



Annual Report

**Staffordshire Safeguarding
Children Board (SSCB)**

2017/18

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Foreword

It is my privilege as Independent Chair to write the Foreword to this Annual Report of the Staffordshire Safeguarding Children Board.

The current economic and social climate continues to be very challenging for families and for those professionals working with children who are at risk of neglect and abuse. Statutory services are working to capacity in response to demands and at the same time partner agencies are facing pressures from further reductions in public funding that in practice is contributing to heavy caseloads. A combination of socio-economic factors linked to poverty and deprivation within communities can result in extremely vulnerable families and the potential for neglect and abuse of children and young people.

It is against this background that this annual report provides an overview of the work of the Board and how, despite operating in austere times with the reality of having to do more with less that, safeguarding partners are making a positive difference to ensuring that children and young people who may be at risk of or experiencing abuse or neglect are protected.

As you will read the Board has actively sought assurances as to the effectiveness of the local arrangements to protect children and young people by commissioning audits of the quality of case work practice

in joint working between adult mental health services, drug and alcohol services and children's services and used the findings to drive improvements.

In my role as Independent Chair I have been able to see and continue to be impressed and encouraged by the energy, commitment and enthusiasm of Board members as well as the many front line practitioners that I have met and their clear focus on doing their very best for the children and young people whom we are here to protect from harm.

I would like to take this opportunity to acknowledge the commitment of all of our partners and supporters including the statutory, independent and voluntary community sector who have contributed significantly to the work of the Board during the year. I am particularly grateful to all who chair the Board sub groups and the Interim Board Manager Lynne Milligan and the Board Administrators Estelle Landon and Anne Yates who work so hard behind the scenes to ensure that our business programme works efficiently.

Looking to the future there are revisions to the Working Together guidance that will place an equal duty on the statutory partners Staffordshire County Council, Clinical Commissioning Group and Staffordshire Police to agree ways to co-ordinate their services and engage others to safeguard children in our local

area. From my observations of the early work there is a shared determination to ensure that the new arrangements will make a positive difference. I look forward to playing a part in helping to develop the new arrangements.

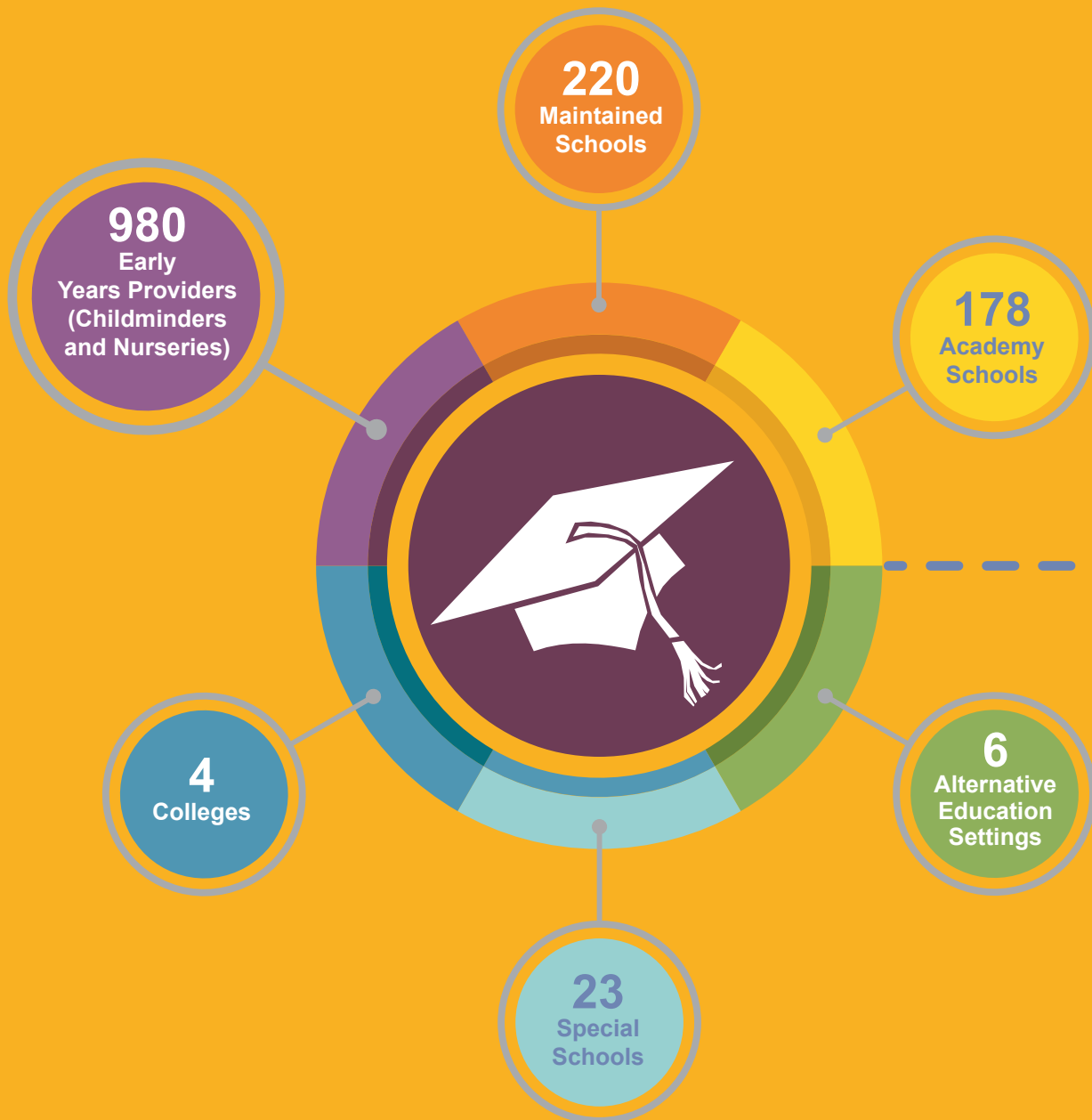


John Wood QPM

Demographics of Staffordshire

Staffordshire is a county in the West Midlands and surrounds the unitary authority of Stoke-on-Trent. It adjoins Cheshire to the north west, Derbyshire and Leicestershire to the east, Warwickshire to the south east, West Midlands and Worcestershire to the south, and Shropshire to the west.

Staffordshire is divided into the districts of Cannock Chase, East Staffordshire, Lichfield, Newcastle-under-Lyme, South Staffordshire, Stafford, Staffordshire Moorlands, and Tamworth.

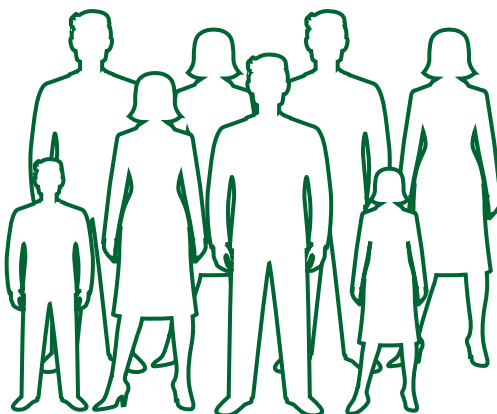


Around

862,600

people live in Staffordshire

(of these 168,900 are children)



**Staffordshire
Moorlands**

**Stoke-
on-Trent**

**Newcastle-
under-Lyme**

6

Clinical Commissioning Groups
(CCG)

Stafford

**East
Staffordshire**

Cannock

**South
Staffordshire**

Lichfield

Tamworth



County Wide Youth
Justice Service (YOS)

1

Police authority covering
Staffordshire and Stoke-on-Trent



Staffordshire Fire and Rescue
Service conducted safe and well
checks in over 25,000 homes in
2017/18

Chapter 1:

Strategic Vision, SSCB Priorities, Strategic Boards & Funding

Vision

Children and young people are safe through agencies working together effectively to provide the right help to families at the right time.

Our Priorities

Priority One: Child Sexual Abuse (CSA)

To continue to focus on CSA and begin to explore the impact of the broader vulnerabilities for adolescents associated within these areas: County lines, gangs and children missing from home, care and education.

Priority Two: Neglect

To coordinate the effectiveness of what is done by safeguarding partners in relation to substance misuse, parental mental ill health and domestic abuse.

Priority Three: Early Help

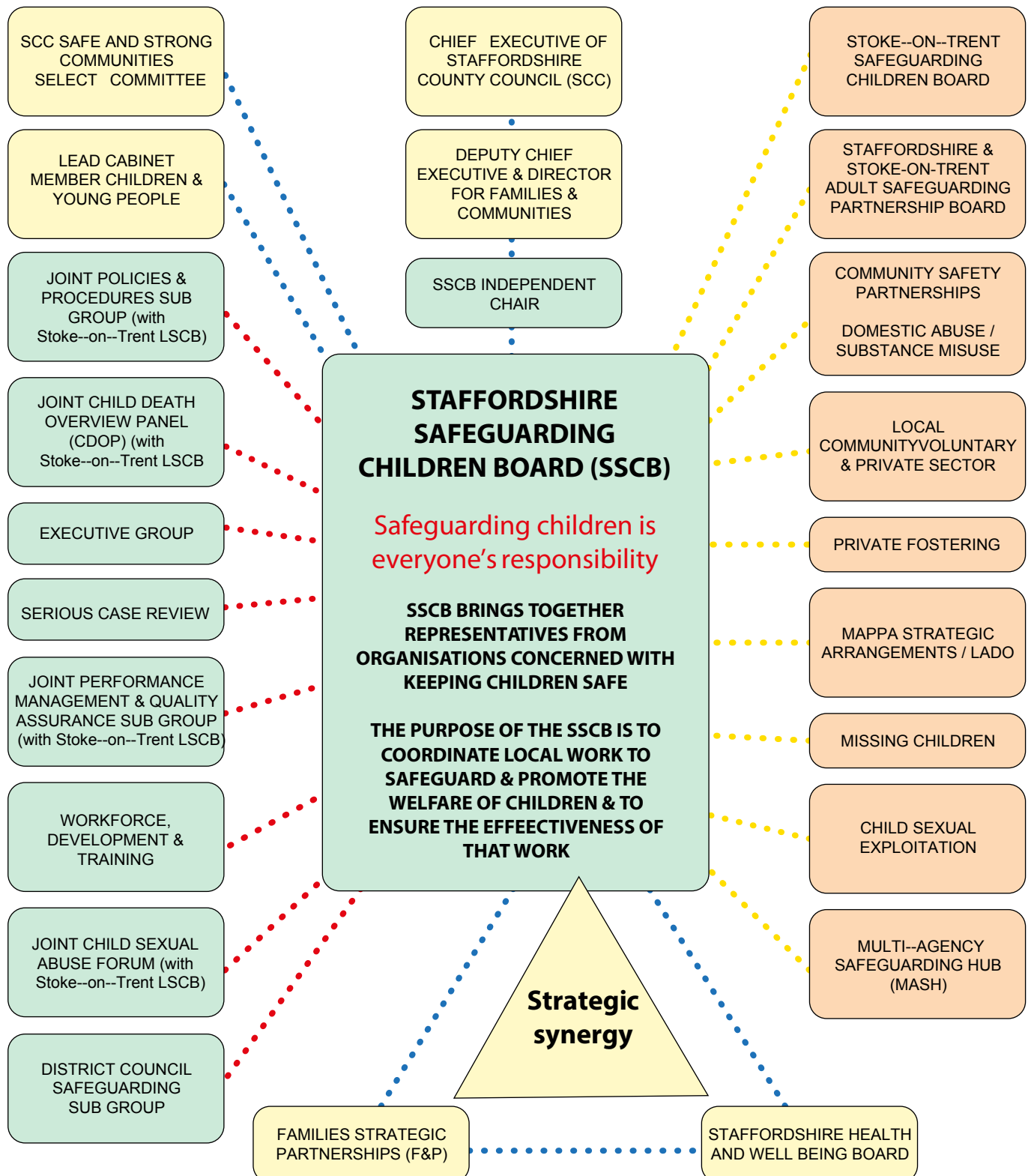
To continue to focus on improving outcomes for children through early identification, effective assessments and targeted early help services that address need.



SSCB Strategic Boards

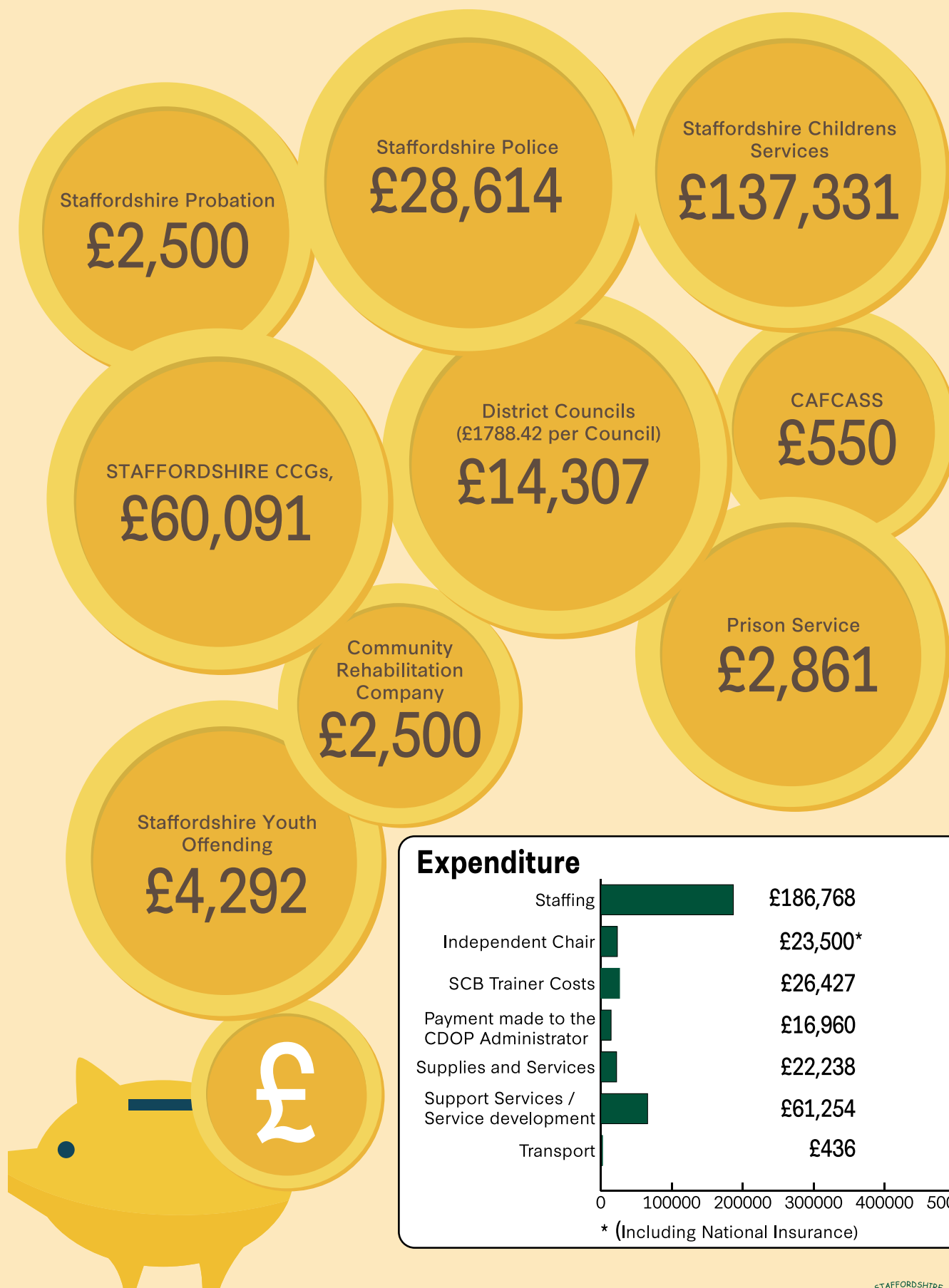
The SSCB Board meets once per quarter with the Executive Group meeting every month (apart from those months where there are Board meetings). The Executive Group provides strategic direction to the Board, with representation from Staffordshire County Council Families First service, Staffordshire Police, Clinical Commissioning Groups and Providers.

Staffordshire Safeguarding Children Board Structure



Funding

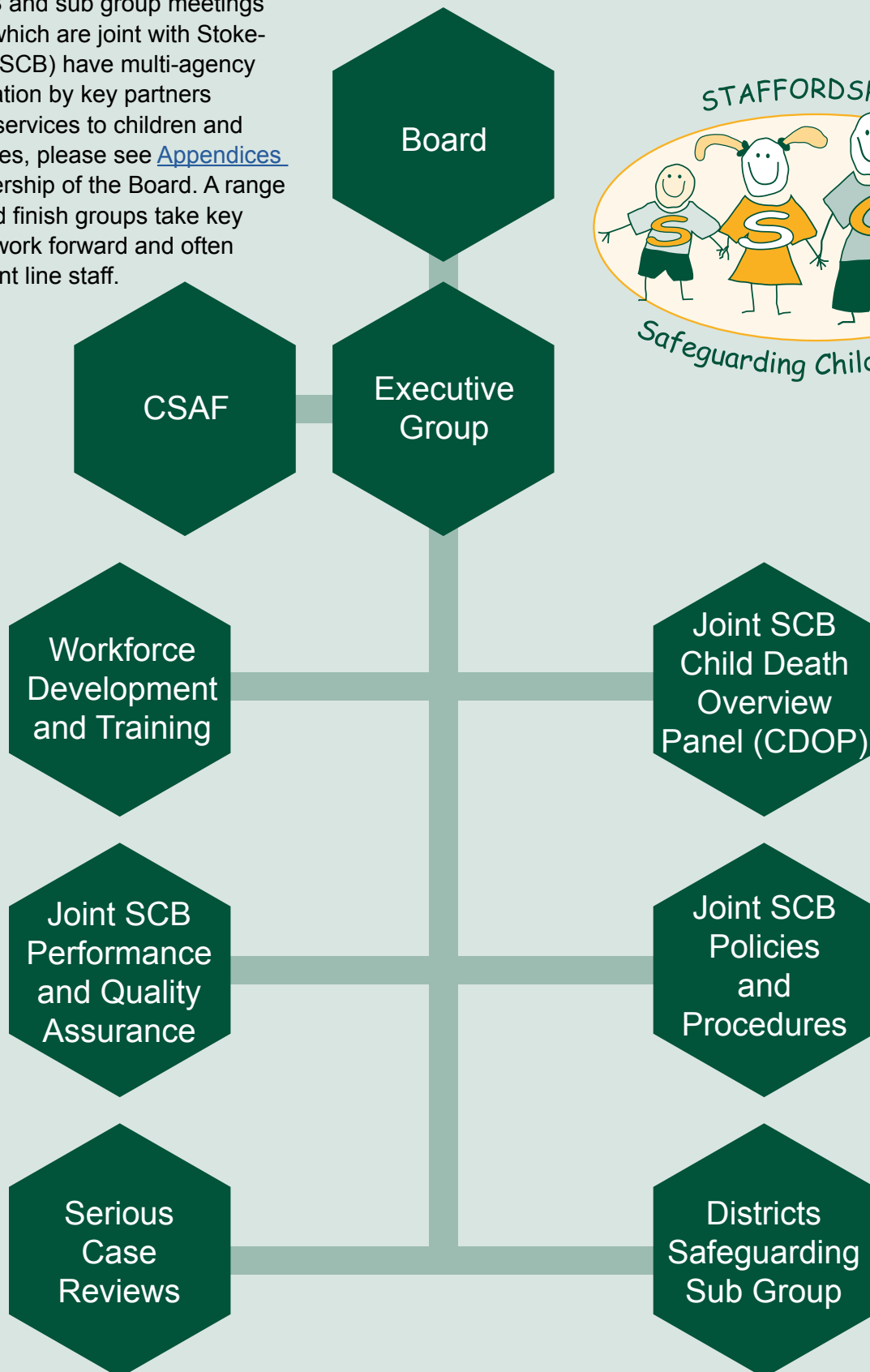
The SSCB budget is derived from contributions from a number of partners. As well as direct funding the SSCB is also provided with services in kind such as room hire by a number of agencies.



Chapter 2:

SSCB sub groups

The SSCB and sub group meetings (some of which are joint with Stoke-on-Trent LSCB) have multi-agency representation by key partners providing services to children and their families, please see [Appendices](#) for membership of the Board. A range of task and finish groups take key pieces of work forward and often involve front line staff.



Joint Child Sexual Abuse Forum (CSAF)

The Joint Staffordshire and Stoke-on-Trent Child Sexual Abuse Forum's primary purpose is to keep children safe from sexual abuse. The sexual abuse of children takes many forms including child sexual exploitation (on-street and on-line), missing children, children who are trafficked and intra-familial abuse. The forum is responsible for coordinating and driving the work of the joint LSCB child sexual abuse strategy and to hold agencies to account for promoting effective local working together arrangements.



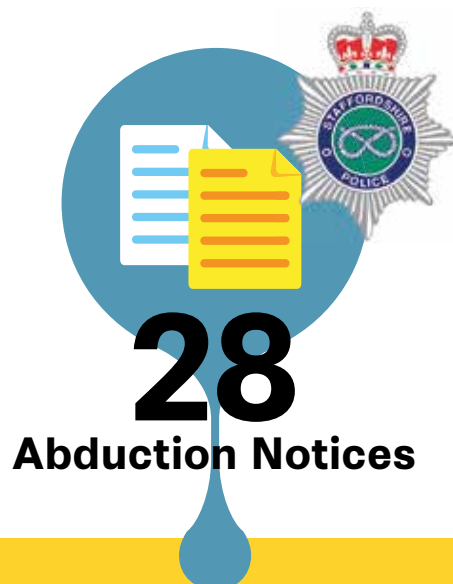
In the 2017 Ofsted ILAC inspectors identified that 'clear processes were in place to ensure strategic oversight of concerns relating to child sexual exploitation, through the Child Sexual Abuse Forum'.

During 2017/18 the sub group:

- Refreshed the joint LSCB CSA strategy in light of the revised focus.
- The CSE Outcomes Framework is more refined.
- The LSCB CSE coordinator has continued to work through the Joint LSCB CSE strategic action plan, key highlights against Year 2 and 3 include:
 - Revisions to the CSE Risk Factor Matrix (RFM) and the guidance took place, with the aim of improving the quality of information coming into the newly commissioned service, Catch22.
 - Initial feedback is showing an increase in the quality of the referrals as well as the soft intelligence that comes with it. The police and other agencies are able to use this information to direct targeted work to specific local hotspots and identify potential perpetrators.
 - A multi-agency communications group has focused on streamlining resources to ensure key messages are efficiently shared and effectively coordinated with front line staff, children and families. Following the consultation with our partner organisation SCVYS (Staffordshire Council of Voluntary Youth Services) where 200 young people took part, work is now underway to develop a 360 degree smart phone, virtual reality on line video and classroom pack to be promoted in schools and colleges, that will help to raise awareness of the risks faced by young people at parties. The product has been built around what young people have told us, which is to know how to deal with situations once they are in them. Plans are in place to pilot the product during 2018.
- Building on the National CSE awareness day the group used social media to advertise a local CSE campaign which reached 450,000 social media accounts, a 5 fold increase compared to previous campaigns.
- Sexting or youth produced sexual imagery is on the increase and trying to understand why this is happening is an area CSAF is currently exploring. Staffordshire police registered 6,238 sexting offences in 2016/17, a rate of 17 per day. The attitudes and culture that exists between young people determine their behaviour and some see 'sexting' as acceptable. The SSCB have introduced a web page with information for parents and carers, whilst work is ongoing through the PSHE (Personal, Social, Health and Economic education) agenda to highlight the risks but more so to challenge those attitudes and beliefs and to help young people use the internet safely whilst still enjoying its benefits. All partner agencies including the OPCC (Office of the Police and Crime Commissioner) have taken a proactive approach to reducing these statistics and more importantly to reducing the criminalisation of children.
- The Board has introduced new guidance for front line staff, 'Responding to Youth Produced Sexual Imagery.' Feedback from schools has shown that this guidance has helped them to actively reduce risks to children and raise awareness amongst staff.
- Plans include increased partnership working with the NSPCC on their development of a Harmful Sexual Behaviour (HSB) Audit tool. The aim of which is to gain an understanding of the scope and scale of HSB related issues, to appreciate what activity is taking place already and to improve confidence in the workforce.

- Full findings from the audit are expected in late 2018. Training on CSE continues to be high on the agenda with multiagency events taking place throughout the year. In addition, free on line training is provided, supported by PACE (Parents Against Child Sexual Exploitation).
- Through their Community Safety Plans, all of the 8 District and Borough Councils have delivered level 1 child protection training to their taxi drivers. This training has now become mandatory and they too are aware of the referral mechanism into Catch22. An audit to assess the effectiveness of this training is due to be completed by the Responsible Authorities Group in 2018/19.
- Multi-agency CSE panels led by the local authority continue to operate on a bi-monthly basis. Continual assessment of the panels effectiveness shows that they are actively protecting children who are most at risk and that they are disrupting activity. The Risk Factor Matrix (RFM) is scrutinised by the panels so that every ounce of information is assessed in order to identify the links to reduce risk. Following each panel, a CSE report card details the data along with localised information as well as good practice. In 2017, Ofsted noted the district panels as areas of good practice.
- The LSCB CSE Coordinator works closely with the local authority CSE social worker and the specialist safeguarding manager to share the learning from panels and to learn from local and national developments with regards to policy and practice. The local authority internal CSE action plan fully compliments the LSCB action plan, ensuring a lined up coordinated approach to tackling CSE.

From April 2017 to March 2018 Staffordshire police served 68 abduction notices to those harbouring children, of these 28 were across Staffordshire



Case Study

West Midlands Ambulance Service NHS Foundation Trust were called to a 15 year old child who had self harmed and had been drinking alcohol. During transportation, the attending clinician built up a rapport with child who disclosed that her boyfriend who was significantly older was forcing her to engage in sexual activities with his friends. She disclosed that she did not want to do this however believed he loved her, as he often bought her expensive gifts. With sensitive communication, police were called and a referral was made to local authority.

Joint SCB Performance and Quality

The joint Staffordshire and Stoke-on-Trent Performance and Quality sub group is responsible for supporting the development and coordination of performance intelligence and quality assurance frameworks which enable the Boards to provide a rigorous and transparent assessment of the performance and effectiveness of local services.

During 2017/18 the sub group:

- Developed and maintained an audit programme which identifies the themes and types of safeguarding audits the SSCB will undertake each year.
- Undertaken an audit of single agency activity to identify the nature of audits carried out within agencies and identify any learning which can be shared across the partnership.
- Began to use the evidence from agencies involved in serious case reviews to plot themes and trends in respect of children's safeguarding. This information was triangulated against the previous years S11 returns and will help to narrow the focus for the peer review due in 2018/19.
- Undertaken case file audits and practitioner based audits on a number of themes including:
 - Early Help
 - Neglect
 - Child Sexual Exploitation
 - Domestic Abuse
 - Children with Disabilities
- These audits and reviews are used to identify areas for development such as changes to policies and procedures and practice guidance ([please see page 26/27 for further analysis](#)). Additionally, they are used to inform the SSCB's training offer in order to improve practice and to assure the Board that agencies are taking appropriate actions to safeguard and promote the wellbeing of children.
- Undertaken the Joint LSCBs (with Stoke-on-Trent SCB) peer audit of partners arrangements under S11 of the Children Act 2004. This measured and focussed annual 'check' assures agencies and the Boards that the appropriate processes and procedures are in place to keep children safe and well. ([see page 23](#))
- The annual audit for schools, the S175 audit has improved over time and has led to an increase in the quality of information that schools retain as well as an improved relationship with the designated safeguarding leads (DSL).
- Further work with schools is planned for 2018/19 with the introduction of a DSL conference. Plans are in place to attract DSLs from over 400 schools across

Staffordshire, and whilst it is acknowledged that this is a big task, the Board are committed to working with its partners in order to help build strong relationships. Emerging themes from local serious case reviews and learning reviews aim to inform a variety of interactive workshops at the conference and will include awareness of adolescent neglect, child sexual exploitation and escalation.

- Work continues to develop and refine the Joint SCB multi-agency data set and ways of reporting the information will be revised during 2018/19.

Please refer to Chapter 3 for more detail of the work undertaken



Joint SCB Policies and Procedures

The joint SCB Policies and Procedures sub group is responsible for developing policies and procedures for safeguarding and promoting the welfare of children and young people across Staffordshire and Stoke-on-Trent.

A continued and regular programmed review of policies and procedures is undertaken and is informed by local and national reviews, national policy changes and local inspections.

During 2017/18 the sub group:

- Created and published the following policies and procedures
 - Joint Protocol to Reduce Prosecution of LAC (Looked After Children)**
 - Sudden and Unexpected Infant Deaths (SUDI) Guidance**
 - Undertaking Assessments and Investigations**
 - Managing Allegations of Abuse**
- Published the following SSCB Briefings:
 - Female Genital Mutilation**
 - What is the Multi-Agency Safeguarding Hub (MASH)**
 - Learning from S47 Investigations and Child Protection Investigations**
 - Proposed changes to Working Together 2018**

Evidence collected through SSCB training helps the Board understand how professionals use these documents and enables the sub group to continually monitor and develop practice on the front line.

The LSCB business team communicate all updates through the use of short e bulletins and through SSCB newsletters. In addition, policies and procedures are brought to life in SSCB multi-agency training where case studies are considered. Evaluations from LSCB training events tells us that front line staff are more familiar with local processes and procedures and are therefore more confident as a result.



Serious Case Review

The SSCB is committed to the importance of serious case reviews (SCR) and learning reviews as an essential element in examining multi-agency working and of informing and promoting more effective safeguarding children practice. All organisations and agencies represented on the Board are also determined to ensure that wherever the need arises for a review, this is undertaken thoroughly, promptly and sensitively; and that any lessons to be learned are acted upon to ensure that any areas in need of strengthening from either a strategic or operational perspective are addressed. An added layer of scrutiny and assurance is offered by the SSCB Independent Chair as it is his responsibility to make the ultimate decision about whether the LSCB should commission a SCR, or a different process for learning lessons.

- In 2017/18 there were no active serious case reviews but the conclusion of a SCR in 2016/17 led to:
 - the production of a series of face to face practitioner briefings across the county involving 3 key agencies; health, children's social care and police. These sessions enabled the Board to understand better the child protection system as a whole and how practitioners work together to keep children safe.
 - A SCR practitioner SCR briefing 'Child B' pulled

together the key learning including the voice of the child, disguised compliance, involving fathers and partners as well as professional challenge/escalation.

- Changes to all SSCB training were made in order to reflect the learning most of which focussed on disguised compliance, the voice of the child and engaging men.
- In that same year, the sub group was responsible for a Joint SCB complex learning review with Stoke-on-Trent SCB, much of which will be reported in the 2018/19 annual report. However, the learning has been embedded this year and as such updates to training have taken place along with revisions to the Joint SCB Complex Abuse policy and procedure and to the Child Protection and Investigation policy and procedure. The Board will continue to embed the learning and this will be evidenced in next years report.



Joint Child Death Overview Panel (CDOP)

The SSCB are committed to learning from the circumstances and factors present in child deaths, and to:

- Identify any changes that can be made or actions which can be taken that might help to prevent similar deaths in the future
- Share learning and good practice with colleagues locally, regionally and nationally so that the findings will have a wider impact
- Analyse trends and targeted interventions that can be delivered in response to findings. For example encouraging safe sleeping arrangements for babies and parents, particularly for those who smoke, drink alcohol or take drugs (both illicit and prescribed).

During 2017/18 25 deaths were expected with 8 unexpected, although some of the 8 were

known to have life limiting conditions. This compares to 27 unexpected deaths in 2016/17.

Consistently for Staffordshire there have been more male deaths, than females (20 males and 13 females). This is echoed nationally. The majority of children who died were under one year of age and the majority were White British.

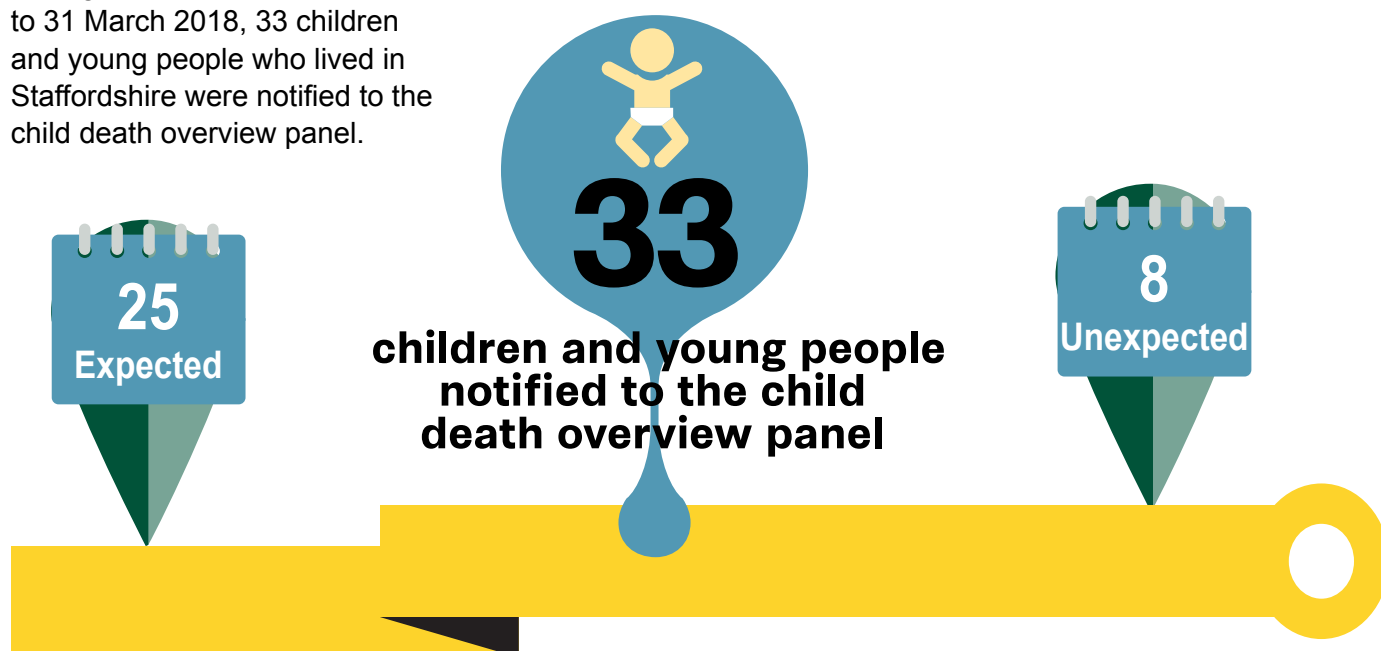
Achievements in 2017/18

The Child Safety Booklet entitled 'Protect Your Little Bundle... From Birth and Beyond' developed in 2015/16 continues to be circulated and promoted. It is in its third print and aims to raise awareness of potential hazards in and around the home and to prevent unintentional injuries to babies and children. Further funding has been provided by Staffordshire and Stoke-on-Trent Public Health for at least another two years. An

evaluation of the booklet was carried out with professionals which and led to changes that include sepsis awareness.



During the period 01 April 2017 to 31 March 2018, 33 children and young people who lived in Staffordshire were notified to the child death overview panel.

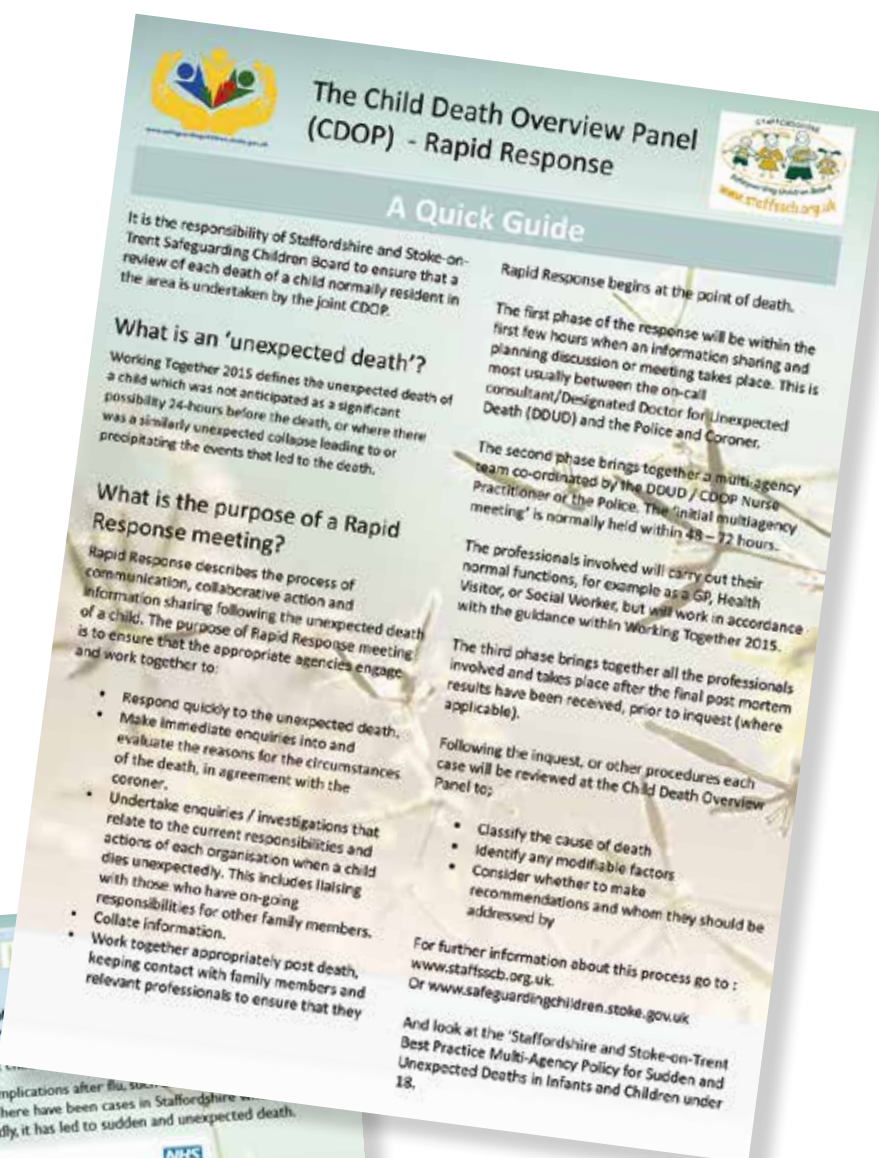


- Safe sleep workshops were held to continue to promote to staff the safe sleep assessment, more are organised for 2018.
- The CDOP created and circulated 11 issues of the CDOP newsletters – now entitled ‘Child Death Prevention Newsletter’. This is designed to raise awareness of key issues picked up from local child death reviews and campaigns including asthma, road safety week and immunisations.
- Staffordshire and Stoke on Trent CDOP is a member of the National Network of CDOPs. This network shares best practice, exchanges information and collectively supports each other to prevent and reduce child deaths. An abstract and poster created by two of the CDOP’s Designated Doctors and other colleagues was submitted and exhibited at the last conference on the 23 May.
- CDOP continue to support the LeDeR process in relation to review of the deaths of children and young people with learning disabilities.
- Alert circulated ‘Bed Side Cribs’, created by CDOP with ROSPA and agency professionals. Two ‘alerts’ were created, one for professionals and one for parents identifying the dangers of bedside cribs. Information was circulated to agencies working with new parents regionally and has also been shared with child safety equipment providers, and other NHS partnerships.
- Contribution to Warwick Medical School study into Unexpected Deaths and push for development of cardiology guidelines.
- Closer working with Suicide Prevention. Targeted work to home schooled children, information and advice given on wellbeing and mental health support.
- Continuation of circulation of ‘Safer sleeping in unwell babies’ leaflet created by the CDOP. Following identification that several SIDS deaths had previously attended hospital unwell, then been discharged home prior to death. Parents/ carers had changed their usual sleeping habits into identified unsafe practices. The leaflet is given to all babies under 12 months on discharge from hospital and minor injury units following illness. This leaflet provides advice and guidance around safer sleeping practices to improve awareness.



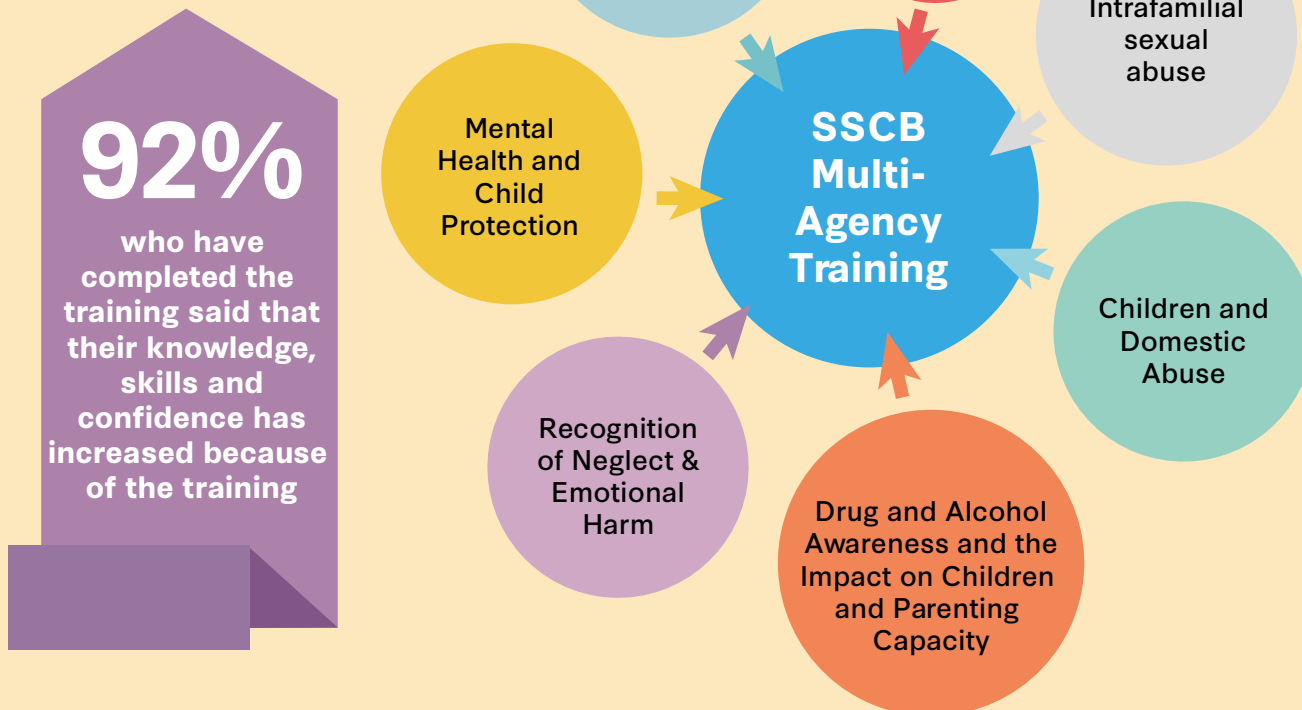
The CDOP Coordinator has developed a range of one minute briefings for professionals regarding the Rapid Response Process and CDOP Process. These are available on the SSCB website.

To access a copy of the 2017/18 CDOP annual report please go to www.staffsscb.org.uk/Aboutus/Annual-Reports/Annual-Reports.aspx



Workforce Development and Training (WD&T)

The WD&T sub group is responsible for monitoring and evaluating the effectiveness of training, including multi agency training, to help promote the safety and welfare of children.



Front line staff tell us:

"The training has helped improve my confidence and my ability to professionally challenge. As a result, I was able to resolve a case that had become 'stuck'. Children are now safer."

"Via the assessment I was able to identify the cause of the abuse which was self harm and better understood the issues in relation to emotional harm. This has given me the confidence to support the child when talking to her parents, to CAMHS and children's social care."

"Case study of child not eating before school and being tired constantly in training, brought to attention of parents who resisted support from school. Now school and family working in best interests of child - who looks and sounds altogether more happy and healthy!"

"In assessing placements identified as being at risk of breakdown and exploring the child's behaviour I have given consideration as to the way in which previous negative experiences (Domestic Abuse) could impact upon and sometimes inform a child's behaviour. I have been able to share this with foster carers and utilised this knowledge to inform suitable interventions."

"Understanding the root cause of an individuals mental health issues has helped me to become more aware of the techniques that can be used to address these issues. Consequently, we were able to engage better with the adult and the risk was reduced soon after."

"I had a family where mother was not engaging despite my best efforts. The training gave me the confidence to challenge her and be more assertive."



Activity throughout the year

In 2017/18 there was an average 18 people per course, compared to an average of 20 in 2016/17. Despite the 19% decrease in the number of those attending SSCB training, we have seen an increase of the number of evaluations being completed.

More detailed information can be found in the SSCB Training annual report www.sscbstaffs.org.uk

Overall, the feedback from front line staff continues to show that they have found the training both informative and beneficial. A large majority agreed that they had gained new skills and knowledge, with 3 month evaluations showing how they have embedded these into everyday practice.

pre, post and 3 month follow up evaluations

	2016/17	2017/18	% increase/decrease
Pre Course evaluations completed	1978	1819	- 8.03%
Post Course evaluations completed	1729	1557	- 9.94%
3 Month Follow Up evaluations completed	682	745*	+ 9.23%

*Some will be received in the next financial year

	2016/17	2017/18
Total number of delegates for all training	2378	1992
Number of courses planned	128	144
Number of courses delivered	115	113
e learning courses completed	5746	5233
Delegates completing CSE	98	81
Delegates completing neglect	76	129
Delegates completing substance misuse	86	53
Delegates completing domestic abuse	91	90
Delegates completing mental ill health	81	61
Delegates completing Lessons learnt from Serious Case Reviews	57	65
New courses for 2017/18	40	65
Forced Marriage, Honour Related Abuse and FGM		



Understanding how partners access training has been an important element to the Board's development and in assuring themselves that the children's workforce is stable, well informed of local processes and learning from reviews, which in turn lead to better outcomes for children and families. This helps to assure the Board that agencies are developing an environment and a culture that increases staff confidence in their practice and ability to meet the needs of children and their families.

The Board recognise there is further work to do in order to simplify access to training which is why there is a review of the on-line booking system. This will enable the Board to better understand the need and be more flexible in meeting the training requirements of our partner agencies.

The Board has retained the majority of its trainers, most of whom deliver the level 2 courses. However, this asset is at risk of becoming even more depleted as wider financial pressures take hold. The Board are sighted on this and recognise the dedication and hard work from our partners that means we can continue to deliver such high quality, multi-agency training.

The Board continues to secure bespoke courses in line with the priorities to ensure the needs of the children's workforce are met.

There is clear evidence that the package the Board offer is fit for purpose, value for money and highly regarded by front

line staff. In 2017, the ILAC Ofsted inspection reported that training has 'created a learning culture and has built a confident and competent workforce. Staff benefit from the training and support that they need to carry out their work. A strong commitment to continuous improvement is evident, through which learning from all activity, including serious case reviews, audit and learning reviews, consistently informs practice'.

Under the proposed new arrangements (The Wood Review 2016, the Children and Social Work Act 2017 and the Working Together 2018 consultation), the Board would need to be clear on its commitment going forward in order to ensure a continuous approach to keeping front line well-trained and confident when working with children and families, whilst maintaining high quality, multi-agency training.



Districts Safeguarding sub group

The Districts Safeguarding sub group is responsible for helping to ensure that the safeguarding children and vulnerable adults' agenda is fully embedded and driven forward in district and borough councils across Staffordshire. This is a joint sub group between the Staffordshire SCB and the Staffordshire Adults Safeguarding Partnership (SSASP).

In the past 12 months the group has accomplished the following:

- Refreshed the joint children and adults Districts Safeguarding Policy to include guidance for leisure centre services.
- The development of a county wide Parish Councils Safeguarding policy that brought about awareness of recruitment and vetting procedures and safeguarding children and adults policies and procedures.
- Further work in terms of child protection level 1 training delivered to taxi drivers has progressed well, with most District and Borough councils near completion. Further detail will be given under the CSAF section. ([see page 10](#))
- An audit on the taxi driver training is due to be carried out by the Responsible Authorities Group (RAG) in 2018.
- Child Sexual Exploitation training delivered by the districts has been extended to council members,

environmental health officers, housing officers, refuse collection staff and licensing staff.

Taxi drivers said, "they knew more about how to effectively tackle abuse and it was a good reminder to do the right thing"

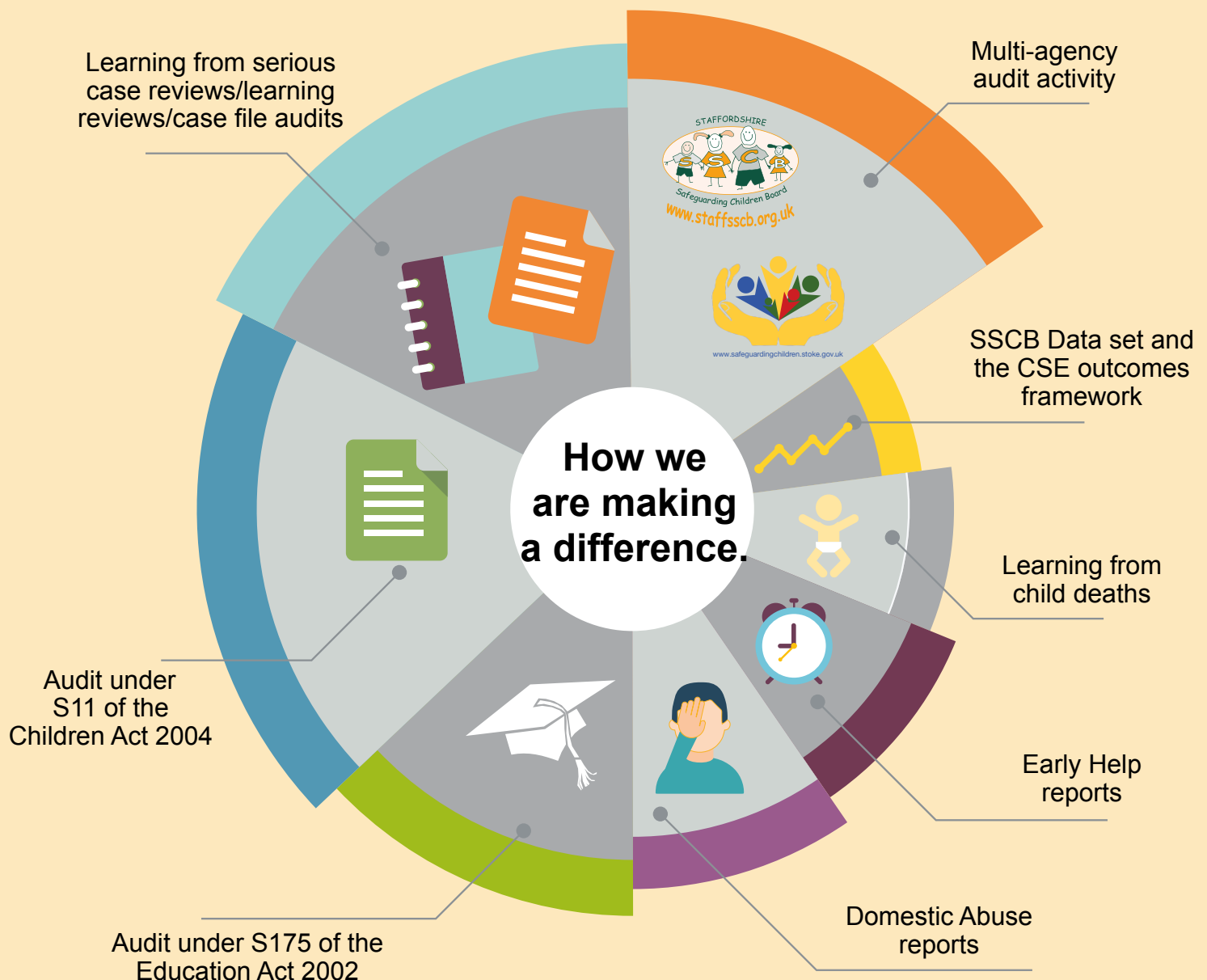


- Many of the district and borough councils are working with Staffordshire Council of Voluntary Youth Services (SCVYS) to enhance good safeguarding practice within organisations that include dance clubs and summer activity groups. This ensures that they have the appropriate local policies and procedures in place, know how to document concerns and who to liaise with should they need to make a referral to statutory services. Feedback from services demonstrates an increase in awareness and an understanding of early help and their role in keeping children safe.
- Commissioning of services based on need is common place within the district and borough councils, with many offering early, targeted support to specific groups of people. Stafford BC for example sought to commission a local alcohol and mental health service which is delivered through outreach work. Much of this work identifies additional need such as housing issues, fire risks within the home and offers signposting for help with managing benefits.
- Over the past 12 months, councils have continued to extend their offer to schools in their area through such enterprises as the Supporting Schools initiative. This preventative and early help approach is proving to be a great success with many schools fully engaged. Their feedback is helping to shape future initiatives. Young people involved in the domestic abuse outreach work have said "it has been so nice to have someone to talk to away from my family" with another saying "I feel like I understand a bit more about feeling safer".
- In Tamworth the Multi-Agency Centres (MAC) continue within its reach of local schools. This initiative offers support and advice to young people from a wide range of services in their school setting. The benefits are 10 fold, with many young people saying how it's increased their sense of well-being and helped them to deal with health problems as well as emotional ones.

Services like this are key to alerting the councils to the wider issues facing children and families which is being used to proactively address needs earlier before they escalate. Those receiving support have said "thank you for all your help in the groups. They are eye opening and inspirational and have become a huge part of my recovery".

Chapter 3: Performance and Quality Assurance

A variety of performance information is scrutinised and analysed that tells us how agencies are working together to keep children safe:



S11 Peer Audit

Section 11 of the Children Act 2004 places a statutory duty on key agencies and bodies to make arrangements to safeguard and promote the welfare of children.

In Staffordshire this assurance is received through audits. Biennially, these take the format of peer audits. The aim is that constructive challenge is provided to agencies to support a culture of continuous improvement and to identify and share good practice. In this year's peer audit the Board focused on a reduced numbers of standards as these were the areas of the full S11 2016/17 audit that were weakest.

They were:

Standard 2 :

A culture of listening to children and young people and taking account of their wishes and feelings, both in individual decisions and the development of services

Standard 3 :

Information sharing

Standard 5 :

Appropriate supervision and support for staff, including safeguarding training

The rationale for the selection of standards was to ensure partner agencies were not only listening to the voices of children, young people and families but also sharing information as these are recurrent themes in serious case reviews, both locally and nationally.

Furthermore, the audit would assist the Board in identifying information gaps when assessing the impact against the Joint SCB neglect strategy.

The Process

Agencies were provided with a template, with pre populated information that pulled together evidence and recommendations from the previous S11 audit, as well as the learning from serious case reviews, multi-agency reviews and case file audits.

Agencies brought their updated evidence to the full day event, where their information was challenged by partners that operate with different client groups. The impact of which enabled partners to focus on progress and good practice, whilst identifying impact. Feedback from the day's event concluded with an overall success at the new approach and opened up discussions about how the Board will take this forward for future events.

Outcomes and Impact

Assurances were given that agencies embraced the new approach and this resulted in a number of positive outcomes in respect of Information Sharing, Staff Support and Training and Listening to Children. For information sharing, peers agreed that all agencies met the standard, providing good evidence all of which lends itself to assuring the Board that this minimises the potential for any delay. Evidence included effective MASH arrangements,

all having information sharing protocols in place that are monitored, multi-agency forums/ panels that facilitate information sharing in relation to neglect and CSE which has resulted in disruption/effective interventions, good information sharing at MARAC to protect children and staff being co-located in an multi-agency settings.

Additional evidence showed how robust staff induction, supervision and safeguarding training arrangements provide support, advice and guidance to staff. This means that cases can be explored, professional disagreements can be addressed and actions are closely monitored to ensure good outcomes for children. Ensuring that reflective supervision is well recorded and the analysis of decision making is also very well recorded. Where service are commissioned out it was brought to the attention of the Board that further work is required to ensure that this is captured in their contracting arrangements. The Police were particularly honest in their evaluation and described the challenges moving forward in respect of organisational changes when supporting staff.

For listening to children, most agencies met the standard, with two 'meeting the standard with recommendations' (Birmingham Community NHS and the National Probation Service). There was some good evidence and examples of good practice including the voice of the children captured in assessments, work undertaken by Staffordshire County Council's Voice Project.

Work undertaken by Staffordshire county council and health services shows how they use survey results to make changes to services and findings used for commissioning. Challenges included ensuring that methods were child friendly and again for the Districts and Borough councils to ensure that contracts hold commissioned services to account for listening to children and young people when developing or evaluating services.

The Board is seeing a real commitment to partnership working and regardless of diminishing resources, a continued focus on the outcomes for children and families. Evidence is compelling and innovative and demonstrates a strong partnership. In the 2017 Ofsted ILAC inspection, it was found that 'Governance arrangements are exceptionally strong The partnership demonstrates a solid commitment to joining up services to provide improved localised support to children and families.'

S175 schools audit

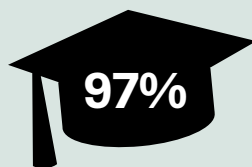
With support and oversight from the SSCB, the local authority's Education Safeguarding Lead continues to conduct an annual assessment of the safeguarding arrangements in schools and this provides the Board with strong evidence that shows the commitment from schools to maintain children's wellbeing and safety. The S175 audit generated a high response rate from schools (364 out of a total of 406) across all educational settings including primary, secondary, special schools, academies and

alternative education provision.

The audit found that:



100% of schools have a nominated a Deputy Safeguarding Lead and identified a Safeguarding Governor.



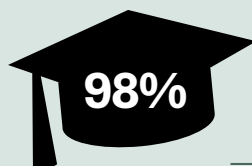
An increase trend to 97% of schools where a child leaves the school, ensuring that their child protection file is copied for any new school and transferred separately as soon as possible, secured with a signature from the new provision. 78% use secure file transfer.



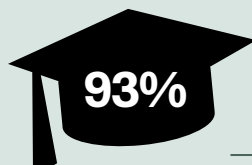
99% report individual child protection records are kept separately from academic records



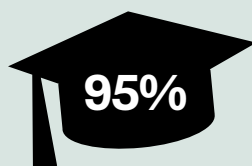
90% recognise the need for a dedicated Safeguarding section to be included in the School improvement plan/SEF/Audit



98% of health care plans for pupils with medical conditions are reviewed on a regular basis.



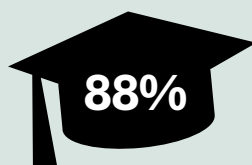
93% accessed Workshop to Raise Awareness of Prevent (WRAP) training.



95% have accessed Safer Recruitment training



91% have accessed Early Help training, a rise from the 85% previously.



88% have accessed Female Genital Mutilation (FGM) training. This is a significant rise on the 54% in the previous audit.

What this shows is that schools understand the requirements set out in Keeping Children Safe in Education (KCSIE) and are developing some excellent safeguarding practice and processes. They are developing a culture that establishes a philosophy towards safeguarding children.

Further work undertaken by the Education Safeguarding Lead (ESL)

Following completion of the audit, the ESL compiled a S175 analysis report which was presented at the performance and quality assurance sub group for scrutiny and challenge. This was well received and identified some learning. This is being actioned and will be reported in next year's annual report.

The ESL leads on the Designated Safeguarding Lead (DSL) face to face briefings held across the county and they provide an ideal opportunity for debate which enables schools to collectively reflect on the learning from the audit and to share good practice.

During 2017/2018 the ESL delivered 3 rounds of double district briefings (12 in all) to share key safeguarding messages and to encourage sharing of good practice. The briefings also provide the opportunity to build supportive networks and facilitate face to face discussions in districts. This has extended to small groups as a means of reflective practice and case review and the ESL has worked with schools to put clear supervision structures in place.

Feedback from briefings has been very positive and this

is demonstrated through the numbers attending each session. These briefings provide the SSCB with an opportunity to communicate and share information about local and national procedures, and to gather views from the front line.

The ESL works alongside schools to ensure safeguarding remains a priority and as such 20 audits have been carried out with individual schools. This shows a strong commitment to keeping children safe.

The Education Safeguarding Advice Service (ESAS) is part of Responsive Services and is located in the MASH. This service offers advice and support to schools and other education settings in relation to thresholds, referrals and general safeguarding enquiries that are not appropriate for First Response. In total the service dealt with 2477 requests for advice and guidance around many areas of early help and safeguarding practice. The service is highly valued by Staffordshire education settings, and supports the Education Safeguarding Lead in her role.

SSCB Dataset and audit activity

The SSCB data set has evolved over time and has enabled the Board and its partners to be assured as to how the child protection system keeps children safe and reduces risk.

The dataset dashboard is shared with partners on a quarterly basis and this identifies themes, patterns and trends. This information serves the Board with opportunities to seek assurances from other Boards and forums

and direct further work that includes audits and progress reports. The dataset is built upon 3 core areas:

Core Safeguarding Dataset –

This is predominantly local authority data (based on National and Regional returns) that provides a core safeguarding set of data indicators which we will start to use to build up the profile of the welfare and safety of children in Staffordshire and Stoke-on-Trent.

Local Safeguarding Dataset –

will also be included based on the priorities of the Board. These have a more multi-agency response to data requirement that starts to build a profile of local activity.

Quality Assurance along with other performance information allows the Board to build a picture of the 'system' in order to appreciate its effectiveness and to drive improvement through scrutiny and challenge.

The dataset adds to the focus of the business plan which in turn directs the work of the sub groups.

[Chapter 4 offers an overview of the data set and its indicators.](#)



Practitioner Thematic Audits

During 2017/18 the Joint SCB Performance and Quality sub group agreed the following audits based on the Boards priorities; Neglect (including those children with disabilities), Domestic Abuse, Child Sexual Exploitation and Early Help.


The focus for these audits was to ascertain if the risks to those children and young people had been reduced through the application of appropriate thresholds, effective information sharing and timely intervention across agencies.

The results showed us that:

Neglect Audit



- Good identification of risk to unborn baby
- Appropriate referrals made by the police following a domestic abuse call out and neglect was suspected




- Historical information was not always used
- Child growth not routinely plotted on charts by health visitors
- Greater professional curiosity required in some cases
- Men significant in the lives of children and families not involved in assessments and plans
- Views, or observations of children not routinely recorded in police records

Domestic Abuse

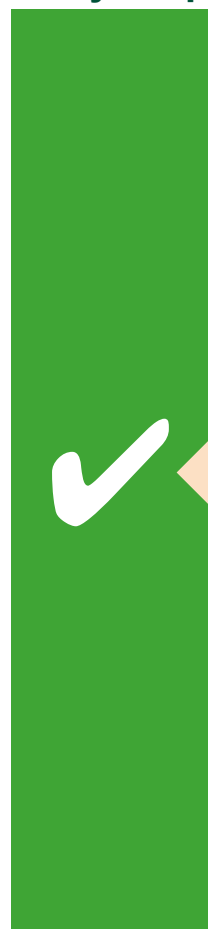


- Appropriate immediate responses to, and identification, of risk across agencies
- Process to identify risk to unborn babies worked well
- Good multi-agency involvement in assessments




- No process in place to share MARAC information with GPs which impacts on their ability to input
- Agencies must be clear that all young people under 18 are children, including those who are parents and alleged perpetrators of DA
- Not all plans were child focussed
- Some evidence of drift in CIN cases

Early Help




- Tenacity on the part of professionals supported families to make positive changes
- Good recording of the wishes and feelings of children in police and health records
- Management oversight was appropriate in all agencies, apart from the GP




- Some EHA's did not consider the needs of all children in the household
- The wishes and feelings of children could be improved in LST records

Children with a Disability

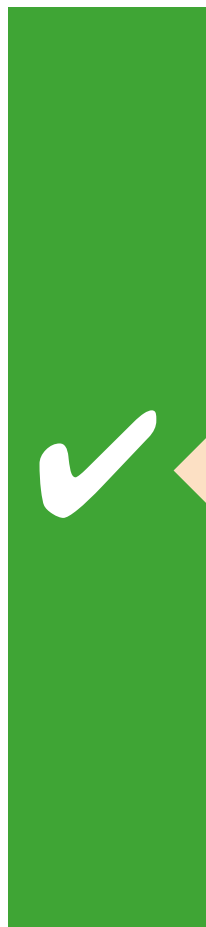


- Good evidence of partnership working, particularly between CAMHs and the residential care home provider
- The management oversight was good, with effective support through supervisions for the social worker
- Strong evidence of good information sharing between the school and the school nurse
- Health visitor records show an understanding of what life is like for a child




- The work generally tends to be parent focussed
- Agency files not complete or with discrepancies between information

Child Sexual Abuse and Missing



- There was strong evidence of the child's wishes and feelings which were documented and used to good effect
- The Risk Factor Matrix was used appropriately and updated regularly
- Risk was managed well between the police and CSC
- Strong evidence of the child being seen alone
- The child had developed good relationships with their social worker



- School nursing did not know about the child's missing episodes and did not have copies of their plans on file

Summary

In 2017/18 the SSCB reconsidered the way in which reviews of practice were undertaken and as such agreed a new approach that has enabled the Board to generate effective learning from both national and local multi-agency reviews of practice and serious case reviews. The aim of which is to improve practice and outcomes for children and families.

During 2017/18 the Performance and Quality Assurance sub group:

- Gathered the views of practitioners and managers on the process of themed audits and used this to re design the format and paperwork
- Considered both the local and national context of SCRs, learning reviews, legislation and Inspections
- Identified and developed agreed strategies to ensure optimum learning and to enable evaluation of the impact in order to inform on-going development.
- Continued to clarify the relationships with other strategic Boards who have responsibility for either the commissioning of services such as the Domestic Abuse Commissioning and Development Board or in respect of operational delivery of services such as the Strategic Missing Children Board, who oversee the work of those children who go missing and maybe experiencing neglect and/ or child sexual abuse.
- Practitioner themed audits enable the Board to get to the bottom of professional practice and explore in more depth why actions or decisions that later turned out to be mistaken, or to have led to an unwanted outcome, seemed to those involved, to be the sensible thing to do at the time. The answers can generate new ideas about how to improve practice and so help keep children safe.
- Developing a framework for understanding the influences on practice has meant that similarities or patterns have been identified which can be either constructive patterns of influence or patterns that create unsafe conditions in which poor practice is more likely. This approach recognises and organises these complex set of factors that influence work with children, families and carers thus generating new ways of redesigning particular parts of the system in order to better keep children safe.



Chapter 4

Staffordshire's Children

According to the Joint Strategic Needs Assessment 2017/18 there are 168,900 children living in Staffordshire.

Tamworth (21.9%) and East Staffordshire (21.6%) have higher proportions of younger populations compared with England (21.3%). South Staffordshire has the lowest at 17.1%.

Based on the Index of Multiple Deprivation 2015, Staffordshire is a relatively affluent area but has notable pockets of high deprivation in some of its urban areas with 9% of its population living in the fifth most deprived areas nationally. In addition, some of the remote rural areas in Staffordshire have issues with hidden deprivation, particularly around access to services.



168,900

children living in Staffordshire
(56,100 in Stoke-on-Trent)

Out of 100 children,:

12

have a statement of educational
need or disability,

10

have a mental health condition
and
one is a young carer.

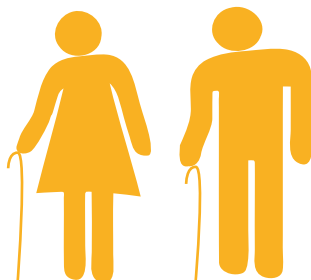
Staffordshire 2017/2018

The proportion of working-age population (aged 16-64) claiming Universal Jobseekers Allowance in Staffordshire is lower than the national average (0.9%)



A new-born baby boy in Staffordshire is expected to live to around 80 years of age compared to 83 for a baby girl.

In addition, babies living in our most deprived areas are expected to live 12-13 years less than those in the least deprived areas.



83
years

80
years

2%

overcrowding

The proportion of overcrowding in Staffordshire stands at 2% however there are pockets throughout the county where this is much higher such as Anglesey in East Staffordshire at 8.9%.

Number of households
253,979

Around **16%** of children live in low income families

Approx. 12 children out of every 100 live with a lone parent

Local Authority rank for Income Deprivation affecting Children Index

120/150

Males subject to a plan stand at **466** whereas females are **502**

Children are living in deprived households

21%

Fuel poverty stands at

11%

Approx. 1 in 10 pupils are eligible for free school meals

Number of children eligible for free school meals

6,025

Number of babies born

8,491

The number of early help assessments initiated by the local authority for 2017/18 stands at

3318

No. of early help

Level 2:
Additional Need
Children who have an additional singular need

Level 1:
Universal Need
Children whose needs are fully met



o assessments

Level 3:

Multiple Need
Children who have
numerous needs



5,524

Number of
children in
need



Increase to
19.83%



192

No of children placed on a
Child Protection plan for a
second or subsequent time.

Level 4:

Acute Need
Children in crisis or
with complex, acute
and long term need



126
Increase

The number of children subject to a
child protection plan for neglect has
seen an increase of 126 to 549.



643

Children made
subject to child
protection plan

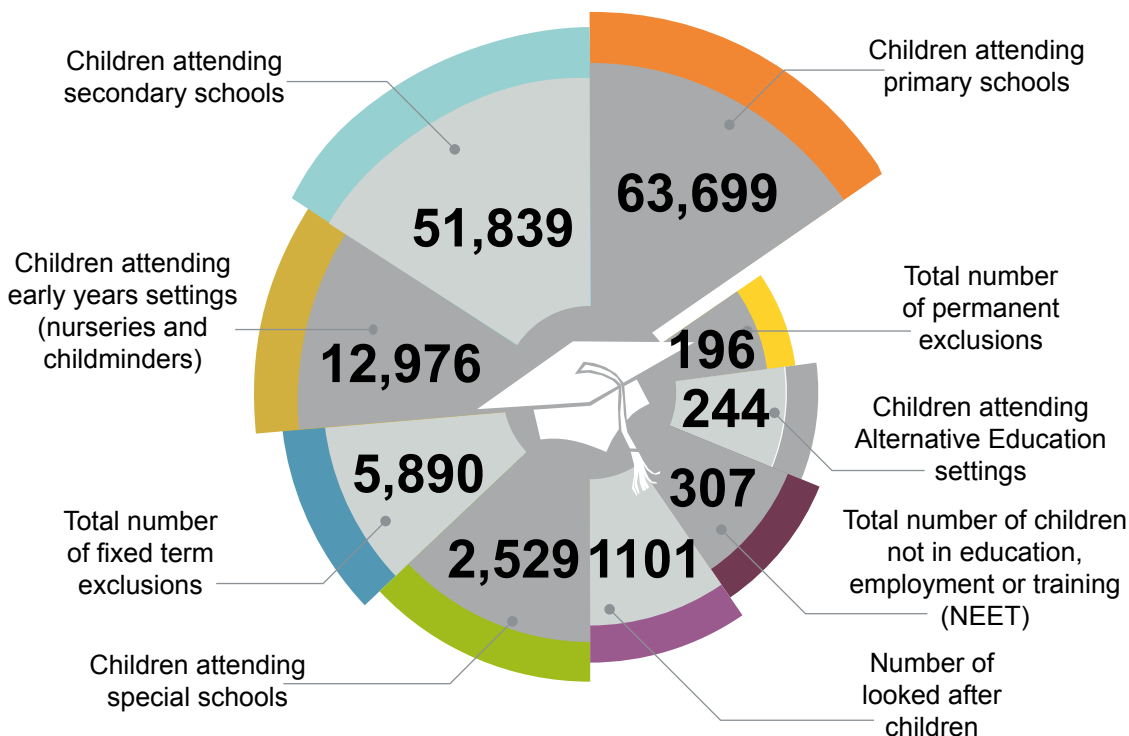
168,900

Number of
children in
Staffordshire
(0-17 years)



118,371

Number of children in schools



62 (16%)

Early years setting
graded good or
outstanding

52 (12%)

Childminders graded
good or outstanding

256

Primary schools
graded as good or
outstanding

50

Secondary schools
graded as good or
outstanding

23

Special schools
graded as good or
outstanding

5

Pupil Referral Units
graded as good or
outstanding

Child Protection Medicals

In 2017/18 the University Hospital of North Midlands NHS Trust completed 136 child protection medicals, compared to 176 in 2016/17. This is due to fewer physical abuse medicals. Children's social care has worked with the paediatricians on call which has resulted in a reduction in requests for medicals.

- The largest proportion of medical examinations undertaken during 2017/18 was for 1 – 4 year olds (34%). This mirrors the findings in previous years
- Nearly half of all the medicals were conducted on children under the age of 4 years (44%).
- The pattern of the types of medical examinations has been much the same, with the majority being for suspected physical abuse.

The South Staffordshire and Shropshire Healthcare NHS Foundation Trust reported a slight increase in the number of child protection medicals that are undertaken by the Community Paediatricians in the East and West team. There were 84 medical examinations undertaken last year, with referrals coming in from children's social care for concerns around physical abuse and neglect. Community Paediatricians liaise with the local Hospital Paediatricians if investigations are indicated and are also involved in child sex abuse examinations but this is coordinated through the Sexual Assault Referral Centre (SARC) in Stoke on Trent. The examination is done jointly with Forensic Medical Examiners

Referrals to the Front Door (First Response)

During 2017/18, First Response received a total of 8891 referrals, a decrease of 247 on last years figures. The highest number of referrals received is from the police, 2422 (27.2%), with education services at 9.2% (814) and schools at 9% (796). A reduction in school referrals has been attributed to the success of the education safeguarding advice line, a better understanding of thresholds and a move to working at the earliest help stage. Police increases account for the increase in referrals for domestic abuse call outs and the efficiency of the DIALs which are improving the identification of children in the home.



West Midlands Ambulance Service made

413 (3.59%)
safeguarding referrals

Case Study

West Midlands Ambulance Service NHS Foundation Trust responded to a 999 call to an unconscious adult patient. On crew arrival, it became apparent the condition of the patient was due to illicit drug use. In the property were two young children under the age of three who were under nourished, in soiled nappies and clothing and were not having their basic needs met. Further resources including second ambulance and police requested. The immediate clinical needs of the adult and children were met and conveyed to hospital and referral to Emergency Duty Team made to provide intervention.



Early Help Strategy 2015 to 2018

A better understanding and awareness of domestic abuse by the general public and professionals led by national and local campaigns can also been seen as an influential factor on the increase in police call outs.

Referral numbers for other agencies such as housing providers (64/ 0.7%), school nurses (33/ 0.4%) and GPs (80/ 0.9%) continue to be the lowest. Children subject to a plan for sexual abuse have seen a drop from 34 to 26, with emotional abuse seeing an increase from 225 to 368. This has been attributed to a better understanding of the effects of domestic abuse and mental ill health on children as previously they would have been placed on a plan for neglect.

Domestic Abuse

Total number of DIALs (Domestic Abuse Incident Log) completed by the Police in Staffordshire 14,306



It is difficult to determine direction of travel for the DIAL data as these figures depend on either the officers identifying the children in the property or the victim disclosing there are children in the property. These figures reflect the occurrences a child or children have been identified rather than the actual number of children affected. The current IT development program seeks to develop the domestic abuse risk assessment tool.

Early Help across Staffordshire

Both local and national research highlights a number of factors that increase the risk of a child experiencing poorer outcomes in relation to their education, health or welfare. The evidence also indicates that it is often the same families and communities that suffer a range of inequalities. So whilst we can look at ways in which we reduce the risk factors that are affecting these children, families and communities in isolation, more consideration needs to be given to addressing the underlying root causes as well as the symptom.

Early Help and the Families Strategic Partnership (FSP)

The SSCB Early Help Strategy

encourages all partners to work together to support the needs of children and families at the earliest possible opportunity, to prevent issues escalating to a point where statutory services are required.

The responsibility for its delivery rests with the FSP and there is now an agreed Outcome Framework and Delivery Plan in place.

The number of early help assessments initiated by the local authority for 2017/18 stands at

Decrease to
3318

Early Help Assessments are initiated by a number of agencies but these figures are for those initiated by the local authority only. The key reason identified for working with children at this level was a child's disruptive behaviour at home or school, followed by poor emotional health and self esteem, and low school attendance. This figure is a decrease compared to 2016/17 and that number is likely now that Local Support Teams no longer work cases with attendance issues only.

Further work by the FSP on the performance framework will help to identify EHA's initiated by other agencies and the reasons why.

Over the last 12 months the Early Help Steering Group has:

Broadened the approach in Staffordshire to include and emphasise the importance of Earliest Help, aligned to the equally crucial, more formal Early Help support offer.

Developed an Early Help Strategy Performance Framework to aid partners in assessing the difference made against key local priorities.

Refreshed and simplified the Early Help Assessment (EHA) documentation and supporting processes following feedback from OFSTED.

Used the Department for Communities and Local Government (DCLG) Maturity Matrix work strands as the basis for our Implementation plan, thereby ensuring key practices and principles are embedded across the partnership by 2020.

Sought to ensure that the development of Earliest and Early Help is intrinsic to the implementation of the locality focused PBA work.

Started to create an evidence bank of Earliest Help case studies demonstrating the breadth of work being undertaken by partners to reduce and prevent escalation of need and demand.

Recommissioned the Child Health and Wellbeing, Early Years Coordination Service and Family Support Contracts (0-19s) to include Earliest and Early Help, and embed the principles of the BRFC Programme.

Initiated the development of an awareness raising Earliest Help video supported by Burton and South Derbyshire College staff and students.

Taken responsibility for mainstreaming the BRFC (Troubled Families) model into the wider Children and Families System and has successfully applied for Earned Autonomy funding from DCLG to support this element of system transformation.

A copy of the FSP annual report can be found here:

<https://www.staffordshire.gov.uk/health/childrenandfamilycare/partnership/Staffordshire-Families-Strategic-Partnership.aspx>



Chapter 5:

Listening to the voice of our children and families

Both local and national evidence from serious case reviews and learning reviews has consistently shown that the child's voice is often not heard and effectively represented in the safeguarding system. What we know from research and from both professionals and children themselves tells us that meaningful engagement with children in the decision making process leads to improved outcomes for children, particularly those at risk. Agencies across the partnership use a variety of techniques to gather the views of children and their families and the examples below tell us how effective this is.

Examples of meaningful contributions come from those who are 'living and breathing the system': pregnant mothers who have experienced domestic abuse; mothers who have previously had children removed and are pregnant again; fathers who have little contact and may lack support and those who are care leavers and are also pregnant.

The Voice project who are part of Staffordshire's Families First service undertake a variety of consultations with a range of families in order to gain a sense of where they are in terms of their circumstances, what this feels like and how they can bring about change through self-empowerment and guided support.

Breathing Space is an intensive support service within the Edge of Care Service and aims to work with those men and women as outlined above. The service delivers a range of programs which vary from low to high intensity depending on need and risk. Mothers and fathers are encouraged to understand where their behaviours come from and

how to re-think their approach to parenting.

Ofsted reported in 2017 that 'there is a focus on keeping children in their families, where possible, through a range of high-quality edge of care services. These (sic) demonstrate a real impact on preventing children's needs from escalating and helping children to remain in their families'.

More focused pieces of work such as Dads Work looks at the father's needs, his role as father, his relationship with the mother and how having a baby can change this. These types of interventions show how risk can be significantly reduced. Local serious case reviews have taught us that fathers are often left out of the decision making, either because they have no parental responsibility, or because they are absent or not living with the mother and therefore have little contact. Preventative work like this helps to engage and involve fathers and works to reduce the risk. It also means that families can stay together.

The Freedom Program is another intervention that is

proving successful. This program delivers one-to-one sessions with the mother who is a victim of domestic abuse. The sessions look at individual characteristics of different types of abuse and what is deemed to be positive and negative behaviours. This is used with women who have previously experienced any form of domestic abuse but has also been used with mothers to highlight their behaviour.

Alongside these programs, project workers will support parents in accessing mental health services and appointments or midwife/hospital appointments where parents are struggling to attend or are anxious.

Once these programs have ended, the Voice project consult with those involved and this is what they had to say:

Single Mother:

"I was reluctant to engage in the beginning - I would not have been able to keep my baby without the 'Breathing Space' programme."

Father:

"I found the male worker with Breathing Space very supportive and non-judgemental. He really helped me understand the responsibility of having a baby."

Health Visitor:

"The communications from Breathing Space staff was excellent, I never felt out of the loop."

Mother:

"Through Breathing Space I was able to take part in the Freedom Programme, this made a massive difference to me as a person and as a mother. I feel stronger now and able to cope, I have a great bond with my baby."

Social Worker:

"I have referred two cases to Breathing Space and both have had successful outcomes - not only did the mothers manage to keep their babies but they were also able to move forward in a positive way after Breathing Space withdrew. I can't recommend the service highly enough."

Summary/Key Headlines

Most families engaged on the Breathing Space Programme have complex needs and often poor support networks around them.

Being able to sign post/refer families to other services/agencies is key to sustaining positive outcomes in the longer term.

Providing a male worker as part of the programme is vital if we want the family to work together to support the child and move forward as a family unit.

Communication and sharing information between all services is vital to supporting the families.

Staff keeping up to date with local services and knowledge is really important so that parents know where to go when Breathing Space have withdrawn.

Overall, most felt the programme could not be improved and would recommend the service to others. However, one mature mother did feel the programme was more focused on younger mothers and suggested they could have a slightly different approach for older mothers, but agreed it was a great service.

The Voice Project

The Voice project, within Families First plan a variety of consultations based on a range of areas that include looked after children, care leavers, those children who have received a service from the local support team, children receiving support for youth offending services and those children who are to some degree experiencing the court process. The outcome from their consultations with children is regularly used to inform service improvement, has led to the development of strategies and resulted in better engagement with children which will be used to inform further consultations.

Make Your Mark 2017

The Make Your Mark campaign was launched in August 2017 and ran until October. During this time the MYPs and their deputies organised school ballots and visited SCVYS member groups to ensure as many young people as possible in Staffordshire could have their say. The hard work put in by the young people paid off, and the number of votes from Staffordshire more than doubled from 2,998 (in 2016) to 6,648.

The results from Staffordshire were shared with the Families Strategic Partnership Board (FSPB), who responded by providing a written response outlining the work that is already happening in the County in relation to the top ten issues. The engagement that SCVYS have conducted led to the FSPB asking us to facilitate and lead a Children, Young People and Families Voice Steering Group, seeking to ensure that engagement with children, young people and families is meaningful, aligned and accounts for priorities from all partners.



Private Fostering

During 2017/18 Staffordshire county council's Family & Friends Team received 16 notifications, compared to 15 in the previous year. Significant work has been undertaken with a wide range of agencies to increase awareness of private fostering and what this looks like, much of which the Board has been in support of. Campaigns led by the service have appeared in SSCB newsletters, briefings and on the website. SSCB training covers a case study where the child's circumstances are explored to help professionals understand the legal requirements and the risks.



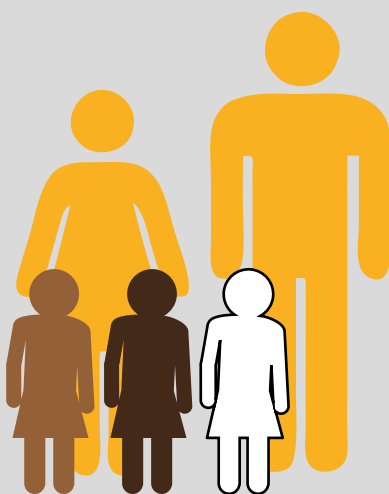
Work undertaken throughout 2017/18:

- Private Fostering posters were devised for schools and other agencies.
- These along with Private Fostering leaflets and explanatory letters were sent to an extensive list of schools (Inc private and language schools), guardianship agencies, AEGIS whom many guardianship agencies are a member of, faith groups and GP surgeries.
- A half day training workshop was set up by the SSCB and the Family & Friends Team for independent schools / language schools / AEGIS, however due to receiving a poor response the training session was cancelled.
- A day in the life of a social worker managing Private Fostering cases is posted on Staffordshire's webpage for Private Fostering.
- SSCB continue to raise awareness with social workers, health and education professionals. Leaflets are also provided and a power point presentation devised to enable all professionals to understand their roles/ responsibilities regarding notifying the First Response Team of Private Fostering arrangements.
- Messages were put on Facebook/Twitter to promote Private Fostering.
- Cllr Mark Sutton also supported in raising awareness - The private fostering story was picked up by both BBC Radio Stoke and Signal FM who both ran the story in multiple bulletins. Cllr Mark Sutton was also in the audio clips. The story was further picked up by the Leek Post and Times.
- Close working / appropriate referrals are made to bordering Local Authorities in respect of children who may be living in Private Fostering arrangements and who cross borders.

The gender and ethnicity of privately fostered children is mainly female (9), with many coming from the UK (10).

The majority of the children were white British, with the other children being from, Asia and Europe.

6 of the notifications were related to children coming in as foreign students.



Chapter 6:

Partnerships and Networks

The Boards relationship with other strategic Boards and Partnerships including links with Stoke-on-Trent is vital to ensuring the safety and welfare of children and families across Staffordshire.

A joint working protocol with the [Health and Wellbeing Board \(HWBB\)](#) and the [Families Strategic Partnership \(FSP\)](#) sets out the framework within which these Boards/Partnerships will work together to safeguard and promote the welfare of people living in Staffordshire, including the distinct roles, responsibilities and governance arrangements for each of them. It also refers to the relationship between the Boards/Partnerships and other partnership forums in Staffordshire and Stoke-on-Trent.

The protocol sets out the shared vision, value and ambition as well as providing a clear line of sight on the partnerships, detailed above, strategic response and how it influences operational practice.

The Staffordshire Health and Wellbeing Board (HWBB)

The Board is a key strategic leadership body that will drive ongoing improvements in health and wellbeing across Staffordshire. The Board is established under the provisions set out in the Health and Social Care Act which received Royal Assent on the 27 March 2012. The Board assumed its statutory responsibilities from April 2013. The terms of reference will be reviewed as appropriate to

ensure they support the strategic intentions of the Board and compliance with all relevant legislation. The Staffordshire HWBB has a number of ongoing responsibilities, including producing the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy (JHWS).

The Families Strategic Partnership Board (FSPB)

The Families Strategic Partnership (FSP) is made up of a Families Strategic Partnership Board (FSPB) that is supported by a Families Partnership Executive Group (FPEG). The FSP reports into the Health and Wellbeing Board (H&WBB) and works closely with the Staffordshire Safeguarding Children Board (SSCB). The partnership was formed in autumn 2015 and has continued to go from strength to strength.

All activities commissioned by the partnership has 'improving outcomes for children, young people and families' at the heart of all that it does and partners work in a true collaborative manner to deliver the Strategy.

Our other partnerships

Staffordshire and Stoke-on-Trent Domestic Abuse Commissioning and Development Board

The Domestic Abuse Commissioning and Development Board aims to prevent domestic abuse from happening and respond appropriately and effectively to those vulnerable to, or affected by, domestic abuse to enable them to move forward safely and independently. In order to deliver this approach, the Board has four priority areas:

Preventing Violence and Abuse - preventing domestic abuse from happening in the first place by challenging the attitudes and behaviours which foster it and intervening as early as possible.

Provision of Services – commissioning a range of effective, joined up domestic abuse related services able to meet the needs of potential victims, potential perpetrators, victims, perpetrators (for both children, young people, adults and their families), ensuring all public services are able to identify and respond to the signs of domestic abuse.

Partnership Working – fostering an agreed partnership approach across Staffordshire and Stoke-on-Trent to deliver robust governance, accountability, planning, commissioning and service delivery.

Perpetrators: holding perpetrators of domestic abuse to account and preventing future offences

Missing Strategic Group

The Missing Strategic Group is a multi-agency group which reports on progress to the SSCB via the Child Sexual Abuse Forum. It monitors the activity of the Operational Missing Group, responds to shared intelligence and analysis to inform commissioning and service delivery, influences joint policy, protocols informed by national guidance and research including joint training, briefing and publicity campaigns.

It has oversight of the management of risk in relation to Staffordshire children who go missing and those children placed in Staffordshire by other local authorities and have developed a strategic approach to addressing and escalating concerns regarding children who go missing, particularly other placing local authorities via ADSS, Chief Executive and Ofsted.

It utilises the learning from serious case reviews, learning reviews, research and inspections to inform audit activity and contributes to periodic themed audits and disseminate findings to partners.

The Strategic Lead for Looked after Children has continued to chair the Strategic Missing Children Board that works to a clear action plan; however this role will be taken on by the police in 2018/2019.

NEW During 2017/2018 733 young people went missing from home and care, with a total of 2284 missing episodes.

This represents an increase in the number of episodes by nearly one third from last year; yet the number of young people going missing has reduced from 882.

15 young people are responsible for 15% of all missing episodes.

The average number of children missing per quarter is 220, with just over a third being other local authority looked after children placed in Staffordshire.

41% (707) of missing episodes are from the independent care sector

40% (695) are children missing from home

10% of missing episodes were from Foster Care provision.

The children and young people repeatedly missing are all known to CSC services and for this particular cohort, there is a high correlation between their missing episodes and vulnerabilities associated with child sexual exploitation, youth offending, learning difficulties or disabilities and problems within the school environment.

There is a continuing trend of females that go missing more than once compared to males and the 15-16 year old age range is the highest cohort.

The Staffordshire Moorland area continues to have the highest number of missing episodes. South Staffordshire and Lichfield remain the areas where young people and episodes reporting have been the lowest.

The local authority is continuing to work in partnership with Staffordshire Police to target hot spot locations, particular children's homes and foster

carers experiencing high levels of call-out incidents. A Care Pack has been circulated to Independent Care Homes and Foster Carers to support them with managing children going missing who are in their care.

There is also an improved recording process on children's social care ICT systems around the missing episode and return interview; this helps to ensure that the local authority and social workers have the relevant information needed to safeguard children and young people. Monthly and quarterly performance reporting systems are in place to monitor demand, manage risk, timescale compliance and to provide general insight into local themes.

The reasons given for young people going missing are consistent with reasons reported in previous years; 'to be with friend' was the most common reason given, followed by 'no apparent reason'. Other reasons provided include coping mechanism, unsettled at home, substance misuse and boredom.

Ofsted reported in 2017 that 'the response to children who go missing is rigorous' also noting the good work of the Missing Strategic Board.

The main focus for the coming year will be to embed the arrangements for the newly commissioned Service for Missing Children and Child Sexual Exploitation Service to ensure consistent quality provision across the County for supporting our most vulnerable children.

Community Safety Partnerships

Within Staffordshire there are 8 local community safety partnerships one for each of the district and borough council areas. They are made up of representatives from:

- The local police force
- Local councils
- The fire authority
- Clinical commissioning groups and
- Probation services

These organisations are collectively known as the "responsible authorities".

They work together to develop and implement strategies to protect their local communities from crime and help people feel safe. They work out local approaches to deal with issues including anti-social behaviour, drug or alcohol misuse and re-offending.

You can find out more about the community safety partnerships for each area here:

[Cannock Chase](#)

[East Staffordshire](#)

[Lichfield](#)

[Newcastle-under-Lyme](#)

[South Staffordshire](#)

[Stafford](#)

[Staffordshire Moorlands](#)

[Tamworth](#)

[Stoke-on-Trent \(Safer City Partnership\)](#)

Prevent Board

In June 2011, the Coalition Government launched an overhauled Prevent strategy. Prevent forms one of four strands of the government's [Contest Strategy](#). An updated strategy was published in June 2018. In Staffordshire the local Prevent Delivery Plan will be reviewed and revised in light of the new Contest Strategy, to ensure that our local activity contributes to the achievement of the shared national outcomes.

The Staffordshire Prevent Board, which is a multi-agency Board will oversee this revision so that it can continue to deliver positive outcomes for vulnerable children and young people.



Chapter 7: SSCB Communications

The SSCB produce a quarterly safeguarding newsletter reporting on the most up to date national and local safeguarding information for front line staff and line managers.

Agencies across the partnership relay these messages either via email bulletins, Internal briefings and training. Some also produce their own newsletter



University Hospital
of North Midlands
NHS Trust

Work continues in the Emergency Department around domestic abuse. The Trust has a domestic abuse/ violence page on the Trust intranet. The safeguarding newsletter has covered neglect in the past year.

SSCB Briefings

Female Genital Mutilation

Engaging with Men

Child B Learning from serious case reviews

Safeguarding in Sport Be Activities Wise Campaign

In conjunction with Stoke-on-Trent city council, Staffordshire county council led on a campaign spanning from June – September 2017 to raise awareness with parents on the steps they can take to ensure their children are safe when taking part in sporting activities throughout the summer.

<https://www.staffsscb.org.uk/ParentsCarers/Be-Activity-Wise-advice-for-parents/Extra-curricular-activity-advice-for-parents>

This campaign informed parents and carers as well as professionals of the various products which were posted on social media/SSCB and SCC

websites / E bulletins/ via elected members/ parish councils and updates on twitter. The 3rd sector also led on a large part of the work through SCVYS, and Sport Across Staffordshire and S-O-T.

To access the annual reports for SCVYS please go to: <http://staffscvys.org.uk/annual-reports/>

And for Sport Across Staffordshire and Stoke-on-Trent please go to <https://sportacrossstaffordshire.co.uk/about-us/>



Appendices

Agency	Board Meetings 2017/18			
	June 2017	Sept 2017	Dec 2017	March 2018
Staffordshire Police	✓	✓	✓	✓
Burton & South Derbyshire College	✗	✓	✓	✓
Staffordshire Fire & Rescue	✓	✓	✓	✓
South Staffordshire and Shropshire Healthcare NHS Foundation Trust	✓	✓	✓	✗
HMYOI Werrington	✓	✗	✓	✓
Staffordshire and Stoke National Probation Service	✓	✗	✓	✓
Army Welfare Service	✓	✓	✓	✓
Staffordshire County Council	✓	✓	✓	✓
University Hospitals of North Midlands NHS Trust	✓	✓	✓	✓
Clinical Commissioning Group	✓	✓	✓	✓
Staffordshire and Stoke Community Rehabilitation Company	✓	✓	✗	✗
Birmingham Community Healthcare NHS Foundation Trust	✓	✓	✓	✓
Entrust	✓	✓	✓	✓
Named GP North Staffs CCG	✓	✗	✗	✓
Barnardos	✗	✓	✓	✓
Cafcass	✗	✗	✓	✗
North Staffs Combined Health NHS Trust	✓	✓	✓	✓
West Midlands Ambulance Service NHS Foundation Trust	✗	✗	✗	✗
Special School	✗	✓	✓	✓
Staffordshire Council of Voluntary Youth Services SCVYS	✓	✗	✓	✓
NSPCC	✓	✗	✗	✗
Independent School	✗	✗	✓	✓
Lead Member for Children and Families	✓	✓	✓	✗
Staffordshire Youth Offending Service	✓	✓	✓	✓
Staffordshire and Stoke on Trent Partnership NHS Trust	✓	✓	✗	✓
Designated Nurse for North Staffs CCG	✓	✓	✓	✓
Designated Nurse for South Staffs CCG	✓	✓	✓	✓
Designated Doctor for North Staffs CCG	✓	✓	✓	✓
Designated Doctor for South Staffs CCG	✓	✓	✗	✓