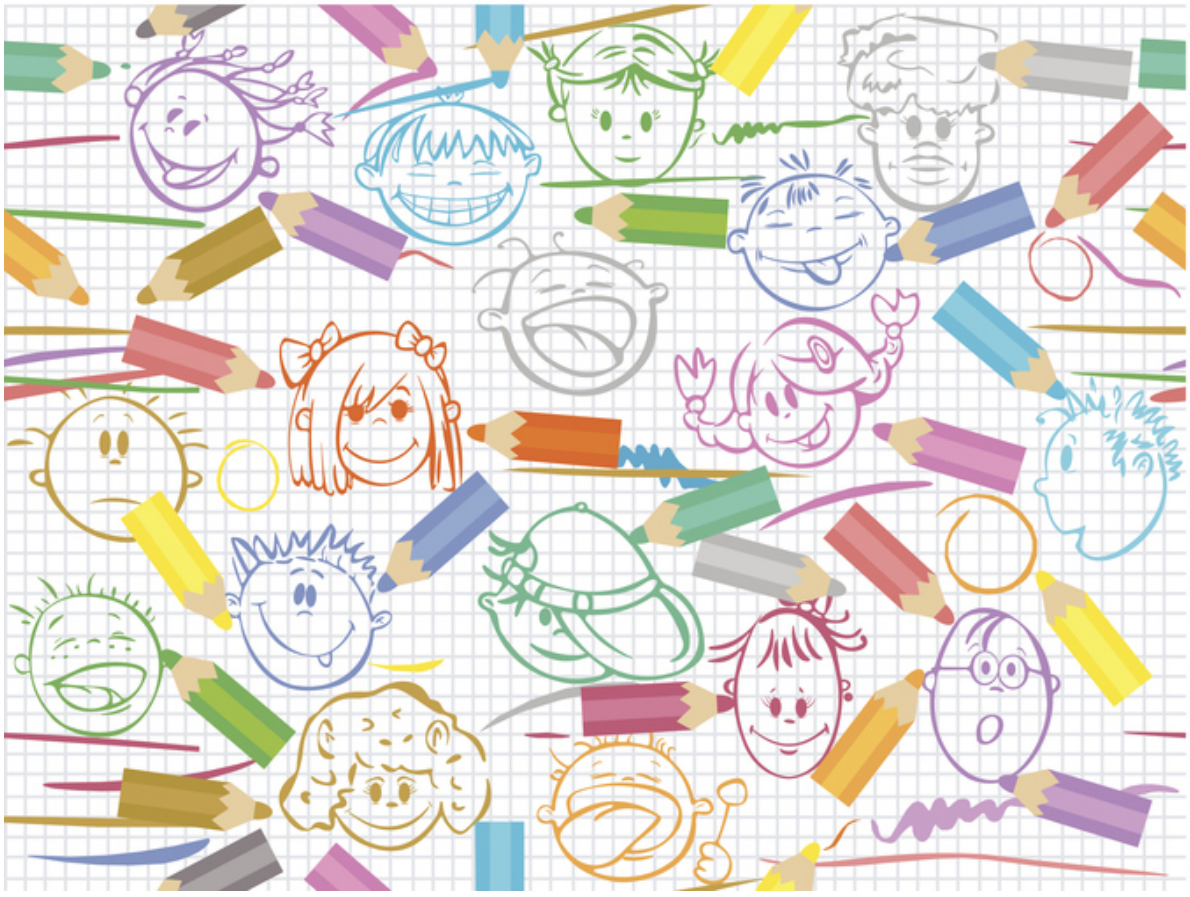
Safeguarding Children in Stockport

Annual Report

2016-2017



This Annual Report is a public document.

It can be accessed on the website of Stockport Safeguarding Children Board:
http://www.safeguardingchildreninstockport.org.uk/practitioners/aboutus/?view=Standard

Approved by STOCKPORT SAFEGUARDING CHILDREN BOARD on the 18.9.2017
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Stockport Safeguarding Children Board Annual Report

Contents

Foreword by the Independent Chair

I am pleased to present the 2016-17 Annual Report on behalf of all the agencies represented on the Stockport Safeguarding Children Board. The reports shows that in Stockport we have continued to build on the strong partnership foundation to meet the many challenges facing agencies in ensuring that we are not only keeping children and young people safe but also improving the outcomes for our most vulnerable children.

We hope that you will find that the report helps you to better understand how organisations and people work together and the contribution the Safeguarding Children Board has made to this. It sets out how these arrangements can continue to improve on the basis of the Safeguarding Board and partners being able to objectively and critically learn from what works well and act to improve what may not work as well as was intended.

This report covers 1 April 2016 to 31 March 2017 and highlights the activity, progress and challenges faced by Stockport Safeguarding Children Board with a particular focus on the journey of the child. The report outlines the ongoing developments in relation to Stockport Family and the impact that the innovative service models are having on our most vulnerable children i.e. Stockport Families First working with children and their families on the 'edge of care'; and a new Complex Looked after Children service who support and accelerate care plans for our children in high costs placements where the outcomes for these children are known to be poor. We have set out the achievements made in 2016-17 and the areas where we need to continue to make improvements.

In 2016/17 Stockport Safeguarding Children Board didn't commission any serious case reviews; and during this year progress was made in relation to the completion of the single and multi-agency actions plans. There had been drift in getting the action plans completed which was addressed throughout the year and the Board is in a better position with the majority of plans having the evidence they have been completed and it is envisaged that these will be completed early in 2017/18. In order to focus on and drive change regarding the key themes, a serious case review improvement plan has been developed. The Board published two Serious Case Reviews reports and commissioned an Independent Learning Review within the year.

In January 2016, the Government commissioned Alan Wood to review the future of LSCBs, and our Board submitted thoughts to this process. The report, and the Government's response, came out early in 2016-17; which made a number of recommendations for the future of LSCB arrangements. With the publication of the Children and Social Work Act in April 2017 the Board and its wider partnership will need to engage in work to determine what the future multi-agency safeguarding arrangements will need to look like in order to continually improve the local safeguarding system.

While we have yet to receive any detail, there is the potential for real change and with this, both opportunities and the risk of instability. My intention and that of the partnership is to ensure that, here in Stockport, we do not let ourselves be distracted from the job we need to do while we manage whatever changes are to come.

To conclude, I would like to thank members of the Board, across the partnership of our voluntary, community and statutory services and all the frontline practitioners and managers for their commitment, hard work and effort in keeping children and young people safe in Stockport. We will continue to seek out what we can do better, to support the community we serve and ensure that children and young people are safer as a result.

Gill Frame

1. Statutory Context

The purpose of this Annual Report is to review the work of Stockport Safeguarding Children Board and to provide an outline of the main activity and achievements of Stockport Safeguarding Children Board from 1st April 2016 to 31st March 2017. This report is a duty of the Safeguarding Board in order to make a transparent assessment of the performance and effectiveness of safeguarding activity in Stockport. The report seeks to identify gaps in services and any challenges ahead. This report provides the means by which Stockport Safeguarding Children Board can be held to account.

This Annual report will be made available to the Chief Executive, Leader of the Council, the Police and Crime Commissioner and the Chair of the Health and Wellbeing Board as required by government guidance. [1]

It will also be available for public view through the Stockport Safeguarding Children Board website.

Governance and Accountability

Stockport Safeguarding Children Board is the key statutory body for agreeing how organisations in Stockport will co-operate to safeguard and promote the welfare of children in the area, and for ensuring the effectiveness of what they do. LSCBs are required to coordinate and ensure the effectiveness of local arrangements and services to safeguard and promote the welfare of children in their area. The development of Stockport Safeguarding Children Board is built on the commitment from organisations across Stockport to keep children safe and the strong and successful partnerships previously developed.

Since its establishment, the Board has worked hard to develop strong governance arrangements, and clear processes for quality assuring safeguarding in the local area. It seeks to raise awareness with workers and members of the public on key safeguarding issues and provides a locally relevant and engaging multi-agency training programme.

This report considers priorities set within the Stockport Safeguarding Children Board business plan for 2016-17, progress made against these priorities and areas for further development in the coming year. It provides detail of the Sub-group activity of the Stockport Safeguarding Children Board, information about partnership contribution to the safeguarding of children in Stockport.

Greater Manchester Safeguarding Partnership

Stockport is committed to the Greater Manchester Safeguarding Partnership, which is attended by the Head of Safeguarding and Learning. Issues that have been a focus for the last year are:

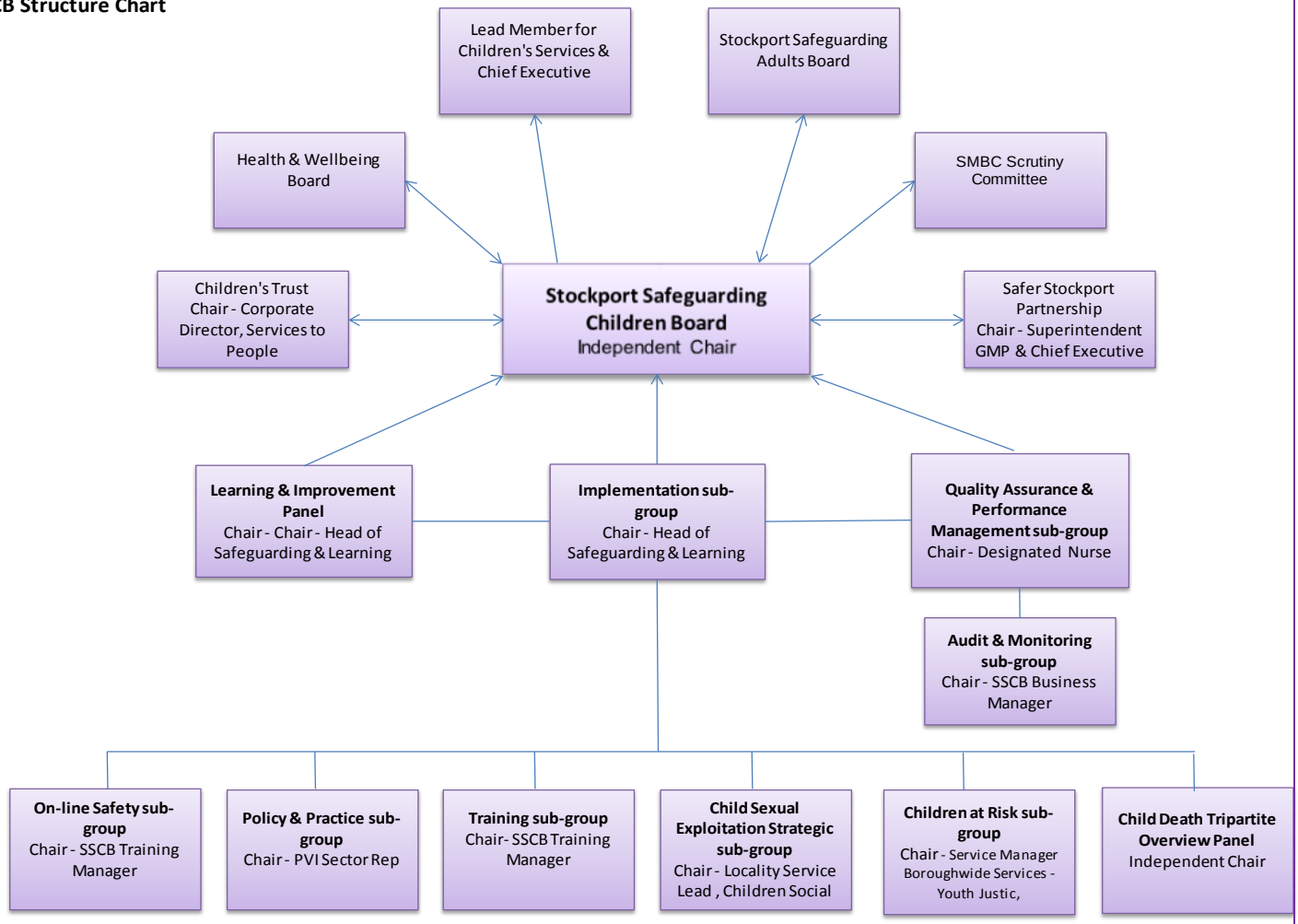
- Greater Manchester modern slavery network
- Independent child trafficking advocates
- Challenger – addressing organised crime gangs
- Child sexual exploitation in sport
- The development of work in response to Devolution Manchester and streamlining of safeguarding services
- It is very likely that this partnership will develop into another form when the Children and Social Work Act in April 2017 permits new arrangements around Safeguarding Boards.

1. Working Together to Safeguard children HM Government March 2015 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf

Board Structure

The Structure of the Board Sub-groups are as follows:

SSCB Structure Chart



Attendance at Stockport Safeguarding Children Board and Sub-groups is monitored. The chart in Appendix 1 shows that overall attendance is good at board level and that agencies are generally well represented. The Independent Chair is committed to seeking explanations from members where attendance is not up to expectation.

Attendance at Sub-groups is not so robust, and reasons for non-attendance are most often given are the need to cover operational duties and capacity issues. The Chair expressed concern with this situation and challenged partners to improve attendance, and this item was placed on the risk register for a period. Attendance improved slightly for a few months but began to decline again during the year. In response, the sub-group structure for the board has been reviewed and attendance will remain an area of focus for 2017-18.

Stockport Safeguarding Children Board

The following personnel were in place to support the work of Stockport Safeguarding Children Board in 2016-7:

- Nuala O'Rourke (from November 2016) - Head of Service Safeguarding and Learning, has strategic oversight of the work;
- Una Hagan – Business Manager, responsible for coordinating the work of the Stockport Safeguarding Children Board;
- Clare Manock - Business Support to the various work streams of Stockport Safeguarding Children Board work;
- Helen Harrison - Stockport Safeguarding Children Board Training Manager, responsible for Multi-agency safeguarding training and development.

Self-evaluation

Over the past two years, Stockport Safeguarding Children Board has been reviewing how it operates to build on its strengths and address any issues hindering its development. A full self-evaluation was completed in February 2017 in preparation for an Ofsted inspection. Stockport Safeguarding Children Board identified that there were many developing strengths within the partnership arrangement to include:

- An effective chair and lay members to provide independent scrutiny
- Good links to other strategic boards in the Authority
- Good attendance at the board at the correct level of seniority
- Sub-group structure in place to drive forward the work of the board
- A quality assurance function which is growing in confidence to offer effective scrutiny
- A robust learning and improvement framework to enable reviewing and learning from serious case reviews
- Quality reports from partner agencies
- Well developed and effective multi-agency training
- Good multi-agency policies and procedures and mechanisms to ensure these are updated regularly
- The development of the challenge function to hold partner agencies to account
- A risk log to mitigate against issues the safeguarding system

However there remains a number of challenges which were impairing the ability to be fully functional as a strong partnership Board. These included:

- Having a dataset that was concise enough to demonstrate the journey of the child through services with appropriate narrative to enable understanding of the trends and themes
- Having appropriate resource to enable the statutory functioning of multi-agency audit and training.
- Achieving sufficient numbers of attendance at multi-agency training events to keep them viable.
- Releasing staff from operational duties to support the delivery of training

Consequently Stockport Safeguarding Children Board assessed itself as 'requiring improvement' against the Ofsted criteria for successful LSCB's and included the areas which needed attention into either Stockport Safeguarding Children Board business plan for the coming year, or into the risk log to develop methods to seek improvement.

The board partners have invested considerable energy in carrying out activity in relation to serious case reviews and embedding learning with the aim to improve basic practice across the partner agencies. They committed to really drilling down on areas that had been identified as needing improvement both in the serious case reviews, but also previous reviewing and auditing activity.

2. Local Context

Demographic Context

Stockport is considered to be a 'typical' district in the country, closest to the national average across a range of indicators. It is an area of relative affluence, but there are polarities of need within neighbourhoods with small areas that rank within the 2% most and 2% least deprived in England.

- The 2014 Office of National Statistics population estimate shows Stockport 0-19 population numbered 67,913 which is 23.5% of the borough's population. The population is predicted to rise over the next 10 years with a rising birth rate and rising aged population. The school age population is rising year on year and in 2015-16 there were 40,359 children compared to 39,851 the previous year.
- 5017 school pupils are identified as having Special Educational Needs and/or a disability that requires additional provision (October School Census 2016).
- 1995 of these have a Statement or an Education Health or Care Plan (as of December 2016)
- 8,228 or 9.6% of children and young people aged 0-25 live in Priority 1 areas (Office of National statistics mid-year 2014 population estimate). However, poverty is not limited to Priority 1 areas, and the Joint Strategic Needs Assessment estimates 8,500 children in Stockport were living in poverty in 2015.
- 5,583 or 14% of children attending Stockport schools claim free school meals (October 2016 census)
- 14.3% of 0-4 year olds; 14% of 5-9 year olds; 11.6% of 10-14 year olds; and 10.7% of 15-19 year olds are from black and minority ethnic backgrounds
- The largest black and minority ethnic (BME) group is Asian. The percentage of Stockport's school aged population who are from a BME background has increased to 17.4 % in January 2017, compared to 15.7 % In January 2015. Stockport has seen an increase in both the Muslim population and people of no religion over the last decade. On the whole, these populations are younger than average.
- 9% of Stockport's children have a first language that is not English

There are 121 schools in Stockport: 5 maintained nursey schools, 84 Primary, 14 Secondary, 9 Independent Schools, 6 Special Schools and 3 Pupil Referral Units. There are currently 3 secondary schools which are academies in Stockport.

The town also has several charities and voluntary sector organisations offering services for children and young people, to include Together Trust, Seashell Trust, Signpost Young Carers, Stockport Action for Voluntary Youth, Beacon counselling, Stockport without Abuse, Disability Stockport, Parents in Partnership, Stockport Action for Voluntary Youth.

3. Safeguarding Activity overview

Early Help Activity and Developments in the Multi Agency Safeguarding and Support Hub

The Stockport Multi Agency Safeguarding and Support Hub (MASSH) is the 'front door' or entry point for referral to Stockport Family Services.

The number of phone calls and emails coming into the MASSH has risen steeply over the last couple of years. In 2015-6, we had 4481 referrals coming in and this year we had 7763. This means there is a high demand at the 'front door' and the role of the MASSH is to decide where referrals go. The First Response Team has been established to deal with referrals and assessments effectively; to provide a consistent hub of practitioners led by an experienced team leader to support an expert and timely triage service. This model supports consistency of decision making. Stockport's multi-agency Levels of Need document, available on Stockport Safeguarding Children Board website, identifies the seriousness of the issue and the action that needs to be taken, i.e. signposting to other services through to immediate action to protect a child.

The MASSH offers appropriate identification and subsequent support to children and families to stop problems getting worse and to reduce the likelihood of statutory services needing to intervene. Stockport MASSH has become well embedded.

Stockport Family has invested in a good range of effective targeted early help services including:

- The Family Nurse Partnership which is now working at full capacity with young parents and their babies. There is evidence of strong joint working with social workers for young vulnerable parents and their babies; evidence of a comprehensive health assessment to earlier unborn baby assessments, and the ability to provide contribute earlier to care planning and decision making;
- Brinnington integrated early-help pilot focuses on early identification of poor child development and identification of those at risk of poor outcomes. Additional resource has been allocated to the health visiting and early years team in order to offer an additional developmental assessment at 18 months to ensure that young children are given developmental support prior to starting a 2 year playgroup place.
- The Parenting Team offers a programme of regular Incredible Years parenting courses for families with an identified need;

Social Care Involvement with Families

Of the 7763 referrals to the MASSH, 3204 went to children social care for further consideration. At this point a proportion will be referred to an agency for an early help assessment and some will go for social work assessment as a child in need, and some for a child protection enquiry (also known as a Section 47 investigation.

There were 2432 Early Help Assessments (EHA) completed and this figure is rising year on year. For those referrals which go for early help assessment we have a high rate (92.1%) of those assessments being completed, which demonstrates that the right referrals are coming in, many from partner agencies, and a commitment of our partners to the early help assistance to families. We have 1843 children in need of services and these are being managed in Team around the Child arrangements.

The 'front door' as we know it, is managed well. Overall the picture is that the referrals that are coming in are the right ones, and are managed appropriately. We also know that the number of referrals that are made again about the same child within 12 months is consistent at 21.4%, lower than our statistical neighbour but consistent with the national average.

The number of children that proceeding to a child protection inquiry has been consistently going down over the past 3 years. There were 546 cases which were received as a child protection inquiry compared to 603 the previous year 2015-6 and a high proportion of those (91.4%) result in a comprehensive social work assessment. The proportion going for social work assessment is rising and a piece of work is ongoing to understand the reason for this. What seems clear, is that demand is not abating at the front door, but that the overall picture is that children and families will get what they need to safeguard children and keep them safe.

Auditing within Stockport Family has identified that on occasion the analysis of the assessments completed lacks vigour and as a result whole team training in the MASSH has been undertaken, with an impact audit to be completed in summer 2017. Case recording is generally accurate. The timeliness of recording standard, five working days, is sometimes challenging. Case auditing indicates that workers frequently have very rich and detailed knowledge of the family, which is not always reflected in case records.

Information from assessments is used to inform plans and needs are effectively considered at Team around the Child[2] and core group meetings. Case auditing has shown that that some plans need to be SMARTER in some cases and in August 2016 a new plan format was introduced which explicitly requires concerns, desired outcomes and SMART actions to be stated with clear timescales (SMART planning refers to Specific, Measurable, Achievable, Realistic and Time limited actions contained within a plan).

Children subject to a child protection plan

At the end of March 2017, there were 239 children subject to a child protection plan, an increase of almost 50 children from the previous year. There was no obvious explanation for this rise but audit activity demonstrates that cases are being brought appropriately. However, the figure is the same as 2014-5, so it is a return to previous levels, and we are in line or lower than our statistical neighbour. The highest number of plans are made as a result of emotional abuse which is usually related to domestic abuse, recognising the high levels of emotional abuse that are inflicted on children as a result of domestic abuse between parents and partners. This is followed closely by neglect which can consist of a number of factors but usually involves parents placing their own needs before those of their children or being unable to manage themselves effectively.

The categories under which children were made subject to a plan at the end of the financial year March 2017 are as follows:

Emotional Abuse	121
Neglect	106
Physical Abuse	7
Sexual Abuse	5
Total	**239**

There has been a strong improvement in children subject to a child protection plan recorded as being seen by their social workers at least every 4 weeks (59.9% for 15/16 to over 82% for the first half of 16/17). This is reviewed weekly by children social care service leaders and where there are gaps in recording or visiting this is addressed through action planning in supervision. Children are encouraged to attend their child protection meetings and all young people involved in the process are offered a participation worker to facilitate their involvement.

[2] Child in Need s17, Children Act 1989

In 2016/17, 42 out of the 336 initial child protection conferences carried out over the year (12.5%) did not result in a child protection plan which indicates good oversight and challenge from Independent Reviewing Officers who felt the case could be managed safely at a lower level of need.

Child Protection case conferences are generally well attended by partner agencies, particularly the initial conference. The police always contribute to S47 strategy meetings/discussions, but attendance at conferences has been raised with the Police as an issue and it is recognised that operationally they cannot get cover for key tasks. Recent serious case reviews and multi-agency learning reviews have identified some issues around attendance at team around the child (TAC) meetings and making sure that the right people are invited to and contributing to these meeting is an important role of the chair. If practitioners are unable to attend meetings they are expected to submit reports or updates. Health and school colleagues are very good at appropriate information sharing.

There has been success in dropping the rate of child protection plans which last for 2 years or more from 8.7 % last year to 2.4 % this year. This represents a sharpening up of the review process which ensures cases do not drift on too long, without taking decisive action to escalate the case when improvements are not being seen within the family.

Looked After Children

Looked after children are those that are looked after by the local authority either voluntarily or through a statutory order. The overall number of children looked after in Stockport is increasing with 331 children at the end of March 2017, whereas this figure has been consistently sitting close to 300 for several years. The rise is attributed to the increase in the number of children who remain on a care order placed with their parents, which appears to be an emerging trend nationally as a result in a change in court timeframes.

There are three distinct groups of LAC for whom we have safeguarding responsibilities.

	2014/15 year end	2015/16 year end	2016/17 year end
SMBC LAC placed IN Stockport	208	204	225
SMBC LAC placed OUTSIDE Stockport	83	91	106
TOTAL	291	295	331
Out of area LAC placed in Stockport	267	318	388

When children who are the responsibility of other local authorities (OLAs) who are placed within Stockport, the impact of this is considerable for services such as the Youth Offending Service, Health and the Police. Clearly this is a demand that is growing as there were 121 more children in this category than there was 2 years ago.

Stockport has a clear edge of care strategy focused on supporting children to remain with their families, where it is safe to do so. The Stockport Families First team, Stockport's innovative edge of care programme, combines wraparound support through family group conferencing, short breaks and intensive family support to assist family functioning and help children to remain safely within their own families or rehabilitate from care in a timely and supported fashion.

An analysis of activity shows that the Stockport Families First (SFF) team demonstrates this is having an impact on cost as well as good outcomes for children. There has also been a reduction in the use of residential provision and have the largest % decrease in use of residential placements in the North West:

- 14/15 - 9.2% of LAC were in residential provision
- What is the 15/16 figure?
- 16/17 - 5/5% of LAC were in residential provision

The Integrated Looked after Children Board (ILAC) presented an annual report to Stockport Safeguarding Children Board in July 2016 in relation to provide assurance around the safeguarding of looked after children. That report covers issues such as health care, employment training and attainment, New Belongings post-care, children's rights and participation issues and provides the means by which robust challenge could be put in place if it was required. The report demonstrates the good outcomes for LAC children. However, Stockport Safeguarding Children Board challenged the Integrated LAC Board in relation to timeliness of health assessments for looked after children and received assurance that extra resource was in place to improve the information flow and capacity to complete the assessment.

Recent successes for care leavers in Stockport

- Personal advisers for all care leavers up to age 25 years were introduced from 19th May 2016.
- Information for care leavers been revised and is available on the internet.
- Finance policy and young person's entitlement booklet updated.
- Department of Work and Pensions protocol reviewed with partners.
- Council tax exemption for care leavers in education or living on a low income up to 25.
- Entitlement to assessment from adult services for vulnerable care leavers under Care Act.
- Introduction of pre-payment cards to provide more choice and flexibility for care leavers i.e. setting up home grants.
- The Care Quality Commission's national report *Not Seen, Not Heard* praises our mentoring for care leavers provided through Café Zest.

Providers Forum

Previously known as the Residential Homes Forum, this group has now changed its name to the Providers Forum as foster carers are now invited. The aim of the quarterly meetings is to provide information and support around safeguarding issues such as missing children and sexual exploitation, to improve communication and therefore enhance outcomes for children. The meetings have been well attended and have run as "speed-dating" tables where delegates spend 15 minutes at four different tables, gathering information.

Private Fostering

Parents can choose to have their children cared for away from home by someone who is not a close relative (e.g. Grandparent, sibling, aunt/uncle or step-parents of the child). This is known as private fostering. The Local Authority must be notified of these arrangements who have a duty to assess the suitability of the arrangement. It remains a difficult area to monitor. And low levels are reported across the country. It is recognised however that ongoing awareness raising is a priority, to ensure that those children subject to private fostering arrangements within the borough are notified to children's social care.

Referrals and numbers of private fostering notifications have increased this year. As of 31st March 2017, there were 11 young people formally notified as falling under the Private Fostering Regulations. 9 of these arrangements have ceased with 2 children currently living in private fostering arrangements. This is an improvement from the trend in recent years and this may be the result of a specific awareness event in 2016 and monthly 'tweets' from Stockport Safeguarding Children Board to remind professionals. Regular review of the quality of the plans in relation to private fostering is completed.

Child Sexual Exploitation

The work around child sexual abuse continues to have a comprehensive multi agency approach. In 2016-7 there were 984 incidents reported by the Greater Manchester Police to have potential links to child sexual exploitation, compared to 1195 the previous year. They also recorded that 28 young people identified at high risk of exploitation in Stockport, a slight increase from last year (21).

The existing child sexual exploitation strategy and action plan was refreshed at the end of 2016 and approved by Stockport Safeguarding Children Board for 2016-19. The child sexual exploitation (CSE) strategic sub-group of the board has overseen the implementation of this plan meeting on a bi-monthly basis up until February 2017. A practitioner's forum, which sits beneath this sub-group provides a vibrant and productive group of dedicated professionals from a wide range of public, private and third sector services to deliver the operational aspects of the strategic plan.

The Local Authority and Greater Manchester Police have provided a specialist co-located response to tackling CSE crimes and supporting victims through the integrated Stockport Phoenix and Aspire Complex safeguarding team. The team shares an office within the Multi-Agency Safeguarding and Support Hub (MASSH) alongside colleagues from the Public Protection Investigation Unit, Challenger Police team, the First Response team and other agencies within the MASSH at Fred Perry House.

The integrated working is supported by daily governance arrangements. Every day there is tasking meeting chaired by either the Aspire team leader, or Phoenix Sergeant, to discuss Public Protection Investigations over the past twenty hour hours, high risk CSE victims, incidents of missing and ongoing tasks/activities within the team. Intelligence and information is shared and clear decisions/actions agreed to effectively respond to current risks and needs for both victims and offenders. A longer weekly briefing meeting, with multi-agency attendance takes place every Wednesday, for more detailed discussions about individuals or issues which need an integrated response. This ensures that cases are responded to appropriately and the right interventions and safeguarding plans put in place.

The Aspire team provide specialist social worker assessment and interventions and support to children and families affected by, or at risk of sexual exploitation and they co-work children alongside the locality allocated social worker. The team consist of one team leader, two senior practitioners, and five social workers, school nurse, Youth Offending officer and business support co-ordinator. Aside from the case work of the team, they provide consultation, training, advice and support to other professionals within Stockport.

The Phoenix police team consists of a detective sergeant, 3 detective constables, and 4 police constables. The case police officers investigate CSE crimes and public protection investigations. They gather evidence to arrests offenders, build case files to present to the Crown Prosecution Service and attend court, liaise with appropriate partners and make relevant referrals e.g. National referral mechanism for trafficked people. They assist with safeguarding and supporting young people through the investigation/court process. All the work that CSE police officers complete is underpinned by building a relationship with the young person.

The team now has two intelligence police officers attached from the Intelligence and Development Unit. This has been a fantastic addition to the team. The officers will attempt to fill in intelligence gaps regarding where young people are going and who they are associating with and build on intelligence already in place. The two officers are able to use covert police tactics to identify offenders so that proactive interventions can take place. One officer's role is to gather intelligence from the community.

A proactive police operation entitled Operation Phoenix takes place every Friday night in Stockport; this began with CSE officers, but has since been integrated into the neighbourhood policing team's responsibility. A special police constable and neighbourhood police officer utilise a plain vehicle and plain clothes to provide reassurance visits to the most vulnerable victims, ensuring that they are not missing and not being reported and feel safe. They will also visit offenders and suspects who have been issued child abduction warning notices, bail conditions or prevention orders, to ensure that they are abiding by their conditions. Identified hotspots where both vulnerable children and offenders may gather are also visited to gather intelligence, provide reassurance and prevent any offences taking place. The information obtained during the Operation is fed directly back into the Aspire/Phoenix Team via intelligence.

The specialist work of the teams has been externally scrutinised through the yearly Project Phoenix Peer review process. The last review was conducted in September 2016 and found:

"The practice in the Phoenix/ASPIRE team to tackle CSE is amongst the best that the panel has observed in Greater Manchester in the seventeen Phoenix peer reviews conducted to date. Everyone we spoke to have a thorough understanding of the cases we discussed, knew the children and families and showed genuine care for their safety, security and wellbeing. The cohesion of the multi-agency Phoenix/ASPIRE team was evident to the panel and we heard lots of examples of the lengths that staff have gone to in order to build that team ethos. The leadership at every tier of management shone through and to have delivered these changes in such a relatively short space of time (approximately eight months) is a truly exceptional achievement and is to the credit of everyone involved".

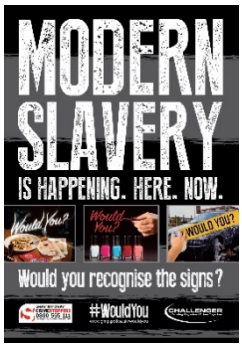
The Phoenix/Aspire team lead on the delivery of yearly weeks of action to highlight the risks of CSE and raise awareness in the community, public sector and with children and families. These multi-agency events have delivered an impressive and creative programme of events during each week focusing on specific areas of interest such as sport, transport, missing etc.

The efforts of Stockport Safeguarding Children Board and the specialist teams over the past two years or so have been effective in implementing consistent response to CSE across the borough and in raising awareness in both the professional and public communities. This may reflect the rise in reports and incidents of CSE over the years, as we are consistently better at identifying when children are at risk and we have robust services in place to respond to victims and offenders. The number of children identified last year dipped slightly which is starting to demonstrate that awareness in young people is growing and the risk for themselves is recognised earlier.

The CSE strategic group has now merged with the child at risk sub-group of Stockport Safeguarding Children Board to form a new complex safeguarding sub-group to focus on the following areas of practice, which mirrors the work of the Aspire team:

- Domestic Abuse including honour based violence and forced marriage
- Child Sexual Exploitation
- Serious Organised Crime
- Modern Slavery and Trafficking
- Female Genital Mutilation
- Radicalisation and Extremism

- Children missing from home, care and education.



The complex safeguarding sub-group is in the process of developing a Strategy and action plan to take forward the work which will address these areas and embrace the opportunities to join up the work in these overlapping areas of concern to reduce duplication of effort and resources.

Greater Manchester Police commissioned a problem profile for CSE specific to Stockport early this year and this was finalised in June 2017. Work is under way to understand the findings and analysis within this problem profile and to ensure that the recommendations are considered, and taken

Children going missing

Most of the children who go missing in Stockport go missing once, and go missing from their home. Some children go missing many times and this includes children who have moved between care and home/semi-independent living and those who are cared for. Our data on children who go missing demonstrates slight increases in the rates, and continues to demonstrate that almost twice as many children are reported missing from family homes. Recent data revealed that 18 children were identified as being responsible for 42% of the missing episodes. The Independent Reviewing Officers have been tasked with doing some work with the persistent missing children as we need to better understand why they are repeatedly going missing and whether there is a simple solution.

	2014-15	***2015-16***	***2016-7***
Missing from Home	***278***	***290***	***302***
Missing from Care	***132***	***152***	***159***

A problem profile was presented in July 2016, to provide a profile of the previous calendar year of 2015. Although figures showed that 61% of children going missing from a family home, there are more repeat missing incidents from children in care homes. Children between the ages of 12yrs and 16yrs make up the highest percentage of missing children. When comparing figures of missing children across Greater Manchester, Stockport is situated 7th in the table. There was a total of 39 children's home in Stockport and only one is managed by SMBC. There are 3 children's homes which are privately managed have recorded 90 or more incidents over the period January-December 2015.

The Participation team struggled to manage the high level of work required in relation to missing children in terms of independent return interviews and there were issues in relation to timescales for return interviews in time for those missing from the family home. This resulted in a review of capacity, by the children at risk sub-group, who looked at streamlining processes. A great deal of work was achieved to streamline the procedures for missing, those at risk of CSE children and other children at risk and this is included in the daily tasking meeting, within the MASSH. This ensures that information is passed on in a timely manner and informs strategic and operational direction. Our data information is now better than it has previously and we are now confident that our system in relation to missing children and flagging up risk areas quickly are working more effectively.

Children Missing from Education

Missing from Education refers to children who are no longer enrolled at a school and who the local authority has lost track of. The number of children missing education (CME) at 31st March 2017 was 8 young people compared to 5 the previous year. Missing from education refers to children who are no longer enrolled at a school and who the local authority has lost track of.

Children missing education (CME) and children missing out on education work has made good progress in the past year and the Stockport Family transformation programme has enabled the development of a re-focussed education welfare team. Two education welfare officers sit in the MASSH and deal with all the missing from school enquiries that now come through the front door and work with relevant colleagues on welfare checks. There is a new children missing education task and finish group (reporting to the children at risk sub-group) which is building on current work to improve systems and practice. A key piece of work for the year is to consolidate individual sets of data that are currently monitored by different teams into a coherent picture that can be effectively monitored by the group and used for strategic and operational direction.

Electively Home Educated Children

Elective home education arrangements are closely monitored. Whilst most parents make the decision to home school children for legitimate or principled reasons, there is potential for safeguarding issues to be hidden within this cohort, hence the interest of Stockport Safeguarding Children Board. Numbers have increased year on year over the last five years, from 50 in September 2011, to 133 in December 2016. Thirty children who were previously electively home educated were supported back into education in 15/16 and in the same period parents made 49 new home educated arrangements.

Children exposed to Domestic abuse

The numbers of domestic abuse incident which were referred to the MASSH because of safeguarding concerns for children by Greater Manchester Police dropped in the last year from 2063 incidents in to 1800 this year. The reason for this drop is not yet understood.

Domestic abuse continues to be a significant safeguarding issue for children and young people in Stockport who are harmed through exposure to parent/carer abuse, directly hurt by the same perpetrator and/or develop teenage relationships which are abusive. The impacts on their safety, health, wellbeing and achievement are multiple and can be long lasting. Domestic abuse is often linked to substance misuse and mental ill health resulting in a degree of complexity and interrelated harm which makes safeguarding and co-ordination both challenging and vital across a range of agencies and boards. This work has been reviewed in the last year and has resulted in new Domestic Abuse Steering group chaired by the Police a revised strategy and action plan. The strategic responsibility for this work sits under Safer Stockport Partnership with reporting in to Stockport Safeguarding Children Board to maintain assurance in relation to the children perspective of this work.

259 of the cases heard at MARAC (Multi-Agency Risk Assessment Conference) featured children: This is the process where the most high risk offenders are considered and safety plans made for the other members of the family.

Stockport Safeguarding Children Board was fully supportive to the Police and Crime Commissioner's Yellow Sofa campaign run in November/ December 2016 to tackle domestic abuse in Greater Manchester.

Safeguarding children with a disability

Stockport has 3874 children recorded as having a disability in 2017 which has risen from 3496 in 2015 in 2016-17, only 17 of those children were placed on a Child Protection Plan in the year compared with 9 the previous year.

Stockport has the highest number of pupils with Education Health and Care plans (EHCP) in secondary schools, and the second highest in primary schools, of all North West Local Authorities. Of the 23 North

West Local Authorities, 6 place less than 1% of pupils with EHC plans in mainstream primary schools and 5 place less than 1% of pupils with EHC plans in mainstream secondary schools.

The model of the children with disabilities team (CwD) team has been successful in providing specialist advice, knowledge and practice around the areas of complex health needs and disability. The strengths of the CwD team include: being co-located and integrated with health, education and care services for special educational needs and disability (SEND), joint commissioning arrangements and aligning to localities to strengthen awareness raising, working relationships and availability of specialist advice and support. The CwD team will enable the team to deliver statutory services to children with complex health needs and disabilities in partnership with education and health colleagues as well as providing consultation, advice and co-working to upskill social work locality teams in issues of disability. Further work will be undertaken in 2017/18 to continue to develop the interface between Stockport Family services and education services to deliver the wider 0-25 SEND reform agenda, and work to support the social work team have closer links, with the core locality social work teams.

Children with mental health difficulties

Research suggests there are 4,000 5 to 16 year olds living in Stockport with a diagnosable mental health disorder. The table below illustrates the number of referrals to Pennine Care NHS Foundation Trust (PCFT) Healthy Young Minds (*formerly CAMHS*) Service: April 2016–March 2017.

2014 - 2015	2015 - 2016	2016 - 2017
2,348	2,254	2,465

Rates of admissions for mental health problems and self- harm are higher in Stockport than the national average and are especially high for older teenage females and for those who live in areas of deprivation. 50% of children with a special educational needs statement have social, emotional and mental health needs.

There has been much work done in relation to self-harm and risk of suicide within our school settings including training delivered in partnership by Heathy Young Minds and Public Health, to the designated safeguarding leads in Education along with a practice manual to assist teachers. In addition, there has been a focused learning event on eating disorder as a potential safeguarding risk following on from learning from a serious case review.

A Local Transformation Plan (LTP) for improving children's mental health in Stockport over the next 5years has been approved by NHS England. *Future in Mind: promoting, protecting and improving children and young people's mental health and wellbeing"* (Department of Health and NHS England) makes recommendations in a number of areas across all parts of the children's mental health system:

- Promoting resilience, prevention and early intervention
- Improving access to effective support – a system without tiers
- Care for the most vulnerable
- Accountability and transparency
- Developing the workforce

Following publication of this report the government announced a programme of investment and each local area had to develop a CAMHS Transformation Plan which set out how they would use additional investment to meet the recommendations. In Stockport, Healthy Young Minds (HYM *formerly CAMHS*) is delivered within Pennine Care NHS Foundation Trust (PCFT) who work in partnership across services to support further developments.

The full plan and an easy read summary is available on Stockport Clinical Commissioning Group website www.stockportccg.org.

Young Offenders

There has been a steady rise in youth offending caseloads, which reflects a general increase in crime rates. The latest 16/17 data is yet to be published but is expected to continue in the same trend. First time entrants have shown a slight increase but they are still at a low level (168 in 2015-16), when compared to the several hundred that were coming through 10 years ago, which is testament to the early intervention strategies employed through Targeted Youth Support (TYS) and early prevention models**.**

The Head of Stockport Youth Offending Service is the Greater Manchester lead for safeguarding children in police custody. Much work has been done on a Greater Manchester level to address the problem of overnight detentions and appropriate transfers, and this culminated in the development of the Greater Manchester Local Authority (PACE) protocol. This has been widely adopted across Greater Manchester and it sets out the roles, responsibilities and expected response of each service if a child or young person is likely to be detained overnight. This has led to a significant drop in the numbers of overnight detentions across Greater Manchester.

Overnight Detentions relate to children who have been detained in police custody when arrested and subsequently held overnight in a police cell until their court appearance the following morning. The guidance for this comes under the Police and Criminal Evidence Act (1984) and the ambition is to reduce the numbers across Greater Manchester to as few as possible and ensure that the accommodation needs of children and young people are addressed in a timely manner, as it is widely recognised that detention overnight in a police cell is not an appropriate or safe enough environment for a child or young person. Each child has an assessment individual to their needs.

In 2016, the number of beds requested from Stockport Local Authority by Cheadle Heath custody suite for transfer under PACE was 13 - the Courts for remand under PACE was 13 - 69% (9) were provided. (PACE – Police and Criminal Evidence Act – is the term commonly used to refer to the transfer of children from police custody to local authority accommodation) 3 secure placements were required and found. Stockport are one of the highest performing areas within Greater Manchester, routinely following the agreed protocol and ensuring that the limited number of children and young people who come into this category are transferred under PACE appropriately.

Children at risk of violent extremism

The Channel Panel has been operational for several years in Stockport to respond to the national Prevent agenda in order to manage adults, children and young people at risk from being radicalised or being groomed into becoming involved in acts of violent extremism. The multi-agency Channel Panel manages risks on a ‘case by case’ basis through meetings. Referrals remain appropriately low given the level of threat and risk in Stockport but nevertheless it is an issue we are alert to. There were 5 children considered last year compared to 1 the previous year and 8 the year before that. The majority of concerns are identified within School settings where much work takes place to raise awareness.

4. Learning and Improvement

Stockport Safeguarding Children Board Learning and Improvement Framework provides the structure for the board to learn from audits and to deliver its statutory function "to undertake reviews of serious cases and advise of lessons to be learned from them". Using the framework, the board has ensured focused dissemination of learning from audit activity, multi-agency learning reviews and serious case reviews. Training and development needs are also identified as a result of the emerging learning both at a local and national level.

Risks Issues

The board established a risk register in the year to identify analyse and prioritise risks to the board's plans and this is reviewed and updated bi-monthly at the Implementation Sub-group

These risks were identified in the year:

- Stockport Safeguarding Children Board business unit does not have capacity to complete multi agency audit given SCR work ongoing. This means one of the functions of the board - to ensure oversight of effectiveness - is limited.
- Attendance at training had dropped which has resulted in cancelled courses. There is a risk that staff will not be suitable trained in multi-agency processes. The impact might be that changes in practice will not be learned and achieved and outcomes for children and families will not be improved.
- Governance arrangements between other strategic groups requires strengthening, e.g. Safer Stockport Partnership and Health & Wellbeing Board
- Capacity to oversee serious case review action plans and ensuring that learning has been embedded. Risk that agencies won't understand or see as their responsibility
- There is an issue with the narrative re data in relation to quarterly report of Stockport Safeguarding Children Board dataset.
- Timeliness of missing from home interviews. The timescales for completing independent return were not at the desired level
- Looked after Children's health assessments - A decline noted in timeliness of health assessments. The governance of this issue sits with ILAC and Children's Trust Board.

Challenges made in 2016/17

Stockport Safeguarding Children Board made a number of challenges to agencies during 2016-2017. These are collated in a challenge log which tracks and monitors the responses, ensuring that issues are addressed. When challenges are made the Chair expects that explanations are sought and that the board is updated. Each of these challenges resulted in improvements to processes where possible. Some of the challenges and responses are outlined in the table below:

Challenge	Outcome
The decline in missing from home return interviews being achieved in a timely manner	Review of the arrangements and new process put in place at the MASSH to complete reviews
A decline in the number of children being considered through the multi-agency sexual exploitation process	Review of the arrangements and new process to consider each case immediately through Daily tasking meetings within Project Phoenix police team

Delays in achieving completion of serious case review improvement plans	New timescale and arrangement for quality assurance sub-group to moderate each plan
Low or consistence attendance at sub-groups	Each agency to review non-attendance within their agency
The delays in progressing domestic abuse co-ordination	Head of Safeguarding and Learning to lead the agenda
Data issues - ineffective method to gain information re trends and risks demonstrated by the data	Work to review dataset and new arrangements to present and understand the data picture under development

Audits of our safeguarding arrangements

Section 11 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. These detailed audits provide assurance that agencies understand their safeguarding responsibility and have processes in place. Each partner agency comes to present their audit in turn and provide any evidence that is required and have processes in place. The board achieved its objective to complete Sec 11's from all partners and particularly partners in education services who have previously not been asked to complete such audits. Section 11's were received from:

- National Probation Service
- Youth Offending Service
- Stockport Music Service
- Virtual Schools Service
- Sensory support Service

It was agreed that going forward that we would adopt the Greater Manchester tool which the National Probation Service completed as a trial, and that we would ask for all agencies to submit Section 11's at the same time and use these as the basis for peer mentoring in the coming year.

For school their responsibilities are written into their safeguarding checklist done at the beginning of each academic year – known as Section 175 or 176 Audit and the Senior Advisor for Safeguarding for Education reports on this to the Education Partnership Board.

Reviewing Serious Cases and Child Deaths

Stockport Safeguarding Children Board are required to consider undertaking a review of serious cases. These reviews are called serious case reviews (SCRs). The purpose of a serious case review is to establish whether there are lessons to be learnt from the case about the way in which professionals and organisations work together to safeguard and promote the welfare of children.

It was reported in the 2015-6 annual report, that the Stockport Safeguarding Children Board had commissioned 5 serious case reviews in the preceding 2 years and a further independent learning review was commissioned in September 2016. The substantive work on the reviews was completed in 2016-17. We have learned that we are good at the front end of this process - that is the notification processes, screening the cases for considering the serious case review, and running the serious case reviews. Agencies safeguarding unit staff were pressurised with the volume of activity related to the reviews with several reviews running at same. Nevertheless, the impetus to learn and improve our services to children to prevent future serious incidents was evident.

Two of the serious case reviews which had the reports completed last year were published on the Safeguarding Board Website. Publication of the other three serious case reviews have been delayed as parallel proceedings were in place, either coroner's inquests or criminal matters - as is usual practice. It is anticipated they will be published within the next few months.

Improvements that have come about as a result of the reviews include:

- An increased focus on managing neglect through well managed plans
- A review of levels of need document
- Development of a mental health protocol between children services and mental health services to improve information sharing and understanding of roles across the two services
- Introduction of the Child Protection Information System (CPIS) in Health, so that immediate checks could be implemented in hospital as to whether a child was known to social care
- An increased understanding of the impact of hidden men in families as a result of training
- An increased understanding of the impact of trauma on parenting capacity
- Serious case review improvement plan and checklist with references attached. (Referenced below in the quality assurance section)
- Consideration of the use of language when referring to sexual violence and abuse of young people instead of calling it 'CSE' which is felt to mask the horror of the young people's experience
- An increased understanding of self-harm and resources to provide support
- An increased understanding about eating disorder and the role of services to support the issues.

Stockport Safeguarding Children Board was keen to disseminate the learning from the reviews in a variety of ways to reach as many people as possible. The methods included the following:

- Two seminars in relation to learning from the serious case reviews. One of these focused on babies, and the other on risk in teenage years.
- For the first time one of these sessions was professionally videoed so that the information could be widely shared.
- The Designated Nurse and the safeguarding board manager produced a short video for staff
- 7 minute briefings - short blocks of information which enable a quick overview of the learning and issues raised.
- Learning circles in teams
- Presentations to partner agency teams
- Themes included in all multi agency training
- A Checklist for Good Practice toolkit was established, with relevant links to Research in Practice to support the evidence base. In short, the message was to do the basic tasks of working with any child or family well – that is Assessment, Plans, Quality of meetings to drive forward those plans and effective supervision.

  http://www.safeguardingchildreninstockport.org.uk/serious-case-reviews/

Deaths of all children

Stockport, Trafford and Tameside Tripartite Child Death Overview Panel (CDOP) reviews the deaths of all children and young people to look for trends and issues of public health, with a view to taking action to prevent future child deaths and to improve the health and safety of the children in the three areas. The aggregated findings from all child deaths informs local strategic planning, including the local Joint Strategic Needs Assessment, on how to best safeguard and promote the welfare of children in the area.

This annual report has a time lag in reporting child death figures as the CDOP annual report is not presented until September of any year. It can be found here: http://www.safeguardingchildreninstockport.org.uk/wp-content/uploads/2015/11/Annual-Training-Report-2016-17-final.pdf

Over the year ending March 2017 there were 16 deaths of children in Stockport, a rate consistent with previous years. Only 1 was an unexpected death, as most were premature babies with a very low birth rate where risk of death is greater. Of the 15 expected deaths in Stockport, 11 were classified as premature or extremely premature. 11 of the deaths were under 28 days old with a further 2 being U'1. It is a consistent feature, both locally and nationally that children under 1 year old account for two thirds of child deaths.

40% of cases in Stockport were in the most deprived areas. However, only 9% of the population live in those areas. There were no reported sudden infant deaths in the year. Only two of the deaths were felt to have modifiable feature - which were smoking, BMI issues and prematurity.

Public Health response

An extremely helpful report was received from Public Health in March 2017 outlining the work that was being done in Stockport to progress the maternal health agenda, to consider opportunities to influence behaviour change and social norms for modifiable factors associated with infant mortality. Work is currently being tested in Brinnington to gain insight into why women continue to smoke in pregnancy. National research findings are being applied which suggest that all services need to be delivering a consistent message around smoking in pregnancy, which is hard hitting

A wide reaching action plan was established to address the following areas was updated February 2017:

- Smoking in pregnancy
- Safe sleeping
- Monitoring in pregnancy
- Weight management in pregnancy
- Alcohol in pregnancy
- Antenatal care
- Home safety

An example of impact is that smokers who have not taken up offer of support are scheduled for dating scans at sessions when the smoking cessation midwife is available. Sonographers then direct these women straight to the midwife who delivers an evidence based hard hitting message. There is an incentive scheme in place for priority areas.

There has been a reduction in the stillbirth rate from 18 in 2015-6 to 9 in 2016-7, possibly as a result of the various strands of information and support that have been developed.

Dealing with allegations against professionals

The allegation management system in Stockport is well established, but there is a constant need to remind agencies that all allegations need to be scrutinised through this system particularly as the workforce changes. There were 198 referrals made to the Local Authority Designated Officer in 2016-17, of which 147 of these were managed without the need for a formal meeting. An additional 45 were directed down a formal child protection route. A further 254 queries were managed by the independent reviewing officers. The number of cases overall were consistent with previous years but the categories of recording these changed slightly last year to track previous queries to allow potential risky people to be tracked over time.

Equality and Diversity

Stockport Safeguarding Children Board takes the view that all children should have a holistic assessment of their safeguarding need which takes account of any issues of equality and diversity and identity and this is central to all quality assurance work. The attention to children from minority ethnic groups is clearly a growing issue for us as we know that the black and minority ethnic child population is growing at the younger end.

Stockport Safeguarding Children Board sought particular assurance in the year about the needs of children with a disability to ensure that arrangements were effective and the lead officer in Children Social Care conducted an assessment exercise against the criteria set out in Ofsted thematic inspection document Safeguarding Disabled Children in England 2012. The strengths of the partnership were the following which provided a strong supporting framework for the development of SEND (Services for children with special educational needs). The self-assessment considered that there was some work to be done around data collection and developing resources and training for communities which is being taken forward and for staff to be particularly alert to safeguarding risks that can remain hidden in this group of children.

5. Progress on Priority Areas 2016-17

Looking back to the years 2015-17 we developed a new strategic plan and trimmed down the number of priorities to focus on areas where we wanted to make improvement in addition to the work of the Sub-groups which each had their own developmental areas as well as 'business as usual'. These were as follows:

1. Learning and Improvement

The focus on the work last year was to develop our quality assurance mechanisms and ensure that the learning which had come out of the serious case reviews was meaningful. Our quality assurance last year has been variable. There was no capacity across the partnership to undertake multi agency audits. However, Stockport Family introduced auditing across the Localities which provided evidence that cases were being considered across some agencies with some objectivity. In addition, there were additional single agency audits from health and the MASSH which demonstrated that the flow of information from Health's Causes for Concern forms were being managed appropriately. The work was carried out by the Quality Assurance Sub-group and the Audit and Monitoring group. (See section below)

- **Serious Case Review Processes**

Stockport Safeguarding Children Board made progress against the recommendations from serious case reviews but the volume of recommendations, and the way recommendations were written, has made it difficult to achieve these in a timely manner. Some of the recommendations were aspirational, for example there was a recommendation to develop a new approach to eating disorder which has become encompassed in the Health Young Minds Transformational Plan which is a complex piece of work in reorganising services to young people with mental health issues. Stockport Safeguarding Children Board recognises that going forward it needs to endure that recommendations are focussed and specific and relate to the learning from the specific case reviews.

However, the following was achieved:

- An effective method of multi-agency checking of recommendation progress, and gaining evidence the action is completed.
- A task and finish group was held in the autumn to agree a way to manage the large amount of single agency and multi-agency in a thematic way to present to staff.
- A serious case review improvement plan was developed and agreed by Stockport Safeguarding Children Board to be an effective way forward.
- Each agency was asked to reflect and focusing on:
  - Assessment,
  - Effective Plans,
  - Quality of meetings to support the plans, and
  - Quality of supervision.

Each agency was asked to attend audit and monitoring sub-group to present the evidence for their own action plans which worked extremely well. After some initial hesitancy with this approach in relation to serious case review improvement plans, and a challenge from the independent chair, agencies grappled with giving robust consideration to improvement across the identified themes and each partner agency plan was presented to the Board in July 2017. The main objective of this approach was to improve basic practice across partners to make good quality assessments from the start of any work with children and families and to establish meaningful plans to improve their lives. Recurrent themes in audit and review are these (nationally as well as locally):

- Assessments not taking account of previous behaviours and historical information, with insufficient analysis
- Allowing plans to drift for too long
- Not communicating adequately with other agencies

- An over identification with adults in a family and not identifying risk to the children or being distracted by presenting problems

The next stage of work for the coming year is the important work of gathering evidence of the difference this work has made to practice. Quality assurance mechanisms to check learning and measure impact need to be developed and robustly applied over the coming year.

- **Quality Assurance Dataset**

A number of years ago, a consultant was bought in to help Greater Manchester develop a comprehensive dataset and at that time our data collection was expanded with an attempt to gather other agency data. This dataset had become too big to fulfil its purpose with any meaning, particularly as agencies were not coming to the quality assurance sub-group sub to consistently provide narrative to the data. Work began to refine the dataset back to the information that we *really* need to assure us that the safeguarding system is really working in Stockport. A task and finish group has been established to complete this work and it is anticipated that a new data set and method of reporting will be in place for September 2017.

- **Young People in Transition**

A further focus was the development around transitions for those vulnerable young people who are not generally eligible for adults' services when they reach 18 years. Stockport has tried to improve the transition service for young people for some years, but there are structural issues which have hampered progress. A joint project was established with money from the Department of Education (DfE) Innovations Fund to research how children make the transition to adulthood and whether there needed to be any changes in service delivery to support our vulnerable groups. The research looked at four key areas: the interface between children's and adult's services, preparation for adulthood, care leavers and children with autism. The project made recommendations to both Safeguarding Children Board and the Safeguarding Adult Board which were accepted.

A development session was held in November 2016 to achieve agency commitment to the work and an action plan was developed. Based on evidence, it was agreed that the project would focus on two cohorts of young people; those who have multiple needs, including learning difficulties but do not qualify for adult services and those who are on the autistic spectrum, including those with Asperger's. It was also acknowledged that whilst there is a statutory duty for young people who are 'looked after' and would be entitled to 'after care' services, there was a recognition that there was a need to work more collaboratively to support the individual in a multi-agency approach.

A report detailing findings and recommendations was presented to both Boards followed by a joint learning event held in November 2016 to establish corporate ownership and develop an action plan for delivery. This has formed the focus for one of the board's priorities for 2017-2018.

The transitions agenda is incorporated into the adult early help and prevention sub-group, which has relevant children's services representatives on it. An important part of the work is the multi-agency adults at risk system (MAARS) panel which specifically considers those young people reaching adulthood, who are not eligible for traditional services, but have complex needs. A small transitions team in adult services was established to manage referrals to adults' services.

Transitions is an ongoing focus for work in the coming year specifically for these young people who present in lots of difference services, and who's ability to manage their lives by complex need.

2. Communication

The main objective in the last year was to disseminate learning effectively and communicating the messages from serious case reviews. In addition, ensuring that there is an awareness of the new areas of vulnerability which have been identified as new and emerging threats, such as forced marriage, human trafficking, radicalisation, and organised criminal gangs was important.

This work was largely driven by the training sub-group and training manager alongside the senior advisor for Safeguarding in Education, who provides a comprehensive package of training to schools.

There were opportunities to look further at the synergies between the adults and children safeguarding units and increased overlap in functions such as training and, reviewing and communication. New methods of communication were trialled used such as Twitter, video and seven minute briefings to facilitate different learning styles across staff. The use of video clips and 7 minute briefings have been particularly successful.

Joint processes for reviews have been established and the adult's board and the children's board embarked on a parallel serious adult review and serious case review, to consider the services to both an adult and a child in a family.

3. Stockport Family

All partners need to maintain a watching brief on the effectiveness of the safeguarding system as our system undergoes change and reorganisation. The role of Stockport Safeguarding Children Board was to be a 'critical friend' to the developments within the Stockport Family Model, and we will hold the 3rd of a series of support and challenge events with partners to carry out this responsibility.

The 3rd session that we agreed to hold last year to support and challenge Stockport family was delayed until the evaluation has been received. In the interim Stockport family provided regular reports to the board about ongoing developments, for example, in relation to Team around the School, the roll out of the early help assessment and their new teams mentioned elsewhere in this report.

6. How our Sub-groups progress the priorities of the Board

There are a number of sub-groups who work on behalf of the Board to achieve the objectives within the LSCB Business Plan. Each sub-group is chaired by a member of the main board or, in the case of joint sub-groups a member of the Children or Adult Safeguarding Board. All sub-groups review their terms of reference and membership on an annual basis and produce work plans that are integrated into the Stockport Safeguarding Children Board Business Plan review. Information on the child sexual exploitation sub-group and the children at risk sub-group is set out in other paragraphs.

Implementation Sub-Group

Chaired by the Head of Service for Safeguarding and Learning, this sub- group and is responsible for the delivery of the business plan. The other sub-group chairs report their progress to the implementation sub and an update report is presented to each board meeting. The business plan is updated and presented twice per year.

Quality Assurance and Performance Management Sub-Group

This sub-group has responsibility to oversee quality and effectiveness of arrangements and practice. The group identified that multi-agency auditing could not be achieved because of a lack of capacity to administer the audits and that the dataset required a changed in presentation of data and method to achieve the narrative required to interpret the story of the data. However, the following did take place:

- New chair- newly appointed Designated Nurse from the Clinical Commissioning Group (CCG) from January 2017.
- Work on the dataset to streamline Stockport Safeguarding Children Board data with that of other strategic groups and analyse to across the journey of the child through services.
- GM section 11 template adopted and decision to require partners to complete bi- annually, from June 2017.
- The sub-group has received increased evidence from single agencies, notably Health and Stockport Family in respect to quality and audit.

Audit and Monitoring Sub-Group

This group, a work stream to the quality assurance subgroup, has been very busy monitoring action plans from the serious case reviews and implementing the serious case review improvement plan. As a result, the action plans are very nearly completed on the serious case reviews and the impact of this is that individual agencies have improved processes to work with children and families.

Multi-agency auditing has been limited in the last year due to the work required as a result of the serious case reviews. However, Stockport Safeguarding Children Board supported Stockport Family multi-agency locality auditing, and several agencies submitted single agency audits. The aim in the coming year is to produce larger dip sampling activity and a more in depth look at a number of cases particularly to ensure that the learning from serious case reviews is embedded into practice and that practice has improved as a result.

Multi-agency Training Sub-Group

Stockport Safeguarding Children Board multi-agency training manager coordinated, promoted and delivered a comprehensive multi-agency safeguarding and child protection learning and development programme, which incorporates the wider safeguarding agenda. Each learning and development activity has been regularly reviewed and redesigned to ensure that it presents up to date, relevant, localised information.

Recommendations from local serious case reviews, learning reviews, management reviews and performance and quality audits have been incorporated within safeguarding and child protection learning and development activities.

A multi-agency pool of front-line trainers support the delivery of safeguarding and child protection, learning and development activities. Front-line practitioners from different disciplines support the development and delivery of safeguarding and child protection learning and development, ensuring that delivery is provided on a multi-agency basis whenever possible.

The Senior Advisor for Safeguarding in Education plays an important role for the Stockport Safeguarding Children Board and had developed a programme of learning and development to provide schools with training packages to assist them to meet their safeguarding and child protection standards. This programme assists schools in meeting Ofsted inspection criteria and the requirements of Keeping Safe in Education 2016. She plays a pivotal role in linking with the Stockport Safeguarding Children Board and the Director for Education to disseminate learning from serious case reviews for example, as well as advising schools how to fulfil their safeguarding responsibilities. In addition she plays a role in allegation management issues where education staff have been involved. (see additional information below in page 38)

As a member of the North West Interagency Training Group, Stockport Safeguarding Children Board training manger revised the toolkit to facilitate quality assurance of the learning and development packages for safeguarding and child protection. Training courses are regularly reviewed and quality assured by training sub-group and external verification has been undertaken with positive outcomes.

A detailed safeguarding training report is published each September with a full appraisal of the training capacity and delivery. It can be found here:
http://www.safeguardingchildreninstockport.org.uk/wp-content/uploads/2016/12/annual_training_report_15-16.pdf add

Policy and Practice Sub-group

This group supports the Greater Manchester Safeguarding Procedures manual and any local policies which may be required. The Greater Manchester procedures manual works well to provide the overarching policy direction for the 10 LSCB's and the expectation is that local pathways for service sit underneath the procedures on a local level. Website analytics demonstrate that this is the page most frequently accessed on Stockport Safeguarding Children Board website. As well as ongoing work relating to the Greater Manchester policies the sub-group did the following:

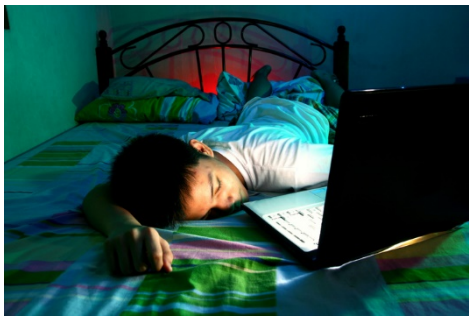
- The Levels of Need have been revised to incorporate Learning from serious case review particularly re eating disorder and impact of trauma.
- Partnership Supervision Protocol has been established as a pilot and will be rolled out in coming year.
- Guidance on the use of the Graded Care profile.
- Female Genital Mutilation Pathway established.

Online Safety Sub-group

Online safety sub-group continues to meet quarterly. There is a core of committed members and attendance is strongly influenced by operational duties. Within the updated structure of the safeguarding

boards the future of the group remains under discussion. Anti-bullying week was promoted across the school and college community. The anti-bullying policy for schools was updated in line with new guidance.

Safer Internet Day offers the opportunity to highlight positive uses of technology and to explore the role everyone plays in helping to create a better and safer online community. Safer Internet Day was on February 7th with the theme 'be the change unite for a better internet'. The event was promoted to schools & colleges and the national resources from the UK Safer Internet Centre made available via Office On-Line; Stockport College undertook work with both staff and students; online safety was promoted at governor conference. The day was promoted through Stockport libraries and in conjunction with Stockport Continuing Education there were parents & children sessions available. The day was also promoted with Stockport foster carers. The Youth Offending Service are offered practical sessions for young people.



The updated policy on youth generated sexual imagery was promoted to schools & colleges via designated safeguarding lead training and designated leads network meetings. The online safety sub has standard agenda items – Trending and Troublesome – which allows sharing of new research and resources but also areas of concern. The social media apps called Musical.ly and Omegle continue to present problems with our young people as they encourage chat with strangers. There have been a small number of complaints to the designated officer regarding the inappropriate use of technology.

New sub-groups

Stockport Safeguarding Children Board agreed the development of new sub-groups for 2017-8 to support the work taking place across the adult and children's safeguarding boards:

- Communication and engagement
- Adult early help and prevention (to include transition)

It is also likely that the complex safeguarding sub-group will be a joint sub-group with an agenda which includes female genital mutilation, human trafficking, forced marriage, organised criminal activity as well as child sexual exploitation and missing children. This work has a strong steer from Greater Manchester developments. As complex safeguarding affects both adults and children adults in the remit, it makes sense to address with a joint strategic response.

7. Partnership Reports

Stockport Family

The change programme known as Stockport Family, has been in development since December 2014, when a bid for Department of Education innovation funding was successful. Based on the earlier Integrated Children Services arrangement around early help, and using the underpinning approach of restorative practice already being used in Stockport in schools, the Stockport Family finally became fully formed in April 2016. Integrating key health services for children, teams were established for the 4 localities of Stockport, to offer a single multi-disciplinary service with designated links to other services offering support to children and families. The last year has been concerned with bedding the model in and keeping standards in place.

Stockport Family is an ambitious model, aiming to produce a whole system change in the delivery of social care at reduced cost. Stockport Family aims to work with the whole family, building on their strengths, with the expert assistance of a motivated workforce, supported by whole system training in restorative approaches – that is supporting families to find their own solutions to their issues where ever possible.

The overall objectives were:

- 20% reduction in spend on looked after children
- Reduction in children subject to child protection plans
- Sustained reduction in families needing repeat support
- Reduction in the need to remove subsequent children from a family where a child has previously been removed.

Quality Assurance

During 2015-2017, the children's social care framework has been in place and regular quarterly reports of quality assurance activities such as case file auditing, senior management shadowing exercises, thematic reviews and student mapping, have been produced. These have been shared and discussed within the monthly children social care performance management meetings. Quality assurance activity, feedback and shadowing exercises have identified that there are a number of individuals, teams and service areas which consistently perform well. It is believed that the focus on developing the best the workforce over the past two years has created the right environment and conditions to scale and spread the excellent practice and performance at speed.

Quality assurance activity in 2016/17 has highlighted areas of improvement and a number of priority development areas. There has been a focus on assessment which has also been one of the four identified thematic areas from the overview of the Serious Case Review activity in 2015/17. In 2016, a course on analytical assessment was delivered to all teams using a team based approach to training. In 2017, there has been an impact audit which is currently part- way through. The quality of chronologies had been identified within audits as an area for development, which resulted in a programme of targeted training and there is emerging evidence of improvement both in the creation and quality of audits.

Other areas for further focus are reflective supervision, and the evidence of this on child's files, and the variable quality of children's plans. These will both be specific areas for development and focused training in 2017/18.

Stockport Family Evaluation

As part of the funding agreement the model was evaluated for the Department of Education early in 2017.

"The scope and scale of these changes has been substantial, involving a structural and physical reorganisation through locality-based working and co-location, as well as an attempt to alter the overall culture of the organisation to establish an aligned, restorative focus. It is no small achievement to have delivered these activities within the planned timescale, and for staff to have had a clear understanding of the programme's aims and objectives since the programme's inception." [3] (Stockport Family Evaluation Research report March 2017)

In real terms, there have been very significant financial savings made, particularly through the Stockport Family First team working with children on the edge of care. That team has seen some innovative example of work which has prevented children coming into care or has allowed the return home more quickly through meaningful engagement with families to promote.

Whilst the number of children in care has remained stable in 2016-17, contrary to the national trend of rising numbers, the cost of placements reduced. It was anticipated that there would be a decline in children on child protection plans, or less children coming onto a plan for a second time. This is not yet seen, but it is still early in development and signs such as these will evidence that whole service change is really being effective.

Families were surveyed between June and September 2106 as part of the evaluation of Stockport Family. 106 families returned the questionnaire.

71% (75) said that staff were available when their family needed them
75% (79) said that staff listened to their family's views
73% (77) said that staff did what they said they would

This clearly provides impetus to progress the model and it seems certain that Ofsted will take a particular interest in the model when the Inspection of services for children in need, of help and protection, children looked after and care leavers takes place at some point this year.

Team around the school

The Stockport Family Team around the school programme is a partnership between schools, Stockport Family and key external agencies which identifies and provides early support needs for children and families. All schools within the local areas now have a nominated social worker whose role is to respond to requests for advice, support and decision making. This is a key development as many of the referrals to the MASSH come from the Education sector. It is anticipated this will help to reduce the reactive nature of some of the referral activity when school staff have a direct link to children social care for advice and consultation but the definitive evidence is not yet available. School Age plus Teams are linked to Children's Centres, Nurseries, Primary Schools, High Schools and Colleges in Stockport and offer parenting and other support to ensure early help is offered when problems are identified by schools. This service is generally well received by schools and the following are quotes from schools:

> *"Just wanted say a massive thanks you for all of our school aged plus worker's support this term it has really helped me. She has done some amazing work with several of my families, we don't always get the result we want but it's not for the want of trying!."*

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https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/624802/Stockport_IP_evaluation_report_July_17.pdf

"The school aged plus worker has been fabulous working with the Pastoral staff over the last year. She has been working with students and families with a range of complex needs – her support to engage families and improve outcomes for our young people is really valued. She has shown a resilience with non-engaging families to bring them on board with the broader picture of parental care."

Stockport Family Evaluation (March 2017) said this of the Team around the school:

'The programme is still at an early stage; however, there are reports of positive experiences from both social care and education teams. The school staff who were interviewed gave universally positive feedback on the role of the Stockport Family workers, and the workers themselves reported feeling supported and motivated to work with families. These workers were able to quickly build good relationships with schools in which they were based. They are regularly available and visible, with a dedicated time allocation, leading to fewer referrals to children's services[4].'

The Participation and Rights Team

Each partner agency has their own arrangements to hear children and family voice. The Participation team plays a specific role with missing children and now includes the Children Rights Service, including the Independent Visitors Scheme. This has resulted in the team changing their name to The Participation and Rights Team to reflect this. The team also coordinate the Children in Care Council and the Stockport Youth Forum. The value of the Participation Team to the STOCKPORT SAFEGUARDING CHILDREN BOARD is direct views of children coming through these groups and the business manager of the board meets with Stockport Youth Council regularly.

More generally improvements as a result of the Participation team activities include training for professionals on gender and sexuality by young people themselves, and children's recent involvement in interview panels for staff. In addition Stockport Youth Partnership in conjunction with Stockport College developed a video for young people in relation to child sexual exploitation to highlight the issue of grooming which has been used on the Project Phoenix website as a Greater Manchester resource.

https://play.buto.tv/rPLhc

School Survey Findings

The Participation Team conducted a survey in a targeted school to gain young people's views of the local area they live. Year 11 students were asked about the services available to them and whether they used them. Years 7 and 9 were also consulted. It was clear that bullying and antisocial behaviour and safety in neighbourhoods were key issues for these children as well as opportunities for training and development for their futures. It was particularly pleasing for the STOCKPORT SAFEGUARDING CHILDREN BOARD to hear the direct views of children and these issues have been picked up by the Education board to progress.

Stockport NHS Foundation Trust

In 2016 Child Protection Information System (CP-IS) became live in the Emergency Department (ED) Stepping Hill Hospital. The *Child Protection – Information Sharing* is a NHS England sponsored work programme, focused on developing an information sharing solution that delivers a higher level of protection to children who visit NHS unscheduled care settings such as accident and emergency departments, maternity, paediatric wards, walk-in centres etc.

4

It does this by connecting local authorities' child protection social care IT systems with those used by staff in NHS unscheduled care so that vital child protection information can be shared. The information sharing focuses on three specific categories:

- Children subject to a Child Protection Plan and the year they come off a Plan
- Children classed as *Looked After* by the local authority (full, interim and voluntary care orders)
- Any unborn baby subject to a Child Protection Plan

When a child/woman attends ED the system flags whether the child is known to be subject to any of these categories, it also simultaneously flags on children social care IT systems for the allocated Social Worker's information.

The benefits for the Trust and Stockport Children Social Care (and other local authority social care areas who have gone live) include:

- Facilitates timely and reliable information sharing
- Improved child protection decisions through the access to the supporting information
- Improved intervention to prevent the on-going abuse or neglect of a child
- Delivers a more focused communication between Emergency Department and Children Social Care on child protection issues

NHS Digital reported that Stockport CP-IS was in the top five areas accessing the system nationally. The second phase of this initiative is proposed that CP-IS will roll out to further unscheduled care settings in the Trust i.e. maternity and paediatric wards during 2017/2018.

Partnership Safeguarding Supervision

Each agency has their own arrangements for providing safeguarding supervision for practitioners. The requirement for Trust employees to have access to safeguarding children supervision is laid down in Working Together to Safeguard Children (HM Government, 2015) and Safeguarding Children and Young people; Roles and Competences for Healthcare staff (March 2014). Working Together states that:

"Working to ensure children are protected from harm requires sound professional judgements to be made. It is demanding work that can be distressing and stressful. All of those involved should have access to advice and support from, for example, peers, managers, or named and designated professionals. Those providing supervision should be trained in supervision skills and have an up to date knowledge of the legislation, policy and research relevant to safeguarding and promoting the welfare of children".

The safeguarding children team have developed various methods of safeguarding supervision to support practitioners working with children and their families, to ensure there is a programme of effective safeguarding supervision across the hospital and community setting.

A new initiative of **Partnership safeguarding supervision** between Stockport Family staff in Health and Social Care has been piloted with success in the Heaton Tame Valley locality. It is not intended to replace single agency safeguarding supervision but to offer an additional function. There has been an incremental approach to widening the access to this positively evaluated model of supervision which is now established throughout the Stockport Borough. Ultimately, we would like to achieve a pathway for inter-agency supervision between all partners both within and outside of Stockport Family. We would hope to evaluate this first roll out phase and develop future pathways supported by evidence and experience.

Purpose of partnership supervision:

- To enhance reflection and understanding in a safe environment. It is intended to be a reflective space, and in this way, differs from the more task-focussed emphasis of a professionals' meeting.
- To enhance workers' development and thinking about a difficult case.
- To identify resistance and generate working strategies
- To enhance understanding of multi-agency knowledge, perspective, roles and responsibilities.
- To explore working hypotheses and triangulate information.
- To develop learning from Serious Case Reviews.
- To address and challenge the potential for de-sensitisation.
- To facilitate SMART planning and better support families to effect change.

Cases brought to partnership supervision by either health or social care have been complex and not limited to a certain type, with referrals across the tier range, and at various points in the step-up/down child's journey i.e.

- Complex cases
- Cases where workers have different views about case direction.
- Cases which are stuck, lacking in direction or where there is drift.
- Cases where intuitive concern exists but is unsupported evidentially.
- Cases where there have been repeat child protection episodes.

Pennine Care NHS Foundation Trust

Assurance structures and developments:

A number of established internal governance arrangements/groups within the Pennine Care Foundation Trust (PCFT) ensure a robust management and scrutiny of incidents and oversees the strategic and operational management of safeguarding children across PCFT. These include Integrated Strategic Safeguarding Group, Quality Group, and Patient Safety Investigation Group,Integrated Governance groups across all business units, a Safeguard incident report system and Safeguarding forums.

Safeguarding quarterly reports are submitted to the Trusts Integrated Safeguarding Strategy Group and Safeguarding Families Forum to monitor activity and any themes/trends which can inform staff awareness and training.

The Greater Manchester Safeguarding policies and procedures continue to be promoted to staff during training and supervision via the intranet. In addition staff are encouraged to sign up to these procedures for email updates. A single Safeguarding Families policy promotes a "think family" model of safeguarding within PCFT and supersedes separate Children's and Adult's safeguarding policies.

The Trusts Safeguarding Lead ensures that the named doctor and named nurse for safeguarding have a role in promoting good professional practice within their organisation, providing advice and expertise for fellow professionals and ensuring safeguarding training is in place through working closely with their organisation's safeguarding lead, designated professionals, the Local Safeguarding children Board and Safeguarding Adult Board .

PCFT is monitored through the Clinical Commissioning Groups Safeguarding Children, Young People and Adult at Risk Contractual Standards and Training Recommendations framework. In 2016/17 all contractual standards were met.

Audit and Standard Operating Procedures (SOPs);

A number of SOPs across PCFT have been reviewed and developed relating to safeguarding. New Standard Operating Procedures include:

- The Management of unexpected death and expected death in children up to the age of 18 years.
- GP registration for a child not currently registered
- Non engagement of Looked After Children
- Standard Operating procedure for Review Health Assessments for Looked After Children
- Standard Operating Procedure for transfer of records

PCFT safeguarding teams have also contributed to a number of audits; some are service and borough specific and include:

- Routine Enquiry of FGM by Health visitors at first visit to a family
- "Voice of the child",
- Domestic Abuse
- Neglect
- Safeguarding supervision
- Looked After Children annual health assessments
- Graded Care profile
- Health contribution to PLO (Public Law Outline) process
- "Professional Thinking Time"
- Early help with a focus on neglect
- Missing from Home

Healthy Young Minds

Healthy Young Minds (HYM) has been invested in from the transformation funding to support increased provision across a number of areas. The service is now supporting the delivery of an enhanced offer to schools and colleges, building capacity to recognise and intervene early for a range of childhood emotional health issues. This includes providing consultation to the established "Team around the School" approach, which is aimed at delivering training in key areas to school staff and partnership working with the school nursing service.

In addition, HYM investment has ensured that a specific resource has been attached to the MASSH, the Leaving Care offer has been increased and the transition team has grown and now provides daily triage for 16-18yrs referrals to the adult mental health access team. Strong partnership working exists across the acute Trust Emergency Department and adult mental health colleagues to ensure that agreed pathways around risk assessment and transition remain effective.

Additional capacity within the ADHD pathway has been used to support the increasing demand across both HYM and Paediatric services whilst a dedicated psychotherapist has been providing support to children aged 3-5 years and their families. This role has been embedded within the infant parenting service and has focused on delivery of therapeutic work within priority areas in Stockport.

Overall multi-agency pathways have been strengthened. PCFT and HYM practitioners continue to prioritise the Looked after Children (LAC), child exploitation and domestic abuse (MARAC) agenda thus recognising the need to intervene early and provide appropriate triage and intervention to children and families

presenting with emotional and mental health needs. The introduction of a joint multi agency Children and Adults Complex Safeguarding sub-group will provide further scrutiny of themes and trends emerging.

Learning from Local Investigations:
Two protocols have been developed following the learning identified from analysis of lessons learned. These include;

- A Stockport Joint Service Protocol to meet the needs of children, young people and unborn babies whose parents or carers have mental health problems.
- Protocol for Joint Working of young people with Eating Disorders

A Record Keeping and Safeguarding Documentation audit is currently being completed by HYM staff.

A guide for staff "safeguarding children, adults and families" was produced in May 2016, which is available for all staff and given to all new staff on induction and was distributed via payslips. This further highlights and promotes the safeguarding families model now embedded in Pennine Care.

A number of "7 minute briefings" have proved a popular method of disseminating learning to staff along with a twice yearly safeguarding newsletter and a monthly topical safeguarding message which all staff receive via the intranet.

A successful learning event was attended by staff, with further events planned for 2017/18 in order to disseminate learning from Serious Case Reviews (SCRs) to staff, as well as continued learning through safeguarding consultation provided from the local safeguarding team.

Training:
A new Safeguarding Training Strategy has been developed with the launch of a Level 3 training Passport in July 2017 to support implementation. All safeguarding training is underpinned by the Intercollegiate Document for Safeguarding Children and Young people: roles and responsibilities for Health Care Staff (2014). From April 2016 Level 2 safeguarding training children has been delivered via E-learning for all staff eligible, with a safeguarding training Level 3 "passport" launched in July 2017. A bespoke Looked after Training (LAC) training package has been delivered since May 2017. Training for staff around the "Toxic Trio" has been developed and will be rolled out during 2017/18. This training looks specifically at the impact on children and families of parental mental illness, substance misuse and domestic violence and directs staff around referral processes and interventions.

Supervision can be accessed via clinical and managerial routes with safeguarding supervision to be included as part of the overall PCFT supervision framework which is currently being developed.

Greater Manchester Police - Stockport Division

Stockport Safeguarding Children Board received assurance from the Police representative for the Board following receipt of a letter sent by Sir Michael Wilshaw HM Inspector to Sir Thomas Winsor HMIC regarding issues raised during the 2015/2016 round of Ofsted Inspections. Issues raised as a National Concern from Sir Michael Wilshaw are listed below;

- Sharing information about domestic abuse cases in a timely way
- Notifying social workers quickly enough when children went missing
- Attending important child protection conferences
- Carrying out joint child protection visits with social workers
- Tackling DBS (Disclosure and Barring Service) backlogs.

The Superintendent noted that there were no major local issues in relation to the concerns raised nationally and provided assurance to Stockport Safeguarding Children Board about activity taking place in Stockport around these issues:

- **Sharing information about domestic abuse cases in a timely way**

Domestic abuse referrals are sent through from the Police to the MASSH. Whilst most cases are sent through in a timely manner, there are occasions when this is not the case and reliance falls to an individual triage officer in the system which can create delays in information sharing. New I.T. Infrastructure will provide greater capabilities in respect of domestic abuse and also the communication between both organisations. This is currently being developed.
In addition, Stockport Social Care and the police have met to consider new ways to begin improving information sharing process, drawing on the learning from the integrated response to the child sexual exploitation operating with the Phoenix team.

- **Notifying social workers quickly enough when children went missing**

A triage system operates in respect of incidents of child concern or child at risk of sexual exploitation, to ensure swift dissemination to a police officer for investigation. In addition, the joint working also ensures that the duty 'embedded' social worker is notified at this early stage. This ensures that there is no delay in the referral and relevant information is shared to ensure appropriate safeguarding.
A weekly partnership meeting is also convened, with relevant providers (Health/education/social services, etc.) to discuss longer term cases and relevant intelligence to support this process is disseminated appropriately.
As a final safety net, the local authority participation team follow up all missing`s 24 hours after return and conduct a further safe and well check, and information from this is referred back into the triage team and dealt with appropriately.

- **Attending important child protection conferences**

Due to the embedded joint working, there is always a joint attendance at the most important/high risk CP conferences. This is daily business on the Stockport Division and the strategy meetings around children at risk of sexual exploitation are attended by both Aspire and Police officers.

- **Carrying out joint child protection visits with social workers**

Any decisions around joint visits are discussed at daily governance meetings and where appropriate joint agency visits are carried out. This is again as a direct result of the collaborative working approach the Aspire team operate.
Any proactive interventions (warrants, etc.) are risk assessed for the appropriateness of social workers attendance. The aim of joint proactive interventions with Children Social care is aimed at ensuring the child or young person receives intervention at an early stage. Joint education visit are also conducted to schools, care home and other points of contact.

- **Tackling DBS (Disclosure and Barring Service).**

The DiBS section/unit who process relevant checks to mitigate any risk associated to vulnerable children who wish to visit a particular address and/or social care wish to make sure that the address is safe for the young person to visit only have a one month back log, this has significantly reduced by improved processes and provide a turnaround of results in 4/5 weeks from application.
In addition, the DBS section who undertake checks for coaches and employee applications again have a low back log of two weeks with a turnaround of 60 days to complete an application.

Safeguarding Children in Education

Approaches to safeguarding and child protection in education have an established base in Stockport. We can evidence the commitment of our workforce and that of partner agencies in supporting our children, young people and families in a variety of ways to promote and sustain their welfare. This includes:

- Good use of whole school/setting training for staff to support settings in raising awareness of issues, themes and ways to respond.
- A range of training opportunities (intelligence led) for designated safeguarding leads and pastoral support staff to support them in leading the safeguarding agenda, and promote their own development and awareness, which are well accessed across the year.
- Bespoke training and support packages on request, to help address locality or setting based issues.
- Access to a broad range of training and development opportunities through the Stockport Safeguarding Children Board allowing settings to further develop the knowledge and skills of staff to empower them to offer support to learners with a diverse range of needs.
- Access to accredited safer recruitment training and follow on support.
- Access to home Office training in respect of the prevent agenda, delivered by Home office accredited facilitators.
- Engagement in and contribution to local learning reviews, giving a voice to colleagues from education in the safeguarding learning arena.
- Support with policy and guidance for settings, helping colleagues to remain up-to-date in their knowledge and delivery. These include a template safeguarding policy, staff code of conduct, template single central record, self-assessment tools and direct audits.
- Regular briefings to school governors on best practice and policy guidance.
- Access to consultation and support through the Multi-agency Safeguarding and Support Hub (MASSH) and the Safeguarding Children Unit- including the Senior Adviser for Safeguarding in Education and the Local Authority Designated Officer
- Support in respect of managing allegations against staff, critical incidents, media strategies and community impact.
- Established networks with Independent education providers.

The Senior Adviser for Safeguarding in Education develops and delivers training to education settings in partnership with Stockport Safeguarding Children Board Training Manager. Specific courses are delivered to the designated safeguarding leads in schools, colleges and early year's settings, to ensure they remain compliant with guidance. Training for designated safeguarding leads is offered termly to new and existing leads in tailored packages. The training aims to guide and assist them in understanding and applying best practice and procedures in the field, as prescribed within the statutory guidance (KCiSE 2016).

Whole school basic awareness training and refresher training is offered to all school settings and bespoke packages are available on request to schools, colleges, and education services. These sessions aim to:

- Raise awareness of what is in the safeguarding agenda.
- Raise awareness of allegation management.
- Promote thinking about safer working practice within organisations.
- Provide an understanding of the processes in place to support a child's welfare in Stockport.
- To develop an understanding of Child Protection, how to recognise it and respond appropriately.
- Disseminate learning from national serious case review and local multi agency learning reviews.

The schools' safeguarding guidance Keeping Children Safe in Education was reissued in September 2016 with some key changes to the role of the designated safeguarding lead and training requirements for schools. This required the programme to be updated to reflect the changes.

The Safeguarding Advisor for Safeguarding in Education introduced network meetings alongside existing opportunities for designated safeguarding leads (and their deputies in order for them to maintain their currency and meet the needs in the guidance. These were termly and covered the following topics:

- SCRs and functions of Stockport Safeguarding Children Board.
- Organised Crime Groups (OCGs).
- Radicalisation/ British values.
- Transgender issues (the Proud Trust).
- MASSH/Early Help Assessment / ASPRIE updates.
- Self-harm and well-being.
- Complex Safeguarding.
- General updates.

The requirements for whole school training and the development of a safeguarding culture also changed in the guidance. A training for trainer's session was held to support designated safeguarding leads with resources to update their staff with whole school sessions. The following table highlights the activity:

Subject	**No of sessions/ events**	**Attendance**
Basic Awareness	51	Whole setting
Prevent/WRAP (plus)	20	Whole Setting
Headteacher Safeguarding Induction	1	6
Deputy Headteacher Safeguarding Induction	1	4
Safer Recruitment	1	28
Safer Recruitment refresher	2	18 (X2)

The above table equates to training delivered to in excess of 1800 education staff

School Governor training

Safeguarding training is provided by the Safeguarding Advisor for Safeguarding in Education as part of the governor programme. The programme is organised by Governor Services and the following indicates the numbers trained:

· Safeguarding for Governors - 24 attendees
· Safer Recruitment (full day) -28 attendees
· Safer Recruitment (full day) – 30 attendees.
· Safer Recruitment twilight session part 1– 15 attendees
· Safer Recruitment twilight session part 2– 12 attendees
· Safer Recruitment Refresher– 10 attendees

Information about key safeguarding and legislative changes is shared with Chairs of Governors via the termly briefing sessions.

School inspections

There were 31 Ofsted inspections across the academic year 2016/17. Safeguarding arrangements judged effective in 100% of inspections.

Breakdown by setting

1	Nursery school
21	Primary school
4	Secondary school
4	Special school
1	Pupil Referral Unit

Health and Wellbeing School Co-Ordinator

The Health and Wellbeing School Co-ordinator supports school and settings to develop a whole-school approach to preventative education ensures that the curriculum, school policies, pastoral support and the school ethos complement each other to create an environment that helps prevent negative behaviours. An effective curriculum should teach children and young people the importance of healthy relationships both on and off line, assess and manage risk effectively and develop key skills including digital resilience.

To support this agenda the following training has been delivered across Stockport schools:

12 Parent session's e-safety - approximately 400 participants
1 Governors session - 30 participants
22 Staff meetings - approximately 200 staff
2 CEOP sessions - approximately 80 participants
Online network on Learning Leads -750 members
3 PSHE network meetings (always include updates one line safety) - 70 participants.

The Safeguarding Advisor for Safeguarding in Education and the Health and Wellbeing School Co-ordinator work closely together to review training, understand emerging theme and deliver appropriate packages of support to schools and colleges. Anti-bullying week, Safer Internet day and It's Not OK campaign are also promoted with all schools and settings and materials are shared to support these promotions.

Allegations and Safeguarding Concerns

	15/16	16/17
Allegations re; whole school workforce	239	244
Allegations re; education staff	68	94
Ofsted complaints/concerns	14	22

Allegations, safeguarding complaints and concerns for education have increased since last year, the complexities of these notifications are often significant and time consuming in terms of the response and resource needs. This workflow is usually led by the Local Authority Designated Officer and the Safeguarding Advisor for Safeguarding in Education, however increasingly this work also crosses over with the work undertaken by the complaints resolution team.

Other Education Services

The Director of Education Services and the SASE have had timetabled meetings throughout the year. In addition to these meetings the two have worked responsively to emerging themes and situations. This relationship has enabled the mobilisation of other education services to address presenting matters or themes. The SASE has also met regularly with Senior School Improvement Advisors, the Ethnic Diversity Service, the Sensory Support Service, School Inclusion and Education Psychology colleagues to ensure specific tailored responses to issues across the year.

The SASE has an established partnership with School Support and Pupil Admissions. This year the annual Safeguarding and Welfare Development Day for the partnership included updates on basic awareness, transgender issues, complex safeguarding- with a discrete focus on trafficking and modern slavery. Greater Manchester Police, The Border Agency and The Proud Trust were all contributors to the day. This crucial partnership has worked closely and regularly together to ensure high levels of vigilance and good practice, particularly around complex safeguarding matters.

Education and Policing

Stockport Divisional Police through their senior leadership team and community officers have worked with the SASE and Director of Education services on a variety of sensitive matters this year to respond to individual and community issues. These have included, anti-social behaviour, community safety issues and individuals who pose a risk of harm to children.

Section 175/ 157 Returns

The S175/157 audit is used to establish safeguarding standards in schools. Last academic year and an extended version of the last tool was used having been redesigned to capture information on the prevent duty and other areas, to reflect the changing requirements and duties placed on schools and colleges. As well as fulfilling a statutory duty, it allows schools and their advisors to evaluate their progress and development needs with regard to safeguarding.

The audit will work on several levels it will:

- Allow schools to collate and present information on range of Ofsted critical issues to support them through inspection.
- Allow Advisors to understand the current picture in settings and advise additionally on the gathering and monitoring of information-including 'soft data'.
- Provide evidence to Stockport Safeguarding Children Board that schools are engaging in the safeguarding agenda in both a statutory and meaningful way.

Originally the audit was set to be returned by July 2017 and analysed over the summer. However following a high volume of requests the deadline was extended to October and feedback will be provided to the Education Partnership Board in due course.

8. Conclusion and Future Priorities 2017-18

The role of Stockport Safeguarding Children Board is to ensure that partners, voluntary and community sectors are working together effectively to keep our children safe. In Stockport the systems work well together and the standard of service given to children and families remains high on the list of priorities for the Borough. The Multi Agency Support and Safeguarding Hub is effective in managing a large amount of concerns being raised on a weekly basis in response to stress in homes, such as domestic abuse, poverty and mental health. The new early help assessment has been introduced to ensure that assessments for help are completed using the same tool so that the levels of need can be clearly identified and responded to. The formal evaluation of Stockport Family demonstrates that the integration and co-location of services is demonstrating positive benefits for children and families who need support. There is increased communication between agencies and understanding of each other's roles and responsibilities and this in turn leads to better outcomes for children.

Our serious case review work over the last few years has demonstrated that there are always improvements to be achieved to keep the services working as well as can be. Essentially the lessons to be learned are that good assessments and plans which are meaningful for families, created out of respectful, transparent and purposeful relationships, are the means by which families recognise and respond to the needs of their children.

The Safeguarding Children Board itself has had identified a number of areas that are needed to strengthen to governance and influence of the partnership, to include attendance at training and the training pool delivery , quality assurance activity and the links with other Strategic Partnership Boards. It is also envisaged that more crossover between the adults and children boards will take place to develop a whole life approach to safeguarding

Future Priorities 2017-18

Stockport Safeguarding Board and Stockport Safeguarding Adult Board developed a shared vision and 4 strategic objectives for 4 priorities for the coming year to develop a shared understanding and response to key themes. The ambition is to develop safeguarding across the lifespan of the individual with the aim of realising the following shared aim:

'Working in partnership to support and safeguard the people of Stockport to enable them to live safe healthy and where possible, independent lives'.

The shared strategic objectives are:

1. **Governance:** Refresh, improve and strengthen the governance around the safeguarding architecture including Stockport Safeguarding Children Board, Stockport Adult Board and Safer Stockport Partnership to ensure clear lines of accountability and reporting. Ensure that appropriate strategies are in place to support the priorities of the board.
2. **Scrutiny, challenge and quality assurance:** from a safeguarding perspective for the quality, transformation of services including the development of Stockport Family, Stockport Together and all age Multi-Agency Support and Safeguarding Hub. Develop a standardised approach to assessing and evaluating the work of the boards in relation to partners engaged in safeguarding children, young people and vulnerable adults.
3. **Learning and development**: Ensure development of a confident committed and competent workforce operating consistently and effectively across partnerships to safeguard children young people and adults.
4. **Communication**: To promote the work of each Board to the population of Stockport to raise awareness of safeguarding.

A joint Board development day was established to considered a range of options to develop in the coming year with a view to developing work rather than progressing what is considered 'business as usual' that is, core business of the Safeguarding Boards. The themes were those found in the serious case reviews and areas of concern we felt needed attention and developing. The following priorities were chosen across the two Boards:

1. **Transitions** – to develop the work coming out of the DFE funded transition project to improve the identification and referral process for the most vulnerable young people particularly those who do not meet the criteria for adult social care and/or have complex dependencies, and to have data and training in place
2. **Neglect -** development of an all age strategy consistent with Greater Manchester developments and have data and training to support the work
3. **Domestic violence and abuse -** to provide critical challenge to the Implementation and delivery of the Domestic Abuse Strategy, with data and training to support the work
4. **Complex safeguarding -** to develop arrangements for complex safeguarding in line with Greater Manchester, and to ensure data and training is in place to support this.

The Boards also wanted to ensure that mental health was an issue threaded through each of these priorities rather than make it a separate discrete priority.

The Board Plan on a page can be found here:

http://www.safeguardingchildreninstockport.org.uk/wp-content/uploads/2017/04/STOCKPORT SAFEGUARDING CHILDREN BOARD -SSAB-Strategic-Plan-2017-2020.pdf

Delivery plan for 2017-20 can be found here:

http://www.safeguardingchildreninstockport.org.uk/wp-content/uploads/2015/11/STOCKPORT SAFEGUARDING CHILDREN BOARD -Strategic-Delivery-Plan-2017-22.-05-17-004.pdf

9. Key messages for readers

This year, Stockport Safeguarding Children Board would like to convey the following key messages.

For children and young people

- As a safeguarding board, we need to get better at listening to your views on services for children. We think we get a good picture from the participation team and through the services you use but we don't use your views to inform our work yet.
- Your safety and protection is very important to us. Let us know if we can improve it
- Let us know if you think services can be improved to make sure you are kept safe from harm.

For the community

- You are in the best place to know what is happening to children and young people and to report your concerns if you think something are happening.
- Protecting children is everybody's business. If you are worried about a child, contact the MASSH on 0161 217 6028

For Stockport Safeguarding Children Board partners and organisations

- Remember the key areas from our serious case review learning: good practice in these areas will do much to keep children safe:
    - **Assessment** - these must be as good as they can be using all the information you can gather
    - **Plans** – your plan must be meaningful to the family you are working with, and you must be clear what you should do and how it will be achieved
    - **Quality of meetings -** make every meeting matter in order to carry out your plan
    - **Supervision** - ensure that you get time to reflect and understand your families and use your managers to support good practice.

- You are required to assure this Board that you are discharging your safeguarding duties effectively and ensuring that services are commissioned for the most vulnerable children.
- Use the Greater Manchester Policies and Procedures to guide your practice.
- Look at the Safeguarding Board website and twitter feed for updates.
- Make sure that the voices of all children and young people are informing the development of services.
- Take notice of the voices of vulnerable children. Listen and respond, particularly if they disclose abuse.

For schools:

- Make sure that you are compliant with the processes which all schools must follow to safeguard their pupils, whether you work in the maintained, non-maintained or independent sector.
- In particular, ensure that you are familiar and compliant with 'Safeguarding Children in Education' guidance' September 2016.
- Be aware of and compliant with safer recruitment processes.

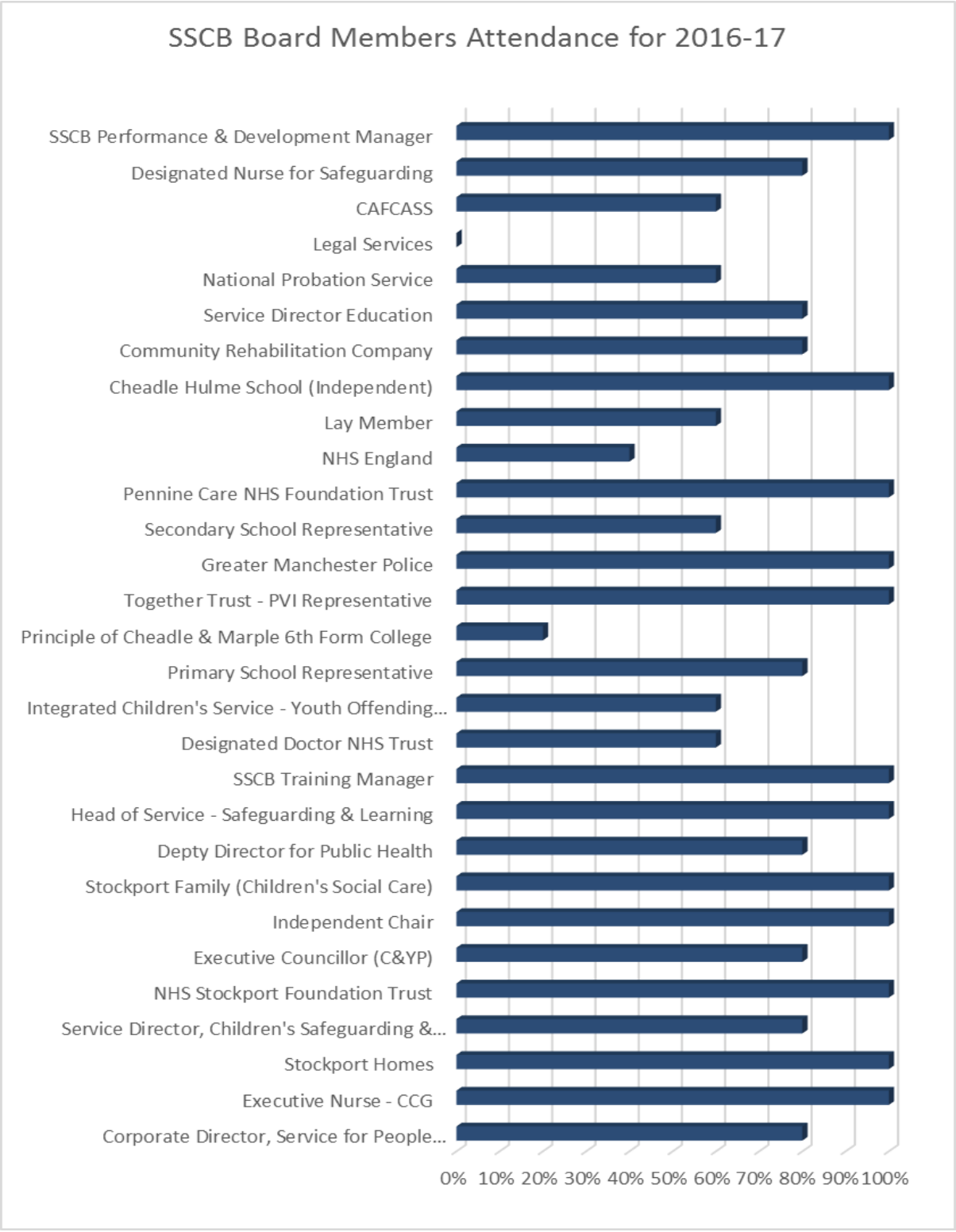
For practitioners:

- Make sure that you attend safeguarding courses and learning events required for your role and that you are constantly up to date with changes in safeguarding practice, guidance and legislation. These change all the time.
- Be familiar with, and use, the multi-agency tools designed for you: e.g. Levels of Need , Good practice checklist
- Resist complacency. Just because certain issues such as child sexual exploitation, trafficking, female genital mutilation and other similar problems are rare in our community, does not mean that they are not present. Indeed, they may be even harder to spot.
- Be 'professionally curious' with other practitioners and when working with children and young people.

For everyone:

- ***'If you see something, say something'***

Appendix 1.


SSCB Board Members Attendance for 2016-17
SSCB Performance & Development Manager
Designated Nurse for Safeguarding
CAFCASS
Legal Services
National Probation Service
Service Director Education
Community Rehabilitation Company
Cheadle Hulme School (Independent)
Lay Member
NHS England
Pennine Care NHS Foundation Trust
Secondary School Representative
Greater Manchester Police
Together Trust - PVI Representative
Principle of Cheadle & Marple 6th Form College
Primary School Representative
Integrated Children's Service - Youth Offending...
Designated Doctor NHS Trust
SSCB Training Manager
Head of Service - Safeguarding & Learning
Depty Director for Public Health
Stockport Family (Children's Social Care)
Independent Chair
Executive Councillor (C&YP)
NHS Stockport Foundation Trust
Service Director, Children's Safeguarding &...
Stockport Homes
Executive Nurse - CCG
Corporate Director, Service for People...
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Appendix 2.

NAME	DESIGNATION
Gill Frame	**Independent Chair**
Andrew Webb	Corporate Director, Children & Young Peoples' Directorate
Anita Rolfe	Executive Nurse - CCG
Chris McLoughlin	Service Director, Children's Safeguarding and Prevention
Claire Woodford	NHS Stockport FT. Acting Director Child & Family Services
Clare Manock	Stockport Safeguarding Children Board Administrator
Colin Foster	Executive Councillor Children & Young People
David Jackson	CAFCASS
Deborah Woodcock	Director of Operations - Stockport Family
Donna Meade	Community Director (CRC)
Donna Sager	Deputy Director for Public Health
Ian Mecrow	Designated Doctor. NHS Trust Stockport
Ian Uttridge	Head of Service - Children & Families, Together Trust
Jackie Stewart	Service Director Specialist Services, Pennine Care NHS FT
Jacqui Belfield-Smith	Service Lead - Boroughwide Services (YOS, TYS & MFH)
Jeanette Warburton	Principle Lead, Social Care & Commissioning
Jenny Curzon	Headteacher, Abingdon Primary School
Jenny Curzon	Headteacher, Moorfield Primary School
Jill Sheldrake	Director of Social Care, Together Trust
Judith Harrisson	Independent Lay Member
Julie Parker	Head of Safeguarding/Designated Nurse Safeguarding Children
Keith Turmeau	Headteacher, Harrytown High School
Liz Hopkinson	Detective Chief inspector, GMP
Liz McCoy	Pennine Care NHS Foundation Trust
Maria Greenwood	Independent Lay Member (Joint Chair of Trustees at SWA)
Mark Sibson	Headteacher, Hazel Grove High School
Martine Webster	Cheadle Hulme Independent School
Nicola Westby	Community Rehabilitation Company
Nuala O'Rourke	Head of Service - Safeguarding & Learning
Phil Beswick	Service Director, Education
Rebecca Key	Service Manager, Children's Social Care
Richard Moses	National Probation Service
Sajada Zaman	Manager, Social Services Legal Team
Sandra Coleing	Director of Neighbourhoods and Support, Stockport Homes
Sarah Johnson	Headteacher, Alexandra Park Primary School
Spencer Davies	Assistant Principal, Cheadle & Marple Sixth Form
Stephen McFarlane	Superintendent, Greater Manchester Police
Una Hagan	Stockport Safeguarding Children Board Business Manager
VACANCY	Director of Nursing and Midwifery, Stockport FT

Appendix 3.

Resources – Finance

To function effectively SSCB needs to be supported by member organisations with adequate and reliable resources. Partners contribute financially and additionally they offer staff time, resources and venues to ensure the training programme is delivered successfully.

The budget for SSCB is made up of contributions by member organisations and the business plan has been formulated to ensure the work of SSCB can be achieved within budget.

SSCB Finance Summary 2016/17	
Contributions received	**2016/17**
CAFCASS	£550
Stockport NHS Foundation Trust	£4,000
GM Police	£13,800
Probation	£1,066
NHS CCG	£32,000
YOS	£8,000
Sub-total	**£59,416**
Income from training	£1,700
Local Authority Contribution	£96,836
LA Reserves for Reviews	£53,420
TOTAL INCOME	**£211,372**
Expenditure	
Staffing costs	£131,944
Independent Chair	£14,215
Sub-total	£146,159
Other costs	
SCR / MALR	£35,830
Court order	£13,500
Sundries	£7,403
Conference venues and refreshments	£5,730
Sub-total	**£62,463**
TOTAL EXPENDITURE	**£208,622**

An interpreting service is available, if you need help with this information.

Please telephone Stockport Interpreting Unit on 0161 477 9000. Email: eds.admin@stockport.gov.uk

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如果你需要他人為你解釋這份資料的內容，我們可提供傳譯服務，

請致電 0161 477 9000 史托波特傳譯部。電郵 eds.admin@stockport.gov.uk

اگر در مورد این اطلاعات احتیاج به کمک داشتید خدمات مترجمی رایگان موجود است لطفا با سازمان مترجمی استاکپورت با شماره تلفن و یا ایمیل آدرس زیر تماس بگیرید.01614779000eds.admin@stockport.gov.uk

Jeśli potrzebujesz pomocy z tą informacją dostępne są darmowe usługi tłumaczeniowe. Prosimy dzwonić do Wydziału Tłumaczeń w Stockport pod numer 0161 477 9000. Email: eds.admin@stockport.gov.uk

اگر آپ کو ان معلومات کے ساتھ مدد درکار ہے تو انٹرپریٹنگ سروس (ترجمانی کی خدمات) دستیاب ہے۔ براہِ مہربانی سٹاکپورٹ انٹرپریٹنگ یونٹ کو 0161 477 9000 پر ٹیلیفون کریں۔ ای میل :eds.admin@stockport.gov.uk