



Annual Report

Stoke-on-Trent and Staffordshire
Safeguarding Children Board (SSSCB)

2019/2020

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Important Note: The body of this report was completed before the current coronavirus pandemic. Its impact on both the local community and local services had not been felt when this was written.

Introduction and Context

This is the first Annual Report of the Stoke-on-Trent and Staffordshire Safeguarding Children Board (SSSCB) since its formal merger in April 2019. The SSSCB was formed in response to the changes set out in Working Together 2018 and in particular the need to step down Local Safeguarding Children Boards and replace them with local partnership arrangements designed to safeguard children. Stoke-on-Trent and Staffordshire partners approached the reforms positively and were one of the 'early adopters' as identified by the Department for Education. The detail of which can be found here <https://bit.ly/3pomZ8H>

The key features¹ of the new arrangements are:

- that children are safeguarded, and their welfare promoted
- partner organisations and agencies collaborate, share and co-own the vision for how to achieve improved outcomes for vulnerable children
- organisations and agencies challenge appropriately and hold one another to account
- there is early identification and analysis of new safeguarding issues and emerging threats
- learning is promoted and

embedded in a way that local services for children and families can become more reflective and implement changes to practice

- information is shared effectively to facilitate more accurate and timely decision making for children and families.

The SSSCB began formally meeting in April 2019 and it is fair to say that much of that time has been focused on embedding the new arrangements and understanding the role and contribution that partners can make. Board members acknowledge that these new arrangements are fairly radical but are necessary given the recommendations set out in the 2016 Wood review where Board arrangements were previously seen as 'not sufficiently effective'.

Early adopter status afforded the safeguarding partners (Local authority, Clinical Commissioning Group – CCG and the police) an opportunity to exercise their statutory functions in a more innovative and flexible way that could respond to the system more efficiently.

Change isn't easy and coupled with the Ofsted inspection that took place soon afterwards for Stoke-On-Trent local authority children and family service department in February 2019, this has meant a busy year for the Board.

Since the inspection the Stoke-on-Trent Children's Improvement Board, chaired by the DFE Commissioner Eleanor Brazil,

¹ Working Together 2018

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has been in place to monitor and drive the improvement plan.

The local authority identified three key challenges which are outlined below:

- Reset and refocus on good practice and outcomes as a system, rapidly improve the quality of front line practice
- Focus on workforce capacity and leadership
- Focus on Children in Care – permanence and sufficiency

The Safeguarding Children's Board have continued to seek assurance from this group, and as such have acknowledged the progress the local authority continues to make.

Some examples of improvements to date include;

- the Children and Families Service have worked closely with their Partner in Practice, Leeds, and now have an agreed programme of Restorative Practice Training for all staff. Train the Trainers sessions will be rolled out in Autumn 2020
- A review of performance monitoring activity through the enhanced reporting system means that children who have missing episodes are now reviewed daily by the CSE coordinator. Links with the developing MACE panels results in closer synergy and early identification of any trend or patterns of behaviour in the area.
- As a result of all the audit activity there is no doubt that this

programme of improvement on the basics of social work practice has had a major and broadly very positive impact. More work is to be done on the rate of progress.

- In 2019/20 court proceedings showed an average length being 38.7 weeks compared to a national average of 30 weeks. As such, all pre-proceedings and family proceedings guidance have been reviewed along with training provided to teams in expected standards. As a result, there is now a clear pathway in place to reduce drift. In summary 2019/20 has been a very busy year for the Children and families Service in Stoke and has seen a number of improvements in practice and partnership working arrangements. The local authority has assured the Board that they are committed to good outcomes for children and young people in Stoke-on-Trent and will continue their improvement journey through 20/21.

Priority areas include the recruitment of a permanent and experienced workforce along with improving the quality of assessment and planning for young people. With the recruitment of a permanent senior management team the foundations are now in place for improvements to begin at pace which will be reported on in the next Stoke-on-Trent partners report for 2020/21.

Governance

A revised structure that sits underneath and reports into the Board provides members with the assurance that the wider safeguarding system is effective in meeting the needs of children and families. The Board agreed to delegate the function of performance and quality assurance to its newly formed Stoke-on-Trent and Staffordshire Safeguarding Children Partnership (SSSCP). This core statutory function as set out in Working Together 2018 is one that requires further development, but in the past 12 months the (SSSCP) have emerged with:

- a successful and smooth formal transition from 2 separate previous Board arrangements to one Board, whilst maintaining the Boards statutory responsibilities including the management and coordination of 2 on-going serious case reviews (outlined later in this report).
- an agreed term of reference that sets out their role and responsibilities for all relevant partners to collectively share performance information that will enable the Partnership to provide the assure the Board need, particularly against the Boards two priorities; Child Exploitation and Neglect
- A draft performance and quality assurance framework, along with a draft workplan, one of which includes a completed multi-agency audit of both local authority front door referral services and preparation for the previous JTAI around mental health
- A proposal for delivering and supporting the performance activity in relation to the previously mentioned framework in the form of a short-term commissioning arrangement.
- Completed 2 reviews. 1 is a serious case review that started prior to the new arrangements and the other is a Child Safeguarding Practice Review (CSPR). Both are yet to be published due to on-going criminal and legal proceedings.
- Via the Child Exploitation task and finish group the Board were successful in their bid to become one of the development sites for the Tackling Child Exploitation Programme² working with the University of Bedfordshire, Research in Practice and The Childrens Society

² Research in Practice

<https://tce.researchinpractice.org.uk/>

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- Oversight of the development of a new Board website and the learner management system for managing and booking multi-agency training



Subgroup activity

Although CSPR and training were initially outlined in the New Arrangement document as functions, the Board agreed to maintain these within a subgroup structure whilst trying to navigate the transition, which at the time involved a significant amount of activity. As such there are 4 subgroups that sit under and report into the SSSCP and the Board. These groups will be reviewed as part of the Boards new arrangements going forward in 2021/22.

These include the;



- **Child Death Overview Panel (CDOP)**
- **Child Safeguarding Practice Review group (CSPR)** – this replaced the previous 2 separate serious case review subgroups
- **Professional Development and Training subgroup (PD&T)** (2 separate subgroups)
- **Review of Restraint task group.** This group has a statutory footing in WT 2018 as a secure establishment exists within Staffordshire, HMYOI Werrington. The annual update from Werrington is shared with the SSSCP as part of their scrutiny and assurance role, some of which is included in this report.

Rapid Reviews and Learning from Child Deaths/ Significant Incidents

Since the introduction of the rapid review process in July 2018 (Chapter 4 of Working Together 2018), the Board have conducted 9 rapid reviews. These reviews take place following a serious incident notification (SIN).

The circumstances surrounding the SIN could be that a child has either died or been seriously harmed. The criteria can also include any child who is looked after by the local authority. Each local authority must notify the Child Safeguarding Practice Review Panel (commonly known as the National Panel) and Ofsted.

Of the 9 cases that were notified, Staffordshire notified 4 and Stoke-on-Trent notified 5. All resulted in a rapid review, which when scrutinised by the National Panel met their satisfaction. This acknowledgement by the Panel reassures the Board that the new process is not only clear and swift, but is also an open and transparent process, with strong evidence from agencies that enables others to see how well they work together to support children and families, as well identifying areas where this needs to improve.

Rapid reviews are a significant shift from what was a lengthy drawn out process to a new and richer more equitable learning space, and one that is showing a reduction in the unnecessary burden of process. The Board continue to work with their regional partners in Birmingham LSCP, also an early adopter, who continue to play a significant part in developing the rapid review paperwork and guidance.

Of the 9 children mentioned above, 7 will be included in a Thematic Review for the under 1's. This particular review aims to explore 4 themes, all of which are recurring and include;

1. professional challenge and escalation through the eyes of the practitioner
2. the child's voice and the impact of parental behaviours on children in terms of their optimum development
3. The quality and timeliness of Early Help Assessments (EHAs) including parental experience of the EHA process
4. domestic abuse with a focus on the impact of decision making through the eyes of the victim (mother)

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To enhance the analysis achieved from the individual rapid reviews, each group will focus on specific learning conversations with front line staff, including those who had some degree of involvement with the families. Feedback from the families themselves, where achievable will be included in the review, the findings of which will be published in next year's annual report.

Serious case reviews (SCR) carried over/ Child Safeguarding Practice Reviews (CSPRs)

- The Board carried over 2 SCRs during its transition and although one is finalised, and the other is nearing completion, neither have been published because of ongoing parallel legal proceedings.
- The learning from those reviews has seen an overwhelming response from agencies, with a real desire to effect change. The importance of recognising low level neglect still exists and further work is needed by all partners to improve the front line response to identifying and then assessing neglect.
- It is the intention of the Board to begin by extending the priority into 20/21 and to commission the Graded Care Profile 2 (GCP2) tool later in the year as a way of improving our collective response. A steering group will be set up to oversee its implementation
- Further work by the SSSCP will aim to measure the effectiveness of the system by way of single and multi-agency audits and other performance measures, as well as an analysis of the support given in the very early days of signs emerging.
- Multi-agency training as well as single agency training all help to embed new tools and approaches such as restorative practice and include reference to revised policies and procedures and learning from reviews.
- More work is to take place with children and young people and the SSSCP are working through the performance and QA plan to agree local pieces of work that evidence the 'so what', and to determine how children's experiences compare to those findings from performance and QA activity.



Embedding learning

With the introduction of the new website, and the agreement by the Board to appoint a campaigns officer, work has started to improve the way in which the learning from reviews is shared.

- Speed is of the essence, as is quality therefore social media platforms such as Facebook and Twitter will be maximised to help facilitate key messages to the front line and wider public. Short video clips and child narrated animations are in the pipeline, as well as short Q&A topic based webinar sessions that will endeavour to help build confidence within the workforce, as well as introducing keynote speakers specialising in their field.
- Regular newsletters continue to raise awareness of Board priority areas, local child safety campaigns, changes to policies and procedures, consultations and much more.
- The richness from reviews is especially important and finding new and innovative ways to embed messages continues to be high on the Boards priority list.
- Closing the loop is just as, if not more important in terms of embedding learning so again through the work of the SSSCP to assure the Board that recurring themes from the rapid reviews are either reducing in number and/or complexity, or where they do continue to exist, the Board have a better understanding of why this is and the steps needed to try and resolve them.



Board priorities

Child Exploitation

The Child Exploitation Task Group was set up in 2019-20 to develop the Child Exploitation Priority.

The priorities set by the Safeguarding Board were:



- Development of a Child Exploitation Strategy
- Development of a multi-agency performance framework to monitor the impact of the strategy

To date the group has developed the strategy which will be launched in the next few months and is working with the Tackling Child Exploitation project team to develop the performance framework.

Neglect

Adopted following the learning from the most recent SCR, this priority area for the Board again raises concerns over our collective response to neglect, particularly for those families that resurface following a period of intervention whether that be early help or statutory support via a child in need plan/ child protection plan, only to be re referred once support is withdrawn.

Low level neglect is hard to recognise and respond to, and we must improve our understanding of the impact if we are to change the lived experience for these children. This begins with the Boards focus on neglect through its performance work, and with the support of the SSSCP an understanding of how agencies currently operate within the system.

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Work is underway to explore the commissioning of the NSPCC Graded Care Profile 2, a tool to identify and assess neglect and a model for train the trainers to support its implementation. A multi-agency steering group will be responsible for the oversight of implementation, with reporting lines into the SSSCP. Neglect goes far beyond the responsibility of the Board therefore further work to align and strengthen the Boards relationship with other strategic Boards is key to its success.



Independent Scrutiny

As outlined in the New Arrangements document, independent scrutiny took on a new look and under the guidance in Working Together 2018 aimed to ensure the arrangements were:

- Objective
- Constructive and
- Promotes reflection to drive continuous improvement

To achieve this the Board

- Agreed to the review commissioned by DFE Commissioner Eleanor Brazil. The review aimed to consider whether the new arrangements would:
 1. Provide the necessary oversight of safeguarding activity in Stoke-on-Trent.

2. Ensure that the strategic leadership across the system will drive the multi-agency improvements needed in services for children in need of help and protection in Stoke-on-Trent."

- Each met with individually with Mark Gurrey, a member of the National Panel and Independent Chair from the Wiltshire Safeguarding Partnership Panel at the request of Eleanor Brazil (also chair of the Children's Improvement Board in Stoke) and was intended to link to her overall review of children's services in Stoke-on-Trent.

- Mark said “A lot of good progress has been made in developing a response to the changes set out in ‘Working Together 2018’ to develop new multi-agency safeguarding arrangements. There is now a need to accelerate the pace of change of those developments and ensure that the partnership delivers on the aspirations it has set for itself and are required now by national guidance”
- In particular, a recommendation was for the partnership to review the governance arrangements and accelerate the arrangements for the delivery of independent scrutiny, the quality assurance work and set out how rapid reviews and individual case reviews are conducted so that together they can enable the safeguarding partners in Stoke and Staffordshire to have more detailed knowledge of and greater influence on the delivery of services to children and families in their areas.
- In response to the recommendations, the Board continued to work with its regional partner Birmingham LCSP, to streamline the rapid review process and further details can be found on page 8.
- Conducted a review mid-way through its new arrangements with support from the National Police Chiefs Council, an independent chair from outside the local area, who is also a member of the National Child Safeguarding Practice Review Panel as well as the DFE appointed commissioner supporting Stoke-on-Trent local authority. This review helped to focus the development plan for the Board and identify further areas for development
- Supported the local authority internal audit commissioned that provided the Board with the assurance that it was fulfilling its statutory functions, and again helped to improve and drive its development plan
- Representation from lead members adds an additional layer of scrutiny that provides a critical friend role
- Internal scrutiny processes enable further assurance of Board arrangements and activity

Relevant Partners

A key commitment within the new arrangements was to ensure that the relationships and coproduction around priorities was valued and owned by all partners across the wider partnership.

The SSSCP has utilised this past twelve months to review how the partnership can be most effective in translating the learning into practice improvements. Achievements so far

- All partners have reviewed the membership as well as the terms of reference offering assurance to the Board of their roles and responsibilities, including the work plan for the coming year
- Supported the design of the new website, the content and re design of new branding including the monthly SSSCB newsletter and supporting key messages through the development of a variety of platforms for disseminating key learning and updates from Board
- Maintaining the quality and content of Board policies and procedures



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A further commitment of the Board was to ensure that there was a more direct relationship with the school designated safeguarding leads. This has begun with positive engagement and sharing of good practice through regular meetings and the dissemination of learning from rapid reviews. The impact is reflected in the quality of requests for children social care support and the confidence reported by those holding these roles.

In addition, the reporting that schools provide to the Board has collaboratively been redesigned and resulted in over 97% schools returning their analysis. This has provided assurance to the Board that the majority of schools are keeping children safe. For those that either self-identified or did not return there has been individual follow up conversations in support.

Workforce Development

Multi agency training continues to be a popular and a well-respected area of work for the Board, with increasing numbers accessing online training and core level 1 slides for those organisations that require a more flexible, autonomous and high-quality training offer. The range of courses offered by the Board covers 4 levels of learning from basic awareness courses, right through to more specialist training, including on-going 'top ups' through the introduction of awareness sessions such as safer sleeping and child exploitation events.

The evaluations suggest a high level of outcomes achieved through accessing the Boards training packages, with many indicating



- ✓ increased knowledge and understanding in a specific subject area
- ✓ increased confidence in spotting the signs of abuse
- ✓ Increased knowledge of the various pathways including referral routes
- ✓ A better understanding of the Board and what we do

Review of Restraint

HMYOI Werrington is a custodial setting which sits in the north of Staffordshire. As an establishment they can hold up to 118 boys aged between 15 & 18 yrs. At the time of writing, they have a population of 84.

Behaviour management remains a priority within Youth Custody as a whole. Werrington staff are trained twice yearly in both behaviour management and restraint minimisation. Restraint on children is only used as a last resort, when other de-escalation techniques have failed.

Any restraints used on children at Werrington are screened via the multi-agency Review of Restraint task group. The panel are able to view CCTV and all Use of Force paperwork. This review allows the Local Authority and the Head of Safeguarding at

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Werrington to identify both good practice and learning outcomes

Annual updates are provided to the Board via the SSSCP Performance and Quality Assurance Framework, which offer assurances to the Board.

Outcomes so far include

- ✓ Improvements in the recording of restraints
- ✓ A reduction in the use of restraints and in particular those involving pain

Barnardo's is the UK's largest children's charity, and commissioned by the Ministry of Justice (MoJ) and contract managed by Youth Custody Service (YCS), to deliver the Independent Children's Rights and Advocacy Service (ICRAS) across the Children's & Young People's Secure Estate (U18 YOIs and STCs) in England and Wales, including Werrington YOI.



The service is publicised as 'Barnardo's: Your Rights, Your Voice' (BYRYV). This visiting and independent service has been delivered by Barnardo's since 2008 and was awarded renewed contract on the 1st January 2019. The ways in which Barnardo's empower children include in our current contract with the MOJ (2019-2023) a focus on:

- Developing children's awareness and understanding of their rights.
- Being required to independently refer allegations against staff to the LADO.
- Within 24 hrs of notification we offer support to children at their debrief, following their first time of being restrained in any establishment, and at future debriefs as requested by children.

As an independent service, Barnardo's would only be aware of safeguarding concerns as disclosed to them by children or others, or through observations made by their staff. As such, it is important to highlight the limited access to information, which is appropriate, but narrows the lens of the service's perspective. Barnardo's is not informed of any safeguarding referrals other than the ones it makes itself. Furthermore, it is worthy of note, that Barnardo's position is not to independently monitor the establishment. All concerns in relation to the use of restraint are viewed as safeguarding concerns by Barnardo's. Any safeguarding concern observed by Barnardo's staff, disclosed to them by children, families, or by other professionals, is reported through Barnardo's jointly agreed local protocols between Barnardo's and the individual establishments; and are contractually required. The safeguarding protocol outlines how Barnardo's staff raise

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such concerns. In all establishments these protocols have been written by Barnardo's as part of our contract with the MOJ, then reviewed and signed by each establishment. Barnardo's staff delivering the service at Werrington YOI are expected to: '*... inform the Local Authority Designated Officer (LADO) where there is a concern or allegation that someone working or volunteering with children:*

- Has or may have harmed a child.
- May have committed a criminal offence related to a child.
- Has behaved towards a child or children in a way that indicates they may pose a risk of harm to children.'

At the time of writing, Barnardo's are working with YCS to reach further clarity on YCS expectations of the service in the management and reporting of allegations against professionals, i.e. Barnardo's referral to the LADO.

Children at Werrington YOI have said about the Barnardo's service:

'Really understanding and open minded when I speak to them.'

'I believe Barnardo's is a great thing because some young people are scared to talk, and that's were Barnardo's help, they are brilliant company and the Barnardo's staff at Werrington are lovely, great.'

'The Barnardo's worker helps and assists me when I need.'



Looking ahead: changes and developments in the structure of SSSCB and Priorities for 2020-2021

Following the Ofsted inspection in Stoke-on-Trent there is a desire for the local authority to move to separate arrangements to enhance the focus on Stoke-on-Trent's challenges and separate arrangements would enable this.

For each new arrangement to agree it's priorities, budgets and staffing arrangements, whilst retaining joint priority areas and activity such as child exploitation and neglect and any ongoing reviews.

