined by the revised Working Together 2023 legislation. We have worked as a collective to review and develop our shared vision, mission and values with children being at the heart of this. The new arrangements will be published by December 2024 with all rebranding also set to completed by December 2024.

The work of the safeguarding partnership and its relevant agencies in Staffordshire is wide ranging. Each agency is working exceptionally hard to improve its services and care to the children of Staffordshire, but it is what we are doing together that is important here.

Through this annual report we shine a light on some of the partnership's key priority areas and the activity that is being undertaken and the difference it is making. We are clear on any further action needed to strengthen local safeguarding arrangements and how this can be approached.

The report aims to provide key stakeholders including members of the public and the wider community with a level of assurance and accountability about the impacts and effectiveness of local safeguarding arrangements in Staffordshire. As strategic safeguarding partners there is a commitment to offer challenge not only to ourselves but to our partnership system. We will continue to seek assurance that our safeguarding system and its arrangements are as safe as practicable and that our workforce feels supported and confident with children being listened to and heard.

We recognise that it is the commitment, dedication, care and passion our practitioners, at all levels, give to the children and their families daily that is at the heart of our arrangements, and we will seek to strengthen this work in 2024/25.

Neelam Bhardwaja
Director for Children and Families, Staffordshire County Council
(Note that Bernie Brown replaced Neelam Bhardwaja as the Director for Children and Families on the 1st July 2024)

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

Colin Mattinson
Detective Chief Superintendent, Staffordshire Police

Ian Vinall
Independent Chair and Scrutineer, Staffordshire Safeguarding Children Partnership

1. Observations from the Independent Chair and Scrutineer

In the summer of 2023, in my role as scrutineer, I undertook a series of face-to-face visits to safeguarding partners, schools, virtual meetings and one to one conversations with a cross section of staff from frontline practitioners to senior leaders. The purpose of these visits and meetings was to assess the effectiveness of the safeguarding arrangements in Staffordshire. I visited colleagues across the county, in their geographical locations and had the opportunity to truly understand their roles, responsibilities and functions in the safeguarding system. I cannot thank all those staff enough for their candidness, insights, honesty, and reflections on the safeguarding system across Staffordshire.

There was much to be celebrated in those conversations. The passion, commitment, and sometimes sheer joy of working with children and young people shone through those conversations. Some practice was inspirational and had a significant impact on the outcomes for children. There was some very positive evidence of partnership working in district offices with a range of partners coming together proactively to address risk and need. There was much to be celebrated.

The work of the safeguarding partnership's Scrutiny and Assurance group, with emerging maturity, is providing some effective challenge and support into the safeguarding system and has been key in driving some improvements into the wider system. These delegated arrangements have worked well. To improve further the lead[1] safeguarding partner and their delegated safeguarding partner need to clearly set the vision and direction of the partnership and agree focusing on a smaller number of refreshed priorities with clear outcomes for children and young people, coupled with good multi-agency data that reflects the system.

The current priorities of the partnership are reflected in this annual report with a mixture of positive outcomes achieved coupled with more work to do. Reflecting impact on the outcomes for children and young people remains a challenge yet positive work is highlighted including the development of the Learning Hub focusing in on one practice area for a thorough assessment of its effectiveness with key learning from the experiences of children and young people.

This positive work was balanced against the many challenges faced by safeguarding professionals across the system, not unique to Staffordshire, yet impacted their ability to carry out effective practice. Staffing capacity, resources, case complexity and at times the sheer volume of work, presented challenges to staff working on the frontline. These issues have also been reflected in some children's situations where partnership working has been challenging and at times ineffective. Those children have been brought to the attention of the delegated safeguarding partners and I would encourage more opportunities to hear the voices of children and young people at the partnership meetings.

These conversations, together with the review of data and information provided by safeguarding partners and the wider safeguarding system, enabled an assessment of the effectiveness of the arrangements, provided to the safeguarding delegated partners in

[1]As defined in Working Together 2023 Chief Executives of Local Authorities, Chief Executives of the ICBs, and Chief Officers of police forces.

October 2023. This assessment from a wide range of perspectives made a series of recommendations which has reflected much of what has been written in the Working Together Statutory Guidance published in December 2023.

In summary, I recommended a 'refresh' of the safeguarding arrangements, with the lead safeguarding partners taking more of a strategic oversight role of the arrangements, including the independent chair and scrutineer of the partnership reporting directly to them. It is vital that the strategic leaders are seen as working as a team. The term partnership is key, language is important and with that in mind, a reframing of the arrangements to reflect the term 'safeguarding partnership' is needed.

The partnership's collective vision needs to be refreshed, helping all staff from across the partnership understand the role and functions of the safeguarding partnership and how together the three statutory partners drive improvement and address emerging challenges in the system together and not in silos. In this context, it is crucial for the partnership to hear the voices of children, young people and frontline staff alongside effective multi-agency data that underlines the practice challenges and emerging issues.

The assessment highlights the refocus on the partnership priorities which reflect current practice challenges in the system and is robust enough to manage the emerging issues. Having a clear line of sight of frontline practice is key.

Statutory inspection frameworks in the last 12 months across the safeguarding system have presented some challenges to agencies, teams, services, and safeguarding partners with a number of agencies having to present action plans and reporting to their statutory regulator. Although the partnership should seek assurances that those plans are effective, it requires proactive relationships with those bodies accountable for those services to avoid duplication and clarity of responsibilities.

The funding of the arrangements has remained unresolved and the partnership cannot continue to rely on reserves to fund the arrangements. With the suggested refresh of the arrangements, vision, priorities and together with the engagement of the chief officers, this will hopefully be resolved.

In November 2023, the inaugural safeguarding partnership children's conference was held with school children attending for the day with their teachers and support staff focused on 'trusted adults'. The strapline of 'talk so kids will listen and listen so kids can talk' was reflected in an excellently arranged and facilitated session. The recommendations were presented to the delegated safeguarding partners and will feature in ongoing safeguarding training. This will now become an annual event.

The suggested refreshed arrangements, together with the implementation of Working Together 2023 provides a real opportunity to progress the safeguarding arrangements in Staffordshire where partnership is embedded across the system and children and young people are prioritised in strategic priorities across the safeguarding partnership and wider partners.

2. Neglect

Neglect continued to be a priority for the Partnership 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] Neglect featured in 73% of child protection plans in Staffordshire during 2023/24.

One of the key objectives in the Partnership'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. During 2023/24 we have:

- met regularly with key strategic partnerships to implement our local protocol;
- translated the learning from reviews into evidence-based activities within the delivery plan of the Early Years Advisory Board (EYAB);
- seen an increase in the numbers of women who have access to community perinatal mental health (PMH) teams across the County;
- helped and supported practitioners through the Early Years Safeguarding Forum;
- continued to provide free training on how to hear the voice of the child, 'With or without words' with positive feedback from those who have attended training.

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 the evidence-based Graded Care Profile (GCP2) tool to improve our response to neglect. The GCP2 assessment tool came into service wide operation in April 2021.

At the end of March 2024, across Staffordshire and Stoke-on-Trent we have:

- trained almost 1,900 practitioners to become licensed to use the GCP2 tool across a range of settings including education, health and children social care;
- completed over 500 GCP2 assessments;
- seen an increase the knowledge and confidence levels of practitioners undertaking GCP2 training;
- evidence through the practitioner survey of a confident workforce with a high proportion of our practitioners say they are able to identify, evidence and respond to neglect;
- planned a multi-agency audit for 2024/25 to understand the impact of GCP2 and other tools practitioners use to identify and respond to neglect.

It is important to recognise that GCP2 is one tool in a practitioner's toolbox and it is critically important that this and other tools are used to help identify and respond to neglect so that children in the earliest years can achieve the best outcomes.

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

3. Ensuring effective multi-agency safeguarding practice

As part of our core business, the focus of this overarching priority is to demonstrate and provide assurance that there is a multi-agency approach to our safeguarding practice which is effective in key areas such as listening to children, families and practitioners. This priority is implemented and/or monitored through our structure and sub-groups. The structure allows us to identify learning; embed improvements at both individual and multi-agency level; identify emerging risks; and understand systemic issues which need policy and practice changes to address.

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. Whilst we acknowledge that gaining feedback from children can sometimes be challenging; we are seeing year on year improvements. Some examples of the work we have done this year include:

- Launching the Staffordshire Co-production Promise across the Partnership which will help improve practice and drive a culture change so that children and families who need help and support are continually placed at the heart of all decision-making aiming for them to receive a better experience as well as improved outcomes. Good examples of co-production in practice is the review of access to children and young people mental health services. We are also starting to see evidence of challenge between partners when co-production has not been utilised. Having led the development of the Co-production promise and toolkit, Staffordshire Council of Voluntary Youth Services (SCVYS) are now leading a Task and Finish group to embed the approach across the area. Organisations as well as individual managers and practitioners can pledge their commitment here.

- Undertaking a self-assessment quality assurance exercise, using a tool which was developed by SCVYS, to assess how well we listen and engage with children. The assessment provided assurance and identified good practice particularly around systems and processes, for example our health providers all having user engagement groups for children and young people which feed into service review and development. We have also identified some challenges in the system such as: engaging with 'seldom heard / hard to reach' groups; resources and capacity; accessibility of engagement activities for both children and parents/carers (days, times, formats, venues and tools). The self-assessment found that children were not always involved from the start, and it was sometime unclear how the collected voice of children would influence change and impact on intended outcome both for participants and the wider community. The exercise also revealed that further work needs to be done to ensure that strategically we are better coordinated and aligned across the Partnership. Overall, we were assessed as operating lower on the ladder of participation than we would want (consulting and informing) but are pleased to be on the journey to move up the ladder through the co-production approach.

- Holding the Partnership's first Children's Conference, 'talk so kids will listen and listen so kids can talk', to hear the views, thoughts and opinions of school children aged 10-16 about trusted adults. The conference, attended by 72 children, creatively explored a range of activities where the children could be active participants rather than passive attendees. The range of activities were designed to engage different parts of the children's brains and styles including activities that used writing, drawing and/or creative techniques as well as discussion activities. All activities were informed by gender neutral references in order to eliminate gender bias at the event. The event was supported by the Voice Project, Staffordshire PSHE Education Service, SCVYS, Staffordshire Education Safeguarding and Advice Service (ESAS) and representatives from the Safeguarding Business Team. Recommendations from the conference have been signed off by the Partnership and shared with partners in order to affect work force development and service delivery based on the child's voice.

At an operational level, our survey found practitioners were confident and able to describe how they ascertained the child's voice and lived experience with many able to describe a variety of tools and techniques they used. Audits of health and care plans evidence them being goal-based; focus on the child wishes and feelings in decisions and involvement in decision making about their care. We have also seen a significant increase in the proportion of how the voice and lived experience of the child is captured in Public Protection Notices (PPNs). Outcomes for children are captured via individual case studies.

At a strategic level, we also agree with the Independent Chair and Scrutineer about having more opportunities to hear the voices of children at partnership meetings.

Listening to practitioners

The Partnership is committed to working together to ensure practitioner feedback is consistently used to inform our improvement and development plans so that services for children and families in Staffordshire remain of a high standard.

Partners report many opportunities to collect feedback including supervision, team meetings, regular practitioner forums and drop-ins. Some examples of the work we have done this year include:

- Holding a number of multi-agency practitioner events across the County. This includes holding eight early help networking events (one in each district) to connect people to early help activities across their patch. We have held practitioner forums and used this to influence feedback in partnership meetings e.g. reflecting back to partners that education partners did not feel their views were treated equally to other partners.

- Collating the views and experiences through a practitioner survey across the Partnership to seek further insight into some of our priority areas. The findings from these have been used to evidence impact throughout this report and have also fed into relevant sub-groups.

We have also commenced with a pilot of our Learning Hub model, which is built on good practice in the London Borough of Bexley. The approach involves learning and improvements to be practitioner-led and provide opportunities to learn, share and reflect as a multi-agency group.

We have chosen one of our quality assurance priorities, child exploitation, as the first theme for our Learning Hub with the agreed outcome being "*using the voice of the child to gain an understanding of their experience as they journey through the system in order to improve outcomes for children and young people*" which was one of the areas we identified as a challenge in last year's annual report.

We have agreed a delivery plan; completed a scoping exercise which collates existing information and started to explore good practice and challenges within the system of how practitioners and operational managers across the Partnership listen and understand the voice of children who are at risk of or experiencing criminal or sexual exploitation or go missing. The next stage is to engage directly with children with the support of a young person who has experienced exploitation and is acting as our critical friend. The findings from the learning hub will feed into the child exploitation and missing strategic group and help inform the revised strategy and outcomes.

Initial feedback from colleagues who have participated in the learning hub has been positive. We will include more detailed findings from the learning hub in next year's annual report.

Safeguarding in education

The County Council's Education Safeguarding Advice Service (ESAS) through their highly trained education safeguarding advisors provide a free and central point of contact for all education settings. They provide safeguarding advice and information to education settings across Staffordshire to enhance their safeguarding practice. The intention of ESAS is to empower educational practitioners to make informed decisions. They also provide support with referrals and help schools navigate professional challenge and the escalation process.

Education safeguarding leads from ESAS deliver termly designated safeguarding leads (DSL) briefings as well as a series of focussed drop-in sessions (topics have included forced marriage, learning from child safeguarding practice reviews and child deaths). They also mentor new headteachers from a safeguarding perspective as well as newly appointed DSLs. Education safeguarding leads also undertake free school safeguarding reviews.

ESAS deal with Ofsted complaints providing support and challenge to schools to ensure that appropriate policies and practice are in place and that appropriate actions have been taken. Dealing with these complaints enables us to identify strong practice as well as areas for improvement. Learning from Ofsted complaints informs training and the content for drop-in sessions.

ESAS also continue to strategically lead the Partnership's annual Section 175/157 safeguarding audit. All education settings (maintained, academies and independent schools) are expected to complete this. In 2022/23, 96% of educational settings completed the audit with one academy trust not engaging in the process and as a response the Partnership revised their published arrangements to clarify the local authority's expectations to all schools and academy trusts.

The information from the Section 175/157 audit provides a way of monitoring the strength of safeguarding in schools and assurance to the Partnership. The findings are also shared with education settings as well as a range of other partners. The audit allows ESAS to identify areas of strength and areas for development across the County. The analysis also informs ESAS training, provision of resources, school support and communications. During 2023/24 the analysis from the audit was used to undertake a targeted piece of work with schools trying to understand when and why escalations did not achieve a satisfactory conclusion.

Information sharing

We know that timely and effective sharing of information *"is essential for early identification of need, assessment and service provision to keep children safe"* (Working Together 2023).

During 2023/24 we reviewed and updated our information sharing agreement which covers the sharing of data and information about children to protect children from abuse and harm.

Our practitioner survey found that almost all respondents were confident in sharing information about a child or family. Some of the barriers they cited to sharing information were consent, data protection and General Data Protection Regulation (GDPR). Respondents were also generally confident in seeking information that wasn't readily available. Some of the barriers to seeking out information that wasn't readily available were time and capacity; knowledge of where to find it; information sharing by others; being able to contact appropriate professionals and organisations; and policies and procedures of other organisations.

Since 2011, partners have had co-located multi-agency arrangements for sharing information. This provides opportunity for shared understanding, risk management and multi-agency decision making. There is good multi-agency attendance at strategy meetings, for example the Staffordshire and Stoke-on-Trent Health Safeguarding Collaborative are able to evidence attendance and appropriate information sharing to 98% of strategy discussions they are invited to.

Attendance at child protection case conferences had been raised as a concern in 2021/22, particularly in terms of police attendance at the initial child protection conference (ICPC). This is a much-improved picture with police attendance consistently at or above 96%. Health professionals also attend 94% of all child protection case conferences they are invited to.

We are also one of a small number of local areas who have nightly uploads of data into a data warehouse. We have included for the first-time health data in our Family Identification Operation (FIDO) system. There are now 72 indicators in this system to help practitioners identify the people working with families.

We however recognise as a partnership that we could be more effective at sharing information earlier when concerns first arise, enabling a proportionate and appropriate level of help and support to children and their families at the earliest opportunity. Partners are working hard to embed district-level processes that allow this to take place consistently as part of the implementation of Family Hubs and we will be excited to report on the progress made in next year's annual report.

Inspections

Inspections continue to provide us with an independent assessment of our safeguarding arrangements. They are one of many mechanisms we use to help us understand what is working well and where improvements are needed. During 2023/24 we had a number of inspections published including:

- Royal Stoke University Hospital Maternity Services; University Hospitals of North Midlands NHS Trust (inspected March 2023; published June 2023)
- Staffordshire Police national child protection re-inspection (inspected March 2023; published August 2023)
- HMYOI Werrington (inspected July to August 2023; published November 2023)
- Queens Hospital Maternity Services, University Hospitals of Derby and Burton NHS Foundation Trust (inspected August 2023; published November 2023)
- Staffordshire Youth Offending Services (YOS) (inspected September 2023; published December 2023)
- Inspection of Staffordshire County Council local authority children's services (ILACS) (inspected November 2023; published January 2024)
- Ivetsey Bank Hospital (inspected January 2024; published March 2024)

The findings from these inspections identified a number of improvement areas for either individual organisations or across the Partnership with SSCP having oversight of improvement plans. Some of the areas identified across the area include: staff capacity; listening to children, service users and practitioners; effective leadership and governance; professional challenge and escalation; effective assessment of risk and need; management oversight and supervision; staff training and development; data and information sharing; performance and quality assurance processes; effectiveness of partnership working; and equality, diversity and inclusion. Some of these improvement areas are also recurring themes seen from Child Safeguarding Practice Reviews.

A Strategic Children Improvement Board has also been set up in response to the local authority inspection to ensure that Partners help drive improvements.

Training and development

During 2023/24 the Partnership commissioned and delivered a range of multi-agency training to almost 7,600 colleagues from a range of agencies (Figure 1). The Partnership's training programme complements single-agency training and is based on a combination of mandatory and thematic training based on strategic priorities and learning from the system. The Partnership also offer additional learning resources to the workforce.

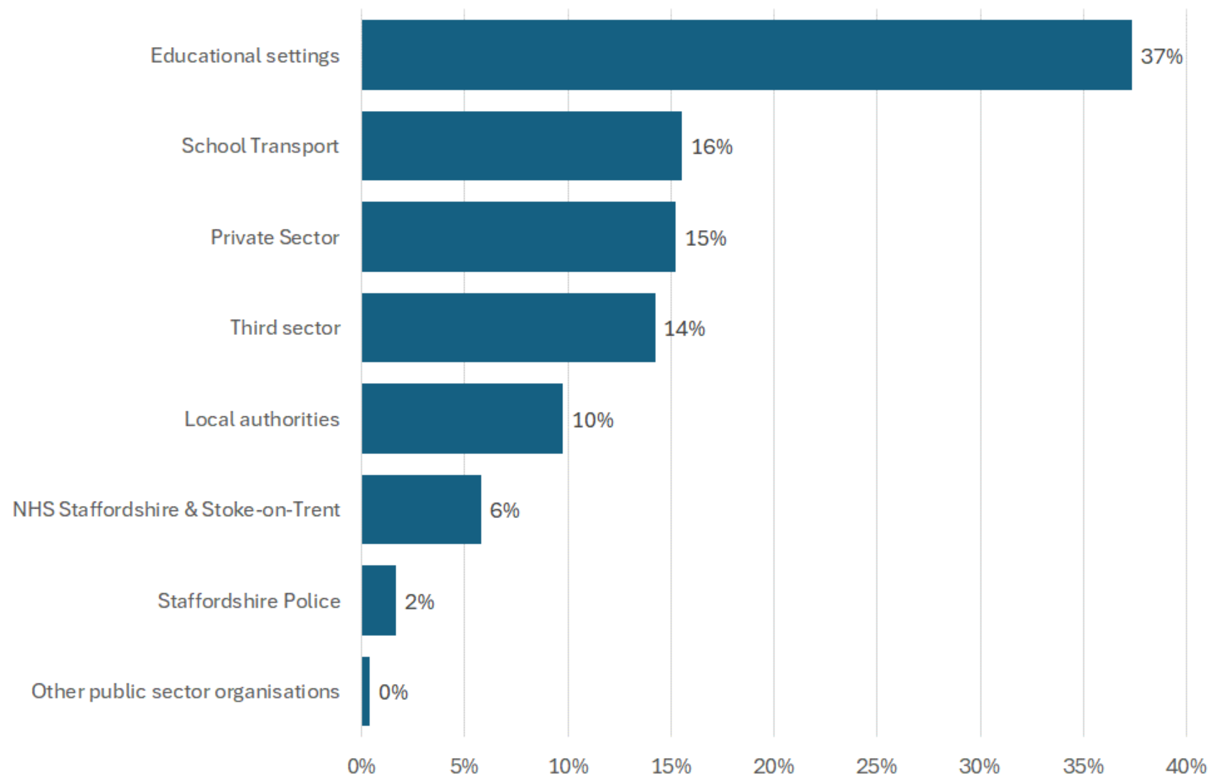
Thematic training that was offered during the year included: adverse childhood experiences (ACEs); domestic abuse; early help; e-safety and Darknet; forced marriage; front door; GCP2; managing allegations of abuse made against a person who works with children; Operation Encompass; persons posing a risk to children (PPRC); safer sleep; unintentional injuries among children under five and With or Without Words. The Partnership also offer various levels of mandatory safeguarding training to support education, private, independent and voluntary sectors to ensure their workforce are compliant with training.

Following a move to online training during the pandemic, the Partnership 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.

All multi-agency training includes pre- and post-course evaluation that demonstrates increases in knowledge and confidence. Colleagues and line-managers are also asked to feedback on how they have used their training at three months to demonstrate impact.

The practitioner survey also evidences that most practitioners are confident in the Partnership's quality assurance areas, i.e., early help, domestic abuse and child exploitation with respondents confident in recognising and identifying signs. However, many respondents said they would like more information on understanding referral pathways and how to access appropriate support for children in these areas as well as more practical/hands-on training alongside more shadowing and mentoring opportunities.

Figure 1: Attendance at SSCP training and e-learning courses by organisation type, 2023/24



Feedback post training

"Feeling more confident when a safeguarding matter arises and how best to deal with the situation holistically, listening to not only the voices of the family but having a real emphasis on listening to the voice of the child and their thoughts/feelings to gain a better understanding to achieve a more positive outcome"

"Understanding the process has given me knowledge and confidence to make appropriate referrals and protect children"

"I am currently working with a family where both parents have a level of learning needs as have the children. I feel the [GCP2] tool will be invaluable to support changes as it is visual so parents can see the progress made in simple terms and where extra help is needed"

"Improved understanding and awareness of the process for local CSPRs, and how reviews can improve practice overall, particularly in relation to information sharing and the ways in which agencies work together to keep children safe from harm"

"I became more aware that even if there was social care involvement in a families' life, didn't mean that anyone should take a step back. To ask questions and be curious. The real-life case study enabled me to reflect on my own approach, very powerful."

In addition to the multi-agency training offer, partners offer single-agency training programmes to ensure their workforce are compliant with mandatory safeguarding as well as learning from the system. This is an area where further work needs to be undertaken to ensure that the Partnership and senior leaders are routinely sighted on compliance levels of the workforce across the area as well as the impact of both single and multi-agency training.

During 2023/24, partners also offered training above and beyond the mandated safeguarding training programmes to their workforce. Examples include:

- the health economy coming together to host a variety of training events through lunch and learn sessions where an average of 300 health professionals from across the system attended each session. These sessions included several national speakers and subject matter experts such as Jan Howarth (child neglect), Lads Like Us (trauma-informed practice) and Nicole Jacobs (impact of domestic abuse). During the annual safeguarding children awareness week the health economy also covered a variety of subjects including child exploitation, non-accidental injury and children as victims of domestic abuse.

- Staffordshire Police hosting five 'vulnerability' training days in collaboration with the National Society for the Prevention of Cruelty to Children (NSPCC). Over the course of the five sessions over 700 front line staff attended. The day was designed based on feedback from staff following previous deliveries. The day centred around all types of child sexual abuse, and featured inputs from The Holly Project (lived experience) and case studies bringing together learning from previous child safeguarding practice reviews along with inputs on online investigation and harmful sexual behaviour.

4. Learning from the system

This section reports on the three sub-groups which have delegated responsibility to oversee learning for the Partnership.

Learning from 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 Partnership to oversee reviews and to report to the national Child Safeguarding Practice Review Panel on learning and progress made in line with Working Together 2023.

In 2023/24, the rate of serious incident notifications in Staffordshire remained similar to the national average. We undertook six rapid reviews during the year of which one has led to the commissioning of a local CSPR. We also published three CSPRs (two on intra-familial sexual abuse and one on potential forced marriage). There are three CSPRs that have been completed and are awaiting publication due to ongoing criminal proceedings. There are also two additional CSPRs that are currently underway.

Learning identified include some recurrent themes as well as some new findings: professional curiosity (critical thinking and good risk assessment); professional challenge and escalation; management oversight; multi-agency approach to identifying and managing risk of significant men; recognition and response to intra-familial child sexual; timely exploration of historical offences, voice of babies and children and understanding their lived experience; cultural bias; understanding and responding to potential forced marriage; embedding of a whole family approach; information sharing; cross border working; and the impact of domestic abuse on the child. Many of these themes are similar to recurrent themes/ learning within the National Panel's annual report. Learning from local and national reviews are used to help identify local priorities and also to develop activities within the sub-group's workplan.

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 / Partnership newsletters, social media, organisation and/or Partnership's website and intranet; team meetings; multiple staff or member learning briefings; mandatory training; development sessions or learning events such as the local authority and ICB's lunch and learn events or learning events which bring together different health professionals from across our system to learn together; and reiteration through learning and development events during national safeguarding awareness week. Many of the messages are also reiterated during individual or group supervision. Learning from reviews are also fed into relevant strategic partnership groups such as the Maternity Transformation Board (MTB), Early Years Advisory Board (EYAB) and Domestic Abuse Development and Commissioning Board (DADCB) through members of the CSPR sub-group who sit on these groups/sub-groups although there is recognition that this area needs further strengthening.

As a partnership we recognise we need to do more to ensure that learning is reaching the front-line with our practitioner survey finding that one in five respondents (21%) were unaware of any learning identified during the last 12 months ranging from 15% in health to over 40% in youth offending services and police.[3] The CSPR sub-group will be looking into ways to improve the reach as part of their workplan for 2024/25.

Following a CSPR, action plans are developed and agreed by the review team which are then subsequently monitored through single-agency plans and processes. The impact of these action plans are brought together by the CSPR sub-group to provide assurance to the Partnership that learning is being embedded within the Partnership.

Some of the impact we have seen from recent action plans include:

- overall increase in engagement in existing services and home visits which has led to increased child visibility

- voice and lived experience of the child more evident, for example within PPNs which had led to improved decision-making

- improved information sharing, for example evidence that the GP protocol has seen a significant increase in the number of child protection conference reports returned; health attendance at core groups has also improved

- enhanced knowledge and understanding around bruising in non-mobile babies, the links between development and neglect

- increased confidence in the whole family approach

- improved understanding of the significance of family history

- improvements in domestic abuse referrals and pathways, for example we have evidenced high levels of confidence in recognition of the impact of domestic abuse on children; improved accurate referral pathways and alerts for those heard at multi-agency risk assessment conferences (MARAC) and domestic abuse ambassador in post within the ICB

- evidencing increased knowledge and confidence in recognising signs and responding to child sexual abuse in the family through feedback from Partners and through our practitioner survey (circa. 60-70%)

- marked increase in knowledge of ‘person posing a risk to children’ (PPRC), offender management and probation

[3] Between June and August 2023, as part of the CSPR sub-group’s workplan we conducted an online survey of practitioners from across the partnership who directly work or provide support to children and their families. The survey was completed by 306 practitioners across the County with almost three in five of these working in early years, educational and health settings. The findings therefore may not be reflective of other agencies where there were smaller number of respondents.

- increased confidence in disguised compliance and professional curiosity

- better understanding of individual partner roles and responsibilities leading to improved multi-agency relationships; over 90% of practitioners feeling confident in their ability to challenge a decision either by another professional or a family member and feeling supported to do so by their manager and/or organisation

We continue to look at different ways to strengthen how we individually and collectively better evidence the impact of learning from across Staffordshire, for example the health safeguarding collaborative have developed a quality assurance framework to identify themes within health safeguarding practice and to strengthen evidencing impact of learning from reviews as a health economy.

Learning from child deaths

The Child Death Overview Panel (CDOP) reviews deaths of all children under 18 years resident in the 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 with updates distributed regularly 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 2023/24 we saw an increase in the number of notifications of child deaths in Staffordshire (64 compared with 51 notified the previous year). Neonatal deaths (deaths within 28 days of life) continue to account for the largest proportion (50%) with 19% of our child deaths occurring in teenagers aged 15-17. Children from a White British background had the highest proportion of deaths, reflective of the population. Of these notifications, 24 (38%) were categorised as unexpected requiring a joint agency response (JAR).

During the year 40 child deaths were reviewed in Staffordshire. Of these 17 were considered to have modifiable factors with the most frequent themes being:

- Smoking
- Maternal obesity
- Alcohol / drug use by parents/carers
- Service provision including access to appropriate and/or timely services
- Unsafe sleeping environment

We continue to implement improvement activity against our recurring modifiable factors through our campaigns and communication channels such as newsletters, posters and briefings to a wide range of partner agencies. We have also continued to support multi-agency training such as promoting safer sleep and sharing information around unintentional injuries and hazards such as hot water bottle scalds and button battery awareness.

Our CDOP nurse practitioners also capture the feedback from parents for sudden deaths which informs our learning. We have also worked with other strategic groups across the area to ensure that learning from reviews are included within delivery plans, this include strategy groups such as infant mortality, suicide prevention, alcohol reduction and asthma care.

Review of restraint

The Review of Restraint group was established under the safeguarding partnership arrangements to ensure compliance with Working Together in providing scrutiny of restraint. The group reviews whether staff in His Majesty's Young Offenders Institution (HMYOI) Werrington are trained in behaviour and de-escalation techniques and ensures that appropriate monitoring arrangements are in place to oversee restraints of children to provide assurance to safeguarding partners that children are safe.

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 group has selected 15 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 this footage evidences that staff are generally competent and confident in their knowledge and skills in this area of work. There have been no concerns raised by techniques or excessive force used in any restraints viewed. During restraints there is good use of communication with the child in questions with de-escalation techniques used although there are some incidents where earlier de-escalation may have been possible.

However, the viewing of this footage has evidenced that there are certain physical weaknesses in the estate which are not unique to Werrington. This includes hotspots within the establishment where incidents are more likely to occur. It has also been noted on viewing these incidents that it has been too easy at times for young people to cause damage to doors and windows and gain access to other young people for the purpose of violence. The group are assured by HMYOI Werrington that these issues are being addressed, and areas of concern have been highlighted and work to make these secure has been undertaken.

Alongside the quarterly review of restraint meetings HMYOI Werrington was subject to an Independent Restraint Review Panel visit on 22 February 2024. Representatives from Staffordshire County Council engaged in this visit and offered feedback on their roles and findings from their quarterly reviews. The visit included meeting with young children, all but one had been restrained at least once. Some of these children were also involved in the restraints which were subsequently reviewed by the Panel. The Panel identified a number of issues for consideration for the Youth Custody Service (YCS) and HMYOI Werrington. There is also one case that is currently awaiting review by the Crown Prosecution Service (CPS).

The Independent Chair and Scrutineer has also met with the YCS to identify opportunities for shared assurance arrangements. This includes working alongside colleagues from Oakhill Secure Training Centre (STC) to share assurance arrangements and peer assessment.

5. Our multi-agency safeguarding arrangements

In line with Working Together 2023, this year's annual report includes a section on the functioning and structure of the multi-agency safeguarding arrangements including a breakdown of costs for delivery of these arrangements.

Governance

The structure of our partnership allows for representation and input of partners at both the operational and strategic levels of the arrangements. Our Partnership is made up of the three statutory safeguarding partners: ICB, local authority and police. We also have an Independent Chair and Scrutineer. The Staffordshire County Council's cabinet member for children and young people also attends the Partnership as a participating observer. The Partnership met nine times during 2023/24 with the attendance of delegated safeguarding partners (DSPs) shown in Table 1. A deputy DSP attends Partnership meetings to ensure quoracy and decision-making when DSPs are unable to attend.

One of the Partnership meetings was held at HMYOI Werrington which provided a good opportunity for DSPs to meet some of children and discuss issues of safety and restraint.

Table 1: Attendance by Delegated Safeguarding Partners at SSCP meetings, 2023/24

	Number	Percentage
Staffordshire and Stoke-on-Trent Integrated Care Board (ICB)	7	78%
Staffordshire County Council	5	56%
Staffordshire Police	5	56%

Note: An acting delegated safeguarding partner was appointed on behalf of the ICB between September 2023 and January 2024.

The Scrutiny and Assurance (S&A) group oversees the delivery of the Partnership's business plan and ensures there is multi-agency oversight of service and programme areas delivered to children across the partnership landscape. The group regularly invite members of the wider partnership to present on service or programme areas for children. The S&A group met seven times during 2023/24 with attendance of the named representative shown in Table 2. A deputy representative will usually attend to represent the three statutory partners to ensure continuity and quoracy.

Table 2: Attendance by named Partners at Scrutiny and Assurance meetings, 2023/24

	Number	Percentage
Staffordshire Police (Chair)	4	57%
Staffordshire Police / Chair of CDOP	3	43%
Staffordshire County Council / Wellbeing and Partnerships (Vice Chair)	6	86%
Staffordshire County Council / Children Social Care	5	71%
Staffordshire County Council / Education Safeguarding Advice Service	5	71%
Staffordshire and Stoke-on-Trent ICB / Strategic Lead	5	71%
Staffordshire and Stoke-on-Trent ICB / Designated Nurse / Co-Chair of CSPR sub-group	5	71%
Staffordshire and Stoke-on-Trent ICB / Designated Doctor	3	43%
Children and Family Court Advisory Service (CAFCASS)	0	0%
HMYOI Werrington	6	86%
Probation	4	57%
Staffordshire Commissioner's Office for Police, Fire & Rescue and Crime	6	86%
Staffordshire Council of Voluntary Youth Services (SCVYS)	6	86%
Youth Offending Service	2	29%
SSCP / Partnership Boards Manager	6	86%
SSCP / Independent Chair and Scrutineer	4	57%

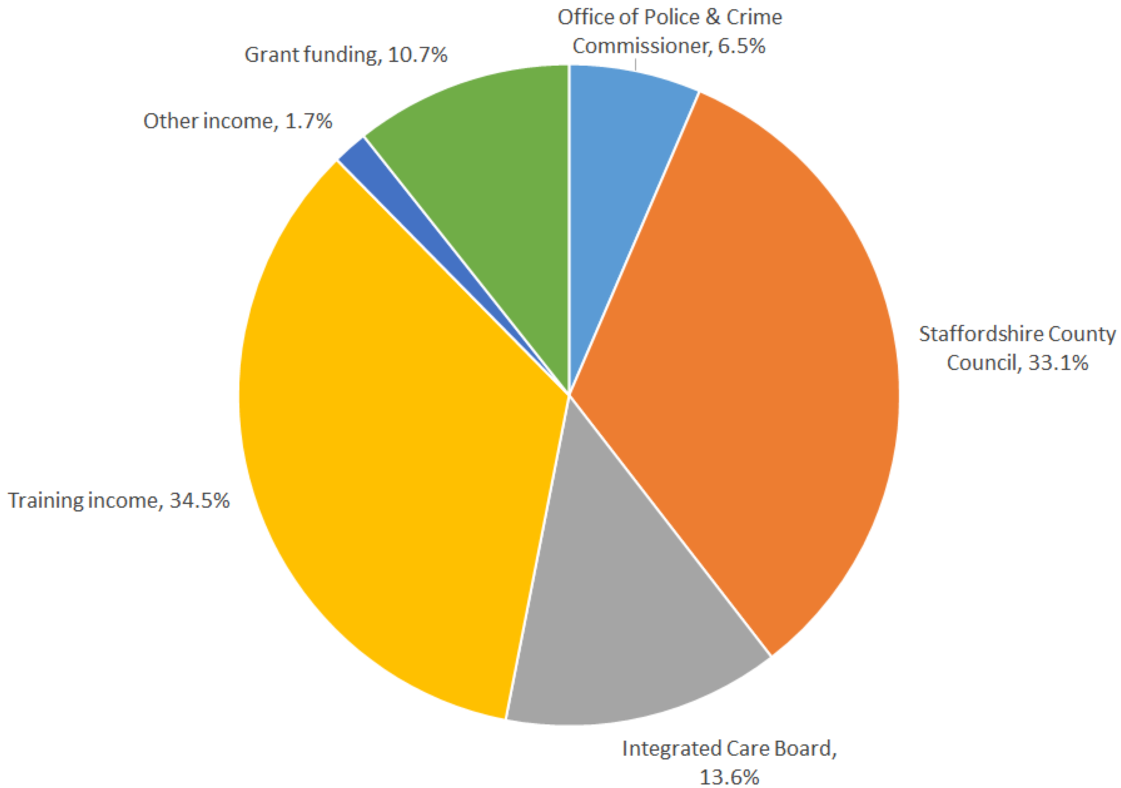
There are over 400 educational settings within Staffordshire. The County Council's Education Safeguarding Advice Service (ESAS) continue to be key in providing a voice for educational settings to safeguarding partners and are represented within the structure of the partnership at both strategic and operational levels, for example the ESAS's School Improvement Officer attends the S&A group and is a co-lead for the listening to practitioners' workstream within the Business Plan. Education safeguarding leads also attend a range of multi-agency meetings within the Partnership's structure such as the CSPR sub-group and Learning Hub and also attend other multi-agency groups such as the Prevent Board and Channel Panel. In September 2023, ESAS also organised a conference that was attended by over 300 education settings and a series of local and national agencies to engage with the sector.

The latest Childcare Sufficiency Annual Report reports there are around 830 private, voluntary, and independent (PVI) childcare providers across the County. The Early Years Safeguarding Forum, developed in collaboration with the sector, provides practitioners access to help and support. 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. We recognise that further work needs to be done to ensure that we engage with the sector in our new arrangements.

Finance

During 2023/24 the Partnership had an income to deliver arrangements of over £443,000 with almost 35% coming from training. The contribution from individual partners was 53%, with a third coming from Staffordshire County Council (Figure 2).

Figure 2: Income for delivering arrangements, 2023/24 (n= £443,245)



In addition to financial contributions, partners contribute to delivery of arrangements in a number of ways such as chairing of sub-groups and rapid reviews, development of workplans, contributing to performance and quality assurance activities including multi-agency audits, learning and improvement activities and delivering multi-agency training. For example, education safeguarding leads in the County Council's ESAS team review the SSCP Level 1 and Level 2 Working Together slides. They also deliver Level 3 and Graded Care Profile (GCP2) training.

The majority of spend during 2023/24 was on staffing costs of the business team to support the Partnership's arrangements (83%) with almost 8% of expenditure on commissioning CSPRs. The remaining expenditure is on administrative costs such as the website and licensing.

Updates to arrangements

In August 2023, the Partnership's published arrangements were updated which made clear the local authority's expectations for all schools and academy trusts in relation to the Section 175/157 audit. These changes are supported by Working Together 2023. We also made some factual changes to our published arrangements during the year. In line with Working Together 2023, the Partnership will be publishing their new arrangements by December 2024.

6. Summary

Despite the challenges of being a large and diverse County, partners have continued to work hard to deliver aspects of the business plan and improve outcomes for children and families.

We have already started to see a number of improvements in areas identified through independent inspections and learning across the system and started to address some of the challenges we identified in last year's annual report such as better connecting learning to other strategic boards and improved recruitment and retention of staff. However, we recognise that there are some areas which still require further improvement. We need to continue to increase our understanding of the child's experience across the multi-agency system and ensure that the Learning Hub model is embedded to allow us a greater line of sight to front-line practice. Further work is also needed to improve how we evidence impact and outcomes.

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 dataset to assess equality throughout the child's journey in the system. We also need to review and update our quality assurance framework to ensure that it helps us monitor the progress we are making towards achieving our outcomes.

During the year we have continued to learn and improve our safeguarding system with the Partnership's structure providing a mechanism for partners to raise constructive challenge, seek suitable assurances and develop, agree and work on plans. We are planning two development sessions with key partners in Spring 2024 to reflect and review our arrangements. One of these sessions will be facilitated by a National Safeguarding Partner Facilitator.

Given that one of the greatest challenges that all agencies are facing is workforce capacity, we also plan to review the current business plan and simplify and focus on a smaller number of priorities. These priorities will be reflected in our updated arrangements which will be published by December 2024 in line with Working Together 2023.