



# **Annual Report (FINAL DRAFT)**

**Staffordshire Safeguarding Children Board  
2021/22**

**Contents**

Foreword ..... 3

1 Our priorities ..... 4

    Neglect (focus on under ones) ..... 4

    Child exploitation ..... 8

2 Ensuring effective multi-agency safeguarding practice..... 11

## **Foreword**

### **Neelam Bhardwaja, Director of Children and Families, Staffordshire County Council**

The safeguarding partnership has continued to build on its strengths to be ready for the challenging agenda arising from local inspections, self-assessment reviews and audits as well as the national agenda arising from the well-publicised deaths of two young children in particular. The stronger partnerships forged during the coronavirus (COVID-19) pandemic continues to assist us to navigate our way through organisational changes and future direction, for example, the review of the Multi-Agency Safeguarding Hub (MASH) and contributions of all agencies to progressing the partnership agenda which will help ensure that we all play our part in keeping children safe and can evidence it through a robust performance management system.

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

The past year has been another significant one for the NHS and partners with the continued challenge of managing the response to the COVID-19 pandemic and we have continued to keep a strong focus on safeguarding children whilst strengthening the partnership arrangements we have in place. This culminated with the appointment of a new Independent Chair who is now in post and bringing fresh eyes and new challenge to the membership.

Alongside this, the NHS has completed the extensive work required to close down Clinical Commissioning Groups (CCGs) and launch the Integrated Care System (ICS) and Integrated Care Board (ICB). Learning from previous NHS reforms, the CCGs gave a commitment that during this transition the arrangements for safeguarding children would not change in order to ensure continued progress of the work across the partnership and this has continued in line with that commitment.

The strength of the Safeguarding Partnership has continued to grow and I am confident that we will work together going forward, as we have in previous years, to maintain a high standard in all aspects of the Safeguarding Children agenda.

### **Jennie Mattinson, Temporary Assistant Chief Constable, Staffordshire Police**

This year safeguarding partners have continued to recovery, adapt and improve services following the COVID-19 pandemic. Progress has been made against the safeguarding board priorities and the partnership is clear about where further improvements are needed. Operation Encompass has been successfully implemented resulting in thousands of referrals to schools to ensure teachers and staff are aware when a child has been exposed to domestic abuse, there is greater recognition of neglect and increased awareness and understanding of the importance of capturing, and acting on, the voice of children across all partners. The work in these areas will continue this year along with work to improve the effectiveness of our MASH arrangements.

Staffordshire Police also have a specific Child Protection Improvement Programme in place following the police specific inspection in September 2021. This has delivered some early improvements and will continue to be a focus throughout 2022/23 with joint working with safeguarding partners in key areas.

## 1 Our priorities

### Neglect (focus on under ones)

Neglect continued to be a priority for the Board with a particular focus on infants under one. As part of our **strategic approach** to addressing underlying issues of abuse and neglect, we initiated the development of a local protocol to start strengthening our relationship with other key Strategic Partnerships in Staffordshire, i.e., the Staffordshire Health and Wellbeing Board (HWBB), Staffordshire and Stoke-on Trent Adult Safeguarding Partnership Board (SSASPB) and Staffordshire Strategic Community Safety Partnership (CSP). The protocol, which has now been endorsed by all Boards, demonstrates our joint commitment to working together to keeping children and adults safe from harm and improving their health and wellbeing. The protocol will improve our links with each other to maximise effectiveness and minimise duplication. Going forward the Chairs and lead managers will meet on a regular basis to share, align and agree priorities across the various Partnerships.

As part of our commitment to ensuring that infants receive help at the earliest opportunity we have continued with our early help/place-based approach work. Some examples include:

- commencing design work on the Family Hub model to ensure access is integrated
- broadening criteria for Supporting Families (Building Resilient Families and Communities (BRFC)) to ensure that low level neglect is identified and worked with under the programme with analysis of audits demonstrating impact
- recommissioning Tier 2 services across Staffordshire to better match need
- commencing the review of our early help strategy

#### Impact of early help interventions (BRFC)

*"...by addressing the financial difficulties this has reduced mother's stress and impacted positively on mother's reduction in alcohol"*

*"[Young person] also engaged with Early Help completing the Bump to Baby and virtual doll programme. He has engaged with the parenting assessment and is on the waiting list for New Era. [Young person] has done very well to abstain from using cannabis in the past three months and is engaging positively with support in this regard..."*

*"The plan has led to positive change for [young person], she continues to be supported by health and receiving therapeutic support from CAMHS. Education provision is in place from September and [young person] has also started to make friendships through InterHigh and sharing her love of music"*

*"It is a positive that there was a clear safety plan in place for parents to follow when mum struggled with her mental health. Mum was engaging well with mental health professionals and taking her medication appropriately at the time of closure"*

*"Keyworker addressed education supporting with College applications with [young person] which has led to [young person] attending College to complete a public services course"*

Audits from early help demonstrate that parents were being engaged and there was a good understanding of the risks children were exposed to enabling informed decisions to reduce or mitigate them. In line with the strength-based approach of restorative practice the majority of assessments and reviews also identified positives within families. However, findings from the audit also identified a significant fall in the number demonstrating whole family working from the previous year. Consent and restrictions were identified as contributors to practitioners not always being able to gain a whole family approach. Think Family is an issue that has also been identified within learning from reviews and further assurance will be sought next year through a Peer Review.

We have also had conversations with parents to understand the challenges that they face. We sought feedback from four parents and the findings were shared with Partners engaged with the family as well as Safeguarding Partners through the Scrutiny and Assurance Group. The findings highlighted little acknowledgement of the views of parents with some practitioners content they had delivered in line with the standard operating procedures (SOPs). These findings have been fed back through commissioners to service providers as part of the contract management process and we will seek assurance from commissioners that improvements are being made through our performance management framework.

#### **Early identification of neglect though improved skills and knowledge in the workforce through the commissioning of evidence-based Graded Care Profile (GCP2) assessment tool**

Last year we reported we had commissioned the use of Graded Care Profile (GCP2) to improve our response to neglect at the earliest opportunity and how a multi-agency steering group (with our neighbours Stoke-on-Trent Safeguarding Children Partnership) was set up to oversee implementation across the area.

During March 2021 we trained 30 professionals from across a range of agencies to become GCP2 champions. These champions have now delivered awareness sessions to over 900 leaders and practitioners across Staffordshire and Stoke-on-Trent and have also trained 940 practitioners to become licensed to use the GCP2 tool across a range of settings including education, health and children social care. Two Police colleagues have also been trained with a view to consider how GCP2 can be implemented, if at all, into the policing landscape; similar to the work being done across policing nationally.

We reported last year on the peer support programme which was set up to support our champions. Our GCP2 champions are instrumental in the development and delivery of the training packages ensuring fit for purpose, tailored training to each audience. GCP2 is referenced in regular communications through the Board's website, social media and monthly newsletter. In 2021 the Board hosted a successful joint neglect conference capturing the voice of the child and showcasing GCP2. The conference was opened by a young person from the Voice Project who called upon delegates to pledge their commitment to the child's voice, a selection are shown in Figure 1.

**Figure 1: Selection of pledges from the neglect/GCP2 conference, 2021**



Discussion held with our delegates a year later showed the messages and pledges had stayed in their working practice to this day.

*"I would say that the sentiment has certainly stayed with me. When attending strategy meetings the voice and the lived experience is something I keep centre of my practice and decision making in regards to threshold."*

Social Worker

*"The voice of the child is fully embedded within our daily practices and is at the centre of all of our policies. We firmly believe that our nursery belongs to our children and their voices shape how our nursery functions on a day-to-day basis. We work on active listening, and we always encourage children to use their voices and words at every opportunity – but this is also equally as important with our non-verbal children and our youngest babies. We discuss daily looking out for those 'little things' that require us to stand back and absorb how children are making choices and voicing their opinions either verbally or through gestures. Sitting back, observing, watching and listening is important for us to piece together children's ideas and opinions about their experiences in nursery"*

Nursery manager

Data from the training evaluation evidences an increase in both knowledge and confidence in using the GCP2 assessment tool. Post-training evaluation also demonstrates a commitment from attendees to use their acquired skills and knowledge to improve outcomes for children and families. However, the number of assessments that were recorded as being completed during the year was still relatively low (70) and further work continues to address the barriers.

The introduction of GCP2 has meant that trained practitioners within the workforce have a clear understanding of neglect in terms of the impact on the child and wider family outcomes. This is also supported by a restorative approach which is evidenced in the audit activity and observations of practice by Children Social Care.

Where the tool was well embedded, practitioners felt it improved their practice and that families had benefited from its use:

- Practitioners felt that referrals were clearer and more likely to lead to actions that would support the child
- Some families were reported to make positive health and lifestyle changes as a result of the use of the tool

#### **Case study**

An early-years setting had concerns about a three-year-old child in their care. The child was seen crossing the road unattended, being left alone at the gate for 20 minutes and their sibling attending with a mark on their face. Each concern was raised with parents, but concerns remained although didn't meet threshold. The designated safeguarding lead conducted a GCP2 with the parents around safety in the home and road. Despite being reluctant to engage, the parents then agreed to worked with the family support worker and manager.

Contact was made with mum weekly through the family support worker or nursery manager. The older child continued to attend nurture groups for his emotional health and improvements were seen both in the nurture group and in the classroom. The younger sibling has had no existing injuries since the meetings and is progressing in all areas of his development. Parent and school communication continues to be good.

*"The GCP2 toolkit was self-explanatory and provided us with the necessary statements and questions to aid our conversation with mum, and to get her the help she needs. We liked the visual aspect of the numbers and found it is encouraging that we could use the toolkit to help mum improve the areas of concern, by suggesting next steps. GCP2 provided a good foundation to start a conversation and to broach difficult questions. Along with very helpful statements the tool provides, we also felt that we could refer to it through each concern and it help guide us through the difficult conversations with the family."*

Whilst it is difficult to attribute impact directly to the work we have done around neglect and GCP2, during 2021/22 we did see a reduced number of re-referrals and children subject to a Child Protection Plan (CPP) for a second or subsequent time where neglect is the main category of concern from the previous year.

In terms of reducing the impact of the underlying causes of neglect we have had assurance that we have set conditions which should see improvements over the next 12-18 months which we will be able to evidence through the Early Year Advisory Board's performance framework.

Our focus next year will be on:

- Implementation of our local protocol with key Strategic Partnerships
- Seeking assurance on how we know every practitioner "gets it" and understands the impact of parental neglect on children outcomes
- Ensuring GCP2 is consistently embedded across the whole system and routinely used
- Continuing to seek assurance on the ongoing impacts of Covid-19, such as reduced face-to-face opportunities for identifying neglect early, and in particular for babies, due to some of our contacts/services still operating as 'digital-first'
- Seeking assurance that professionals acknowledge all new parents' opinions are significant
- Implementing the revised Early Help Strategy and accompanying delivery plan which includes the delivery of Family Hubs
- Improving information sharing - given that most children are known to single-agencies - to proactively help children and families. This was an issue that we were unable to resolve during 2021/22 and discussions between the local authority and health are ongoing
- Improve the recognition and identification of neglect within Staffordshire Police and understanding why we have a disproportional low crime recording of neglect within performance data in comparison to the significant number of safeguarding referrals where it is referenced as a significant cause
- Improving how we triangulate what we do with impact and outcomes

### **Child exploitation**

The Stoke-on-Trent and Staffordshire Child Exploitation Joint Task Group, continue to lead on this priority for the Board with the key objectives being to review the child exploitation strategy which is due for renewal in 2022 and to develop a partnership performance framework to monitor its impact.

Our approach to child exploitation has meant we have seen a reduction of criminalisation of children with reductions seen in both child victims and offenders.

During the last 12 months children have continued to be identified and the latest data from our Multi Agency Child Exploitation (MACE) panels demonstrates that child exploitation is being identified by a range of partners and children are being appropriately referred into services using the Risk Factor Matrix (RFM). The latest data tells us that for 90% of the children the risks are reduced through disruption of those causing them harm and co-ordination of partnership safeguarding measures.

### **Case study**

Child A was thought to be unhappy with her home life which was pushing her towards a group of peers linked to gang culture. There were indications that she was being sexually exploited by a local group of males and then groomed into facilitating the involvement and possible exploitation of additional young girls. Child A was known to Partners through previous receipt of statutory intervention. Child A expressed changeable daily lived experiences of life associated to these peers, undoubtedly linked to fear and anxiety. There were reports that these associates routinely carried knives and an intimidating environment with the group appearing to be widening. Due to long-term absence from school, her parents raised concerns as they were unsure where she was going during school time and reported her missing.

She was referred to the MACE panel which resulted in her receiving services from the commissioned child exploitation service, Catch22. She received a high level of responsive, trauma-informed support and direct work around increasing her understanding and knowledge of child exploitation from Catch-22 as well as access to support services within school. Her parents also received support, education and awareness to help them support their daughter.

Following positive interventions, risk levels for Child A gradually reduced with some feedback around how this has impacted her in a positive way. Child A now has an improved relationship with her parents. She has indicated that she feels safe and is no longer connected to the group. She is now 16 and has applied for a college placement and is also exploring potential employment opportunities.

Through information gathered through the MACE panel, the multi-agency team were also able to understand, map and put in interventions to disrupt the group from exploiting other children.

Partners are continuing to embed the Vulnerability Assessment Tool (VAT) which will provide a multi-agency product that delivers a comprehensive understanding of child exploitation throughout Staffordshire. It will also provide analytical opportunities to better influence all agencies to drive a partnership approach improving our understanding and approach in tackling this area of vulnerability/criminality.

During 2021/22 the Child Exploitation Task Group undertook a number of reviews and consulted with children and practitioners. Based on these reviews they found that there were some common themes which included:

- Fear and intimidation for children who are being actively exploited
- Experiences of trauma and witnessing violence
- Engaged in criminal activity because of the exploitation

As a result of the reviews, a programme of work has been agreed by the Board which will ensure a whole system review and approach:

- Ensuring the development of flexible service offers which meet the individual needs of children and their families whilst also providing clarity in respect of the delivery between the Pan-Staffordshire Child Exploitation and Missing Children Service; Youth Justice Prevention and Intervention; Early Help Services (provided and commissioned) and Children's Social Care
- Ensuring youth violence is acknowledged as a potential symptom of child exploitation, with clearly defined pathways for children who are not yet known within the system (which includes those children and their families where there are no known associated exploitation concerns)
- Ensuring the independence of Staffordshire County Council and Stoke-on-Trent City Council remains whilst sharing a shared commitment to striving towards a Pan-Staffordshire approach to safeguarding children at risk of child exploitation

This work began in 2021/22 and will continue into 2022/23.

## 2 Ensuring effective multi-agency safeguarding practice

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

### **Our workforce**

Similar to the national picture, many of our Partners are facing challenges in staff recruitment and retention. We will continue to monitor any adverse impact this may have on maintaining a consistent and trained multi-agency workforce in the area of abuse and neglect and also how this may impact on us embedding learning and improving outcomes for children and young people.

### **Listening to children and families**

One of the Board's objectives was to seek assurance that the voices of children, young people and families were 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.

Having trialled agenda slots for partners to share examples of where the voices of children, young people and families had been instrumental in shaping the support provided, partners still feel further assurance is required to understand how embedded and effective this practice was across the partnership system.

Innovatively seeking a better solution, Staffordshire Council of Voluntary Youth Services (SCVYS) shared a quality assurance tool they had developed and trialled to self-assess or peer-assess an organisation's engagement against nine key standards: accessible, meaningful, ethical, efficient, clear, coordinated, timely, quality and partnership. The tool can be used equally as well with a single engagement activity or to assess engagement delivery across a whole organisation. Safeguarding Partners have agreed that the self-assessment tool will be used next year as a follow-up to the planned Section 11 peer assessment in July 2022 to provide assurance that the voice of children, young people and families is being heard and considered by all Partners.

Some of the recurring issues identified by children and young people are shown in Figure 2.

**Figure 2: Top 10 recurring issues for Staffordshire children and young people, May 2022**



*Source: Compiled by SCVYS on behalf of the Families Strategic Partnership Board based on various consultations including Make Your Mark, #TheBigAsk, DCMS Youth Review, The Big Vote (Children and Young People in Care) and insight from local youth engagement practitioners*

Some examples of how these are being addressed include:

- Opportunities to contribute - Local Holiday Activity and Food Programme providers have supported older young people as volunteers to deliver the programme. This has engaged the older cohort who are less attracted to participating in the programme, and in some cases has led to sports leader qualifications.
- Climate change - Staffordshire County Council were due to hold a climate conference which included young speakers in June 2022 (unfortunately this was postponed with a new date to be announced).
- Voice and Influence - SCVYS are working with the SEND and Inclusion Partnership on a Co-Production Charter over the next 12 months. This will be co-produced with young people and partners, and should help embed key principles across the partnership that keep young people central and ensure they are heard.
- Mental health - SCVYS have worked with young people to co-design the Wellbeing Health Action Map (WHAM) Plan with CAMHS practitioners. Children's Voice is embedded as part of their plans to ensure that they have the opportunities to participate and contribute in a way that is meaningful for them.
- Staying safe - our 'with or without words' e-learning which supports practitioners on how to use the voice of non-verbal children linked to our neglect priority continues to be promoted within the early years sector.
- Extra help at the right time - the voice of children and young people's has contributed to the development of a revised early help strategy.
- Opportunities to contribute - the Police Cadets scheme has grown post COVID-19 restrictions to ensure more young people have the opportunity to contribute.
- Things to do; place to go - the Space Programme helps ensure children and young people have places to go and things to do during the holidays.

## Our transformational programme

This year has been one of significant change in the health and social care landscape. Further details are highlighted below.

- **Local Authority transformational programme** - during the year Children Social Care have made transformational changes which has included improvements to the front door (Staffordshire Children's Advice and Support). This now means that a discussion takes place between practitioners who have concerns and dedicated social workers. Anecdotal evidence suggests that there are improved conversations at the front door and that restorative practice is becoming well embedded with better signposting. They have also developed district-based duty hubs with dedicated social workers which means there is a timelier response and improved quality in assessment of need at the right time, Family Group Conferences (FGCs) and family meetings.

Following a successful pilot in Cannock Chase, adult specialist workers with domestic abuse, substance misuse, mental health, and financial inclusion expertise have been introduced into the new district operating model to work alongside children's social workers. This will enable dedicated support to the whole family unit, with a focus on helping and supporting parents and their children at the earliest opportunity.

- **NHS reform** - During 2022/23 we will also see the NHS undergo significant change with the abolition of Clinical Commissioning Groups (CCGs) and the development of launch of an Integrated Care Board (ICB) and wider Integrated Care System (ICS) as the local NHS body. The CCGs gave a commitment to maintain current safeguarding arrangements throughout the transition to ICS and ICB and this commitment was met and has continued. As the ICB and ICS mature the arrangements for safeguarding will be further strengthened with additional posts and plans to review how health partners contribute to this vital work whilst ensuring best use of the available resource across all ICS health partners. (NB: The new arrangements commenced on 1st July 2022).

The ICS are in the process of developing and launching a new approach to key work programmes which will be known as portfolios. One of these portfolios will be children, young people and maternity. This will support further development and strengthening of joint work but will also support further progress on the safeguarding agenda and executive leadership for this will be provided by the Chief Nursing and Therapies Officer who is also the ICB lead for Safeguarding thus further enhancing the opportunities to continue to improve joint working whilst maintaining a clear focus on the safeguarding agenda.

- **Staffordshire Police** - Staffordshire Police have reviewed and agreed a new local policing operating model which will go live in Summer 2022. This will see increases in the number of staff and officers working in district-based harm reduction hubs. This allows for closer working with many partners and families to ensure the correct support is available at the right time.

In 2022 there will also be a full review of the police operating model across the areas of public protection. This will improve the quality of criminal investigations and ensure departments are suitably staffed in terms of the numbers of people working within them and also that staff have the correct skills and training.

### **Multi-Agency Safeguarding Hub (MASH)**

As well as delivering value around decision making where concerns are considered with reference to a continuum of need and an understanding of thresholds, which is its core purpose, the MASH delivers additional value as it:

- Enables more effective and efficient downstream work within agencies by providing information (particularly about involved agencies)
- Provides awareness raising by informing agencies already working with a family/individual (for a different purpose) of concerns that have been identified
- Provides benefits simply because agencies are co-located or virtually, which enables sharing of information to support downstream agency core business and general multi-agency working

During the year and as part of the MASH review, Partners have had more honest conversations about the areas for improvement. We have:

- initiated a review of the governance and working of the MASH to capture strengths and weaknesses
- reviewed the staffing structure and appointed new staff with renewed focus on the areas of weakness in the MASH, namely performance and operational effectiveness including investment in sergeants to improve child protection strategy discussion and outcomes
- launched a new governance structure which includes regular reporting to the Board on delivery under the new arrangements

We are also looking at replacing our current Information Sharing Log (ISL) and have held workshops with operational colleagues to understand the requirements as well as what works well and areas of improvement in order to improve our assessment of risk and decision-making. We are linking this work with our multi-agency performance and audit requirements. Unfortunately, the impact of Covid-19, major transformational changes by both Children Social Care partners and recruitment gaps have delayed the pace of improvement. However, we do have plans in place to undertake a self-assessment during 2022/23 which will help us further understand our strengths and weaknesses.

## Working with educational settings

- **Operation Encompass** - this national initiative went live in Staffordshire in February 2021 and was a significant step towards better partnership working to protect children living in households where domestic abuse occurs. Operation Encompass ensures that information is shared between the police and the child's school so that effective support and safeguarding can be provided. This has seen in excess of 4,000 children whose schools have been notified that they are living with domestic abuse (meaning that they are a victim of domestic abuse by their presence in the household). Operation Encompass is currently being evaluated for effectiveness by Staffordshire Police with findings due in November 2022.
- **Support and training** - GCP2 training has been delivered to a large number of schools and many have now completed assessments within their settings. Colleagues from schools have also attended two Synergy events with Counter Terrorism colleagues. This is a table-top exercise where they talk through a real case study and it is regarding far right ideology. The Education Safeguarding Advice Service (ESAS) deliver half-termly briefings to Designated Safeguarding Leads (DSLs). These briefings have a specific focus and always now contain a section covering learning from reviews such as domestic abuse and sexual abuse. DSL drop-in sessions have also been trialled to deliver additional support and guidance on a variety of current topics. Over 120 schools have attended these weekly drop-ins run by which are subject specific including: sexual violence and sexual harassment (including consent/coercion/control), Ofsted inspections for safeguarding, Operation Encompass and bullying. These are also recorded and are now included via YouTube clips on the Education Safeguarding page of the Staffordshire Learning Net (SLN) and are sent out in the weekly school bag.
- **Access to information** - ESAS have reviewed and updated the Education Safeguarding section on the SLN which now contains a wealth of resources for schools including recordings of our new focussed drop-in sessions so that schools can access them as required. We have been informed that more schools are accessing the ESAS SLN pages and those pages are having an increased number of hits. Schools are directed to this as well as the SSCB website for advice, support, guidance and a wealth of tools for them.
- **Section 175/157 audit** - following a comprehensive review of the Section 175/157 safeguarding audit a new online audit was procured by ESAS. This new tool will allow both school settings and ESAS richer qualitative information to inform practice and action planning. The survey includes sections on neglect, peer on peer abuse, Prevent and a section focussing on the Virtual School. The findings, due in Autumn 2022, will enable ESAS to tailor training, newsletters and briefings to reflect the safeguarding needs of schools.

## Inspections

Staffordshire Police underwent a National Child Protection Inspection during September 2021. This examined how effective the police's decisions were at each stage of their interactions with or for children. This was from initial contact through to the investigation of offences against them. The inspection also scrutinised how the force treated children in custody and assessed how the force is structured, led and governed, in relation to its child protection services.

In preparation of the force inspection, force audits were undertaken and highlighted several areas of focus:

- Safeguarding assessments, both their use and grading
- Quality of referral
- Lack of supervisory oversight in investigations
- The Voice of the Child not being present

Following the inspection, whilst pockets of good practice were identified, significant areas for improvement were apparent. As a result, the force adopted a Child Protection Improvement Programme and Chief Officer oversight is provided by ACC Jennie Mattinson who chairs a Strategic Child Protection Board.

The programme focuses on delivery of improvements against 15 areas identified by the inspectorate. Key areas include:

- A review of training for all officers and staff which seeks to improve risk assessments, raise awareness of the voice of the child and ensure specialist investigators are appropriately trained and accredited.
- Improvements in the risk assessment process and management of missing children.
- An introduction of new and improved risk assessment processes within the Contact Centre where telephone and digital contact is received from the public.
- Improving practices and partnership working when children are taken into emergency police protection.
- A review of how the force use Public Protection Notices (PPNs) to understand risk and threshold and make referrals to partners.
- Training for all custody staff to ensure full understanding of safeguarding responsibilities to children in police detention. Appropriate and adequate arrangements will be made through multi-agency partners including the swift identification and use of appropriate adults, healthcare provision and information sharing with Children Social care for every detained child.
- A review of the staffing levels within specialist child protection teams.
- Improved governance and oversight of performance for all areas of child protection.

### **Making policies and procedures more accessible**

In 2021, the Board initiated a project to deliver essential policies and procedures to its front-line practitioners in a more efficient and effective way. Over 400 front line practitioners were surveyed online and in person to discuss the availability of policies on the website and the value of them whilst also establishing what was needed from policies to enable confidence and competence when faced with concerns. This consultation along with analytical evidence of the website demonstrated that many policies were in need of review or not accessed by users due to their format and content.

The Board have now identified a suite of 12 policies to be held on a more assessable format on the Board's website along with a suite of further guidance in the form of seven-minute briefings, video and animation to meet the needs of practitioners who wanted easy to access and concise information at the touch of a button.

This project is ongoing and will continue to provide improved access to policies and procedures.

### **Section 11 assurance: learning and development**

During 2021/22 we focused our Section 11 audit on learning and development. Our findings were positive with most Partners able to evidence how they were providing staff with training and support and the impact of this. Most Partners also evidenced how they had aligned training plans to the Board's priorities as well as learning from the system, for example intra-familial sexual abuse and Think Family. Further assurance will be sought next year on the impact of staff training and development through a peer assessment.

### **Multi-agency performance**

We are continuing to develop our performance data frameworks in several forums as a partnership approach to deliver sustainable change and identify emerging threats. This will help provide a connected view of partnership data which will be supported by further work by the data analytics group through Staffordshire County Council. It will also provide a clearer safeguarding picture compared to the singular view that single-agency data currently gives.

### **Child safeguarding practice reviews**

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

During 2021/22 there were four Rapid Reviews and in contrast to last year were all related to adolescents. Two young people died from suicide, one young person was significantly harmed as a result of child sexual abuse and one Rapid Review considered the potential harm caused to two young people subject to forced marriage and removed from the UK.

Two of the Rapid Reviews have led to newly commissioned child safeguarding practice reviews (CSPRs) involving child sexual abuse and forced marriage. There are also three unpublished CSPRs, one review which is in the final draft format and two reviews completed and awaiting the finalisation of parallel legal proceedings.

The themes identified during the Rapid Reviews and CSPRs involved issues related to failure to capture the voice of the child; lack of information sharing and dilution of information that was shared; parental bereavement and subsequent neglect; lack of professional curiosity, and challenge; ineffective risk assessment; professional confusion related to the terms sex offender status and person posing risk to children (PPRC) and what this means for managing risk; lack of critical thinking leading to over optimism; missed opportunities for intervention and protection; interpreting allegations of domestic abuse; the management of special guardianship orders; children subject to legal care orders, child in need plans and child protection plans, impact of Covid 19 on accessing children face-to-face, child mental ill health and violent suicide.

The findings and learning demonstrate similarities with the national findings identified in the Child Safeguarding Practice Review Panel Annual Report 2020 and some of these are recurrent themes locally:

1. Understanding what the child's daily life is like
2. Working with families where their engagement is reluctant and sporadic
3. Critical thinking and challenge
4. Responding to changing risk and need
5. Sharing information in a timely and appropriate way
6. Organisational leadership and culture for good outcomes

They also highlight the potential impact of Covid-19 as this cannot be avoided as being a significant factor in the lives of families across Staffordshire.

Findings have been identified using a system-focussed approach and there have been some positive outcomes achieved over the past year where agencies have worked well in partnership to improve systems and processes and ultimately improving safeguarding practice and outcomes.

We have started to include a broader range of partners on learning reviews such as commissioners so that learning can be embedded into performance and quality assurance conversations. Commissioners have embedded lessons learned into contract review mechanisms where required. Learning has also been shared with other Partnership Boards such as the Early Year Advisory Board (EYAB) and Early Help/Place Based Approach Operations Group to help shape the development of their delivery plans.

The focus for next year remains on being able to evidence the 'so what' factor and demonstrating that things are improving for children and young people in Staffordshire. During 2022/23 we also plan to commence discussions with our academic partners to understand why we are seeing recurrent learning.

## Learning form child deaths

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

During 2021/22 we saw an increase in the number of notifications of child deaths (93 compared with 69 notified the previous year) with neonatal deaths (deaths within 28 days of life) continuing to account for the largest proportion (47%). 14% of our child deaths occurred in teenagers aged 15-17. Of these, 24 (26%) were categorised as unexpected requiring a joint agency response (JAR).

During the year 67 child deaths were reviewed in Staffordshire and Stoke-on-Trent. Of these 17 were considered to have modifiable factors with the most frequent themes being:

- Smoking
- Poor mental health of either parent/carer or child
- Alcohol / drug use by parents/carers
- Access to appropriate services or gaps in service
- Unsafe sleeping environment
- Living in chaotic environments

We continue to implement improvement activity against our recurring modifiable factors. As one of the most prevalent modifiable factors, the smoking in pregnancy service has been recommissioned with a revised process to ensure better take-up of the service and support. We have also rolled out ICON (Infant crying is normal; Comforting methods can help; it's Ok to walk away; Never, ever shake a baby) programme to partner agencies and continue to seek to improve services by engaging child and families in the process. We also have continued our work through campaigns, support and multi-agency training such as promoting Safer Sleep and sharing information around unintentional injuries and hazards such as button battery awareness.

Deaths from suicide (six) continue to be a concern and were the highest since the panel formed in 2008. (Note: fluctuating figures due to the very small numbers involved). As a result, we conducted a thematic review during the year and also participated in a region-wide review. The key findings from the review identified some emerging learning in relation to local pathways and processes.

The common themes were: understanding and accessing the mental health support; communication and support following discharge from mental health services; support for young people aged 16-18 (this cohort of children were managing their own mental health support and many parents expressed frustration of being unaware of treatment plans to support their vulnerable children in this age group); and multi-agency working. The lives of young people were not triangulated by agencies involved in their support and therefore a full picture of the young person's life. Some support services were also working in isolation to support young people.

The findings from the review have been accepted by the ICS Children and Young People's Mental Health Improvement Board through focus on: outcomes; prevention; capacity and demand; service delivery/i-thrive; access; workforce; and care experienced children and young people. In recent months there have been significant developments around the support offered to children and young people in crisis or at risk of crisis. Progress against the findings is being monitored by the Board's Scrutiny and Assurance Group and in particular in terms of the impact on children and young people.

### **Review of restraint**

The Review of Restraint Group is established under the safeguarding board arrangements to ensure compliance with Working Together 2018 in providing scrutiny of restraint. The group reviews whether staff in Werrington Young Offenders Institute (YOI) are trained in behaviour and de-escalation techniques and ensure that appropriate monitoring arrangements are in place to oversee restraints of children. During 2021/22 the group continued to meet despite the challenges of Covid-19 restrictions.

The use of restraint in Werrington YOI is higher than in all other YOIs and has risen in 2021/22. Most incidents of restraint are in a response to violence. All incidents of restraint are reviewed by the social work staff seconded from the local authority into the establishment and a selection are chosen for review by the Review of Restraint Group. Over the last 12 months the Review of Restraint Group has selected 24 incidents of restraint for scrutiny. All of those incidents demonstrated a sound knowledge of applying restraint appropriately and within the expected standards. During 2021/22 the Restraint Co-ordinators introduced a mentoring scheme and early indications are that this is supporting safe application of restraint.

During 2021/22 children within Werrington have attended the Review of Restraint meeting and they have told us the following things:

- They understand why they need to be restrained
- They know where to go for help and support

Given that restraints are more often than not driven by violence our improvement plan for 2022/23 will be focused on driving down violence within HMYOI Werrington to ensure children feel and remain safe.

The Chair of the Review of Restraint Group has also escalated concerns to the Board who are now seeking assurance on a monthly basis and ensuring there is partnership support to the establishment in reducing the levels of violence. To support this area of work Staffordshire's Director of Children and Families is also attending the Youth Custody Service (YCS) Safeguarding Continuous Improvement Board and the Safeguarding Lead from the YCS has attended the Scrutiny and Assurance sub-group to discuss how we can work together to address the issues of violence.