Safeguarding Partnership Annual Report 2021/2022

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Purpose of the Report

Working Together 2018, requires the Children's Safeguarding Partnership to publish a report on an annual basis. The purpose of this report is to:

- Set out what safeguarding partners have done because of the arrangements, including child safeguarding practice reviews, and how effective these arrangements have been in practice.

It contains the following:

- Evidence of the impact of the work of the safeguarding partners and relevant agencies, including training, on outcomes for children and families from early help to children in care and care leavers

- An analysis of any areas where there has been little or no evidence of progress on agreed priorities

- A record of decisions and actions taken by the partners in the report's period (or planned to be taken) to implement the recommendations of any local and national child safeguarding practice reviews, including any resulting improvements

- Ways in which the partners have sought and utilised feedback from children and families to inform their work and influence service provision

- Work undertaken between April 2021 and March 2022

Our vision: is 'working in partnership to support and safeguard the people of Stockport to enable them to live safe, healthy and, where possible, independent lives'.

The vision of the SSCP is translated into action through the three year Strategic Plan underpinned by a Business Plan which is reviewed and refreshed annually. The current Strategic Plan (2020-23) was agreed in January 2020 and updated in September 2021. It is based on three priorities:

Neglect/Self Neglect; Complex Safeguarding and Domestic Abuse.

How the Partnership Works

The Safeguarding Children Partnership (SCP) will include and relate to all agencies with responsibilities and interests in the safeguarding of children and young people, including for example, education and those in the third sector, the three agencies with statutory responsibilities will together share duties with respect to seeing the strategic direction for safeguarding, and for the overall governance of the partnership.

The Partnership comprises of three main groups: The SCP Executive., the Quality Assurance Partnership and the Practice Improvement Partnership. This is supported by two joint working groups which are the Complex Safeguarding Group and the Training and Development Group.

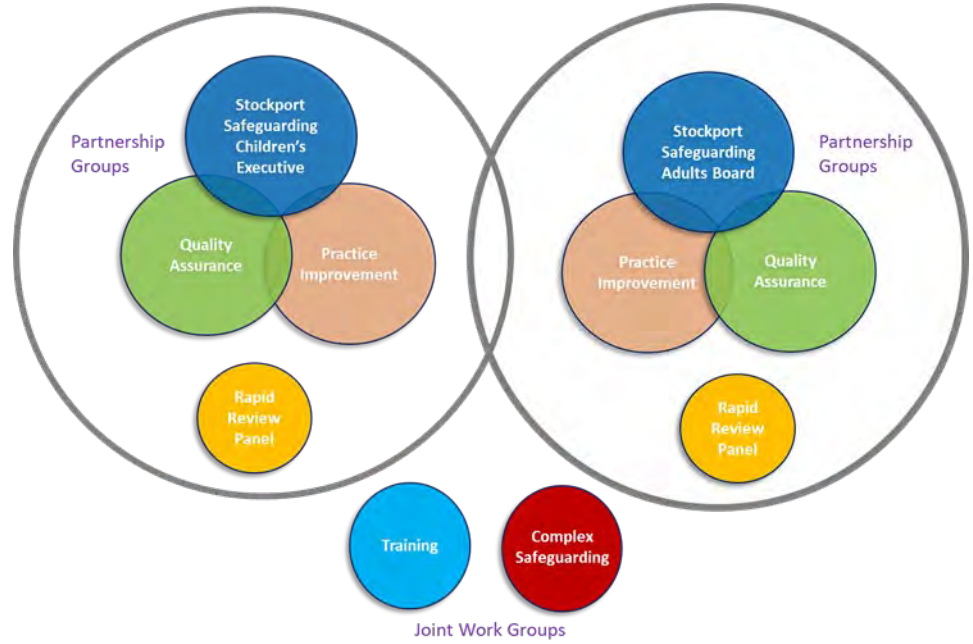
The three main safeguarding partners, Stockport Local Authority, Stockport Clinical Commissioning Group (now the Integrated Care Board) and Greater Manchester Police, contribute most of the funding for the partnership to operate effectively. The contributions can be found in the appendix.

The SCP Executive is chaired by an Independent Chair, under the new arrangements Stockport Safeguarding Partnership continued with the Independent Chair arrangements as they valued the scrutiny and challenge that an independent person brought. The Vice-Chair will be one of the three statutory partners nominated each year.

Practice Improvement Partnership
The work of this partnership group is underpinned by a learning and improvement framework, and is responsible for overseeing case reviews; initiating, reviewing and endorsing policy and practice guidance/standards; learning from published inspections, case reviews and research to continuously improve the quality of services and outcomes for children.

Quality Assurance Partnership
The work of this partnership group is to scrutinise and challenge the work of the partners by integrating a range of information and is underpinned by a quality assurance framework and dataset.

This subgroup is responsible for the moderation of all completed action plans for case reviews that have been overseen by the Practice Improvement Partnership and will oversee a programme of multi-agency audit.



How the Partnership Works - continued

Domestic Abuse Partnership Board
Chaired by Detective Chief Superintendent for the Stockport borough, Greater Manchester Police. The board develops the strategic approach to tackle domestic violence and abuse across Stockport for children, adults and families. Partners work together to deliver on the strategy action plan and identify needs in relation to services and approaches to tackle domestic violence and abuse.

Complex Safeguarding
Co chaired by the Head of Service for social work services and practice improvement, Stockport Family and the Principal Social Worker, Adult Services. Stockport Council. The group develops, implements and monitors the complex safeguarding strategy and action plan to ensure there is a co-ordinated multi-agency response to sexual exploitation, criminal exploitation, missing children and adults, modern day slavery and trafficking.

Training and Workforce Development
Chaired by the Partnership training manager. The group is responsible for ensuring that high-quality, up to date, effective, all age focused, and all age multi-agency training is provided alongside single-agency safeguarding training. The multi-agency trainer will continue to develop the learning hub approach in the next year to ensure learning is embedded routinely for the multi-agency workforce. The dissemination and embedding of learning is available in a separate report, however, the partnership is satisfied and assured that training has continued at a pace through a variety of methods during and following the pandemic.

Rapid Review Virtual Panel
This is generally chaired by the Head of Safeguarding and Learning Service and brings together the three safeguarding partners to decide on whether to progress to a rapid review as laid out in Working Together to Safeguard Children 2018. If a case meets the criteria, then a rapid review panel is convened then this is chaired by the Head of Safeguarding and Learning Service and will consider whether a local child safeguarding practice review is to be commissioned.

Domestic Abuse Operations
Chaired by the domestic abuse programme manager, the group brings together agencies from the community, voluntary and statutory sector. The group analyses domestic abuse data from various agencies to identify trends, themes and focus reviewing activities. The group also reviews progress of implementing the Domestic Abuse Act 2021.

Chair's Introduction

This is my first contribution to the Stockport annual report since taking up the post of independent chair and scrutineer in the autumn of 2021 shortly after publication of the last report and the 2021-23 Joint Strategic Plan.

It has been an unusual time to take up a new role, for myself, two business managers and several partnership representatives. The children and adult partnerships have continued to meet regularly throughout the pandemic period, but the absence of face-to-face working has inevitably had an impact on building professional relationships as virtual meetings, whilst bringing some benefits, do limit the creation of effective working relationships particularly for those new to post and/or the local area.

I have met in person with many partners over the last nine months and found this very helpful. I am grateful to everyone who shared both valuable time and their views with honesty as to how they see the partnership, what works well and how this can be further improved. As a partnership, there are clear strengths to build on in Stockport and a willingness to further develop from partners with whom I met.

Gail Hopper, Independent Chair and Scrutineer

Our vision is to work in partnership to support and safeguard the people of Stockport to enable them to live safe, healthy and, where possible, independent lives

Chair's Introduction continued

The year this report focuses on has been one that has again been directly affected by the global pandemic. Whilst agencies locally and nationally have built experience in dealing with this over the last two years, it has continued to impact on services, how practice is monitored and quality assured and how training and development is provided.

Partnership meetings have continued to be held virtually, but as noted above, hybrid arrangements will be introduced from the autumn. The children and adult partnerships will also come together face to face for the first time in a development event to rebuild relationships with those colleagues who have not met in person in over two years and to meet new ones. This provides a watershed for further change and development, and I look forward to the learning opportunities it will create.

It has been useful to attend and observe sub-group meetings and to explore how arrangements work in Stockport as part of my introduction to the area. A number of questions have been raised about roles, responsibilities and membership, so reviews of terms of reference and membership have taken place, to ensure the focus of arrangements are clear, key agencies are appropriately represented on the partnerships. This has taken account of changes and developments in key agencies, referred to above and has reviewed identified gaps in membership.

Chair's Introduction continued

During the last year, major changes have been underway in the NHS because of the Health and Care Act 2022, and these were implemented in July this year. The NHS has experienced enormous challenges over the last two years, due to the pandemic and this latest change, which removed Clinical Commissioning Groups and introduced Integrated Care Boards as the statutory commissioning body for the NHS has created further pressures. Health partners have worked closely with the partnerships to ensure that from a safeguarding perspective, changes have had limited effect.

Greater Manchester Police has also faced a challenging year, following a difficult inspection by HMIP and the workforce changes that followed. We have been pleased to welcome new leadership in Stockport with the clear commitment to delivering safeguarding responsibilities that has resulted.

Finally, changes in the local authority have meant that that children and adult services have been brought together as a single People's service with a continued focus on developing integration. An inspection by Ofsted of children's social care early in 2022 resulted in a good judgement and recognition of the impact of a strong partnership.

Chair's Introduction continued

Independent Scrutiny

The purpose of independent scrutiny is to provide assurance, monitoring and challenge to the quality of agencies work and to:

- Provide assurance in judging the effectiveness of multi-agency arrangements to safeguard and promote the welfare of all children and vulnerable adults, including appropriate arrangements to identify and review serious safeguarding cases.
- Act as each partnership's constructive critical friend, in which role the scrutineer will remain a key driver to promote reflection, which will ensure continuous improvement in the effectiveness of local safeguarding.
- Judge how effectively the arrangements are working for children, their families, vulnerable adults and practitioners

The following six step approach provides a useful tool for partners to use separately and together in developing their contribution to the partnership and building on its effectiveness. It is relevant to the work of both partnership boards and informs my approach to independent scrutiny:

Step 1 The three core partner leads are actively involved in strategic planning and implementation	**Step 2** The wider safeguarding partners (including relevant agencies) are actively involved in safeguarding children and vulnerable adults
Step 3 Children, young people and families are aware of and involved with plans for safeguarding children In the case of vulnerable adults this directly involves them in developing their own plan	**Step 4** Appropriate quality assurance procedures are in place for data collection, audit and information sharing
Step 5 There is a process for identifying and investigating learning from local and national case reviews	**Step 6** There is an active programme of multiagency safeguarding children and adults training and workforce development

Six Steps for Independent Scrutiny, Safeguarding Children partnership arrangement Jenny Pearce (2019)

Chair's Introduction continued

My approach during this first year has in part, picked up the reins from my predecessor and has continued to include:

- Chairing the Children's Safeguarding Partnership
- Chairing the Adults Safeguarding Partnership
- Chairing the Joint Partnership in which both children's and adult partnerships come together to focus on shared issues
- Chair the meeting of sub-group chairs
- Member of the Stockport Children and Families Partnership Board and Stockport Family Partnership Board

The following arrangements have been introduced with the support and engagement of the two business managers, to further strengthen partnership arrangements. Some are referred to above.

- Regular meeting with the leaders of the three statutory partners
- Membership of the Safer Stockport Partnership
- Quarterly review of progress against priorities in the Strategic Plan
- Review and completion of outstanding actions that have not previously been finalised on behalf of the partnerships
- A development day in September 2022 with members of both partnerships
- Review of both partnership meeting and membership arrangements
- Introduction of a Learning from Practice sub-group to undertake regular review of progress against workplans arising from CSPR and SAR reports (see below)

Chair's Introduction continued

Learning and analysis with both business managers, have revealed several issues the process of familiarisation and from feedback from agency representatives, (for which we are grateful), and from reviews of activity. It includes the following examples, which have led to further plans for improvement. Some are complete whilst others are underway.

- Lack of clarity in adult safeguarding procedures
- Guidance gaps in relation to decision making about Rapid Reviews and Child Safeguarding Practice Reviews.
- Impact of workforce changes /instability on the timely completion of CSPR and Safeguarding Adult Reviews and implementation of work plans arising from these (reference to Learning from Practice sub group above).
- Dated and cumbersome guidance and procedures in some aspects of adult safeguarding. Work had commenced but not been completed. The business manager has worked with partners to address this and I am assured that progress is now being made in this area.
- An absence of regular audit in relation to adult safeguarding (social work) practice has been identified. This will be a priority for me in the coming year and will be supported by the improved guidance and procedures,
- Practice audit arrangements in children's services whilst regular, do not ensure that every practitioner has their practice reviewed This is another area that I plan to engage with, through the next Practice week to strengthen my knowledge and seek assurance
- Stockport is an outlier in Grater Manchester in that the number of Safeguarding Adult Reviews (SAR), referred and undertaken is extremely low, in comparison with other similar areas. An audit of referrals is now underway.
- There is no current workforce development needs analysis in relation to the safeguarding adult's arrangements
- Data is variable and appears to rely disproportionately on information provided by the local authority
- Scrutiny of the findings from recent CSPR cases have been compared with the findings of the National Panel report ' Safeguarding in England', following the deaths of Arthur Labinjo-Hughes and Star Hobson. This revealed some similar issues that will continue to be followed up through the scrutiny function.

A further area of continued exploration, supported by the work of the Learning from Practice sub-group will be on the effectiveness of the role of partners in implementing work plans and actions. Some reliance on the role of the business unit in relation to this, raises concerns about how improvements can be achieved if all leaders and managers do not push this work forward.

Strategic Priorities and Thematic Areas

As a wider adult and children's partnership we have agreed several areas that we want to concentrate our efforts on over three years, our shared priorities for 2020-23 are:

- To improve frontline practice
- Receive assurance that safeguarding arrangements are embedded in all agencies commissioning strategies and service specifications
- Keep the focus on our most vulnerable children and adults
- Effectively engage with our frontline practitioners, service users, families and/or their representatives

Our agreed thematic areas for 2021 – 22 were:

- Neglect/Self Neglect
- Complex Safeguarding
- Domestic Abuse

Neglect

An all-age communication strategy was completed and approved by Practice Improvement Partnership in late 2020. In addition to this private, voluntary and independent (PVI) guidance was completed and shared with the PVI sector.

Training has continued to be offered across the partnership to continue to ensure the Graded Care Profile (GCP) 2 is used by safeguarding agencies in Stockport when neglect is a concern. There has continued to be an increase in the completion of GCP2's which is positive.

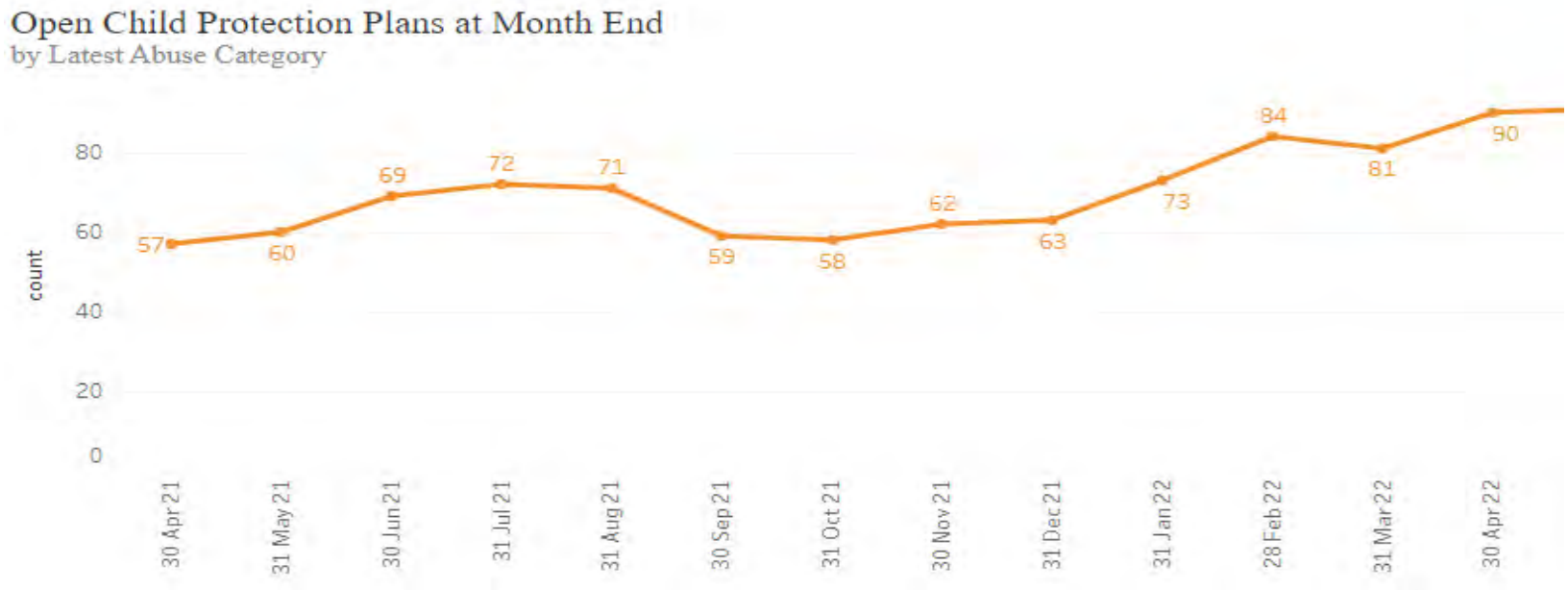
Social Media Campaigns throughout the year continue to raise awareness of neglect and self-neglect.

The last year has seen a reduction in referrals made to the Multi Agency Safeguarding and Support Hub (MASSH) Although the number of children subject to Child Protections Plans under the category of neglect has risen.

Neglect Continued

There has been a 44% increase of children subject to Child Protection Plans (CPP) under the category of neglect. The below graph demonstrates the increase in the number of children subject to CPP plans under the category of neglect;

Neglect continues to be a priority area for the partnership as further work needs to take place to evidence the impact of recent training.



Complex Safeguarding

Why this theme?

There was an increasing presentation of children experiencing criminal exploitation in the borough. This includes children who have special educational needs and disabilities (SEND) There is a consistent presentation of young adults at our Multi Agency Adults at Risk Panel (MAARS) who have experienced contextual harm.

We said we will:

- Support partners to develop a partnership response for contextual safeguarding.
- We will identify gaps and produce an all age contextual/transitional safeguarding strategy.
- Strengthen the partnership approach to vulnerable 16–25-year-olds

Aspire Complex Safeguarding Service

The Aspire service sits within children's social care and forms a multi-agency team which includes social workers, a school nurse, clinical psychologist and the team is co-located with GMP exploitation officers.

35 children and young people were open to the Aspire Complex Safeguarding Service in April 2022 regarding concerns around criminal exploitation, sexual exploitation, modern slavery, threats to life or organised crime groups. On average 45 young people were open to the team at any one time throughout 2021-22.

ii. 70% (39) were already recorded as child in need.

ii. 9% (5) had child protection plans.

iii. 21% (12) were children in care.

Early Intervention

In total 60 referrals were received between April 2021 – March 2022, of which 53 (88%) were accepted/allocated to the Aspire service. Of those accepted, all were either a child in need, under child protection, in care or a care leaver.

Complex Safeguarding - continued

Peer Review

A peer review was completed of the complex safeguarding service in 2021 which offered assurance that practice is good. The review consisted of the following;

• 4 young people's records reviewed – 2 child criminal exploitation, 2 child sexual exploitation
• Focus groups held with relevant professionals involved
• Audits based on the 7 complex safeguarding principles
• Written audits provided detailing reflections and recommendations

• Whilst only 4 audits were completed there are some recurring themes for reflection
• Examples may only relate to one or two cases but are captured for reflection in wider working practices; good opportunities for learning
• Paradoxes in strengths and areas for reflection – varied practitioners, exploitation type

Strengths

Several strengths were identified in the peer review. Some of which include;

- Excellent record keeping detailing children's voices.
- Evidence of advocating and 'championing' children who are central to decision making.
- Excellent examples of social work practice and high quality assessments.
- Language used is empathic, sensitive and contextualised.
- Overall evidence of supervision and management oversight. Aspire supervision is reflective.
- Positive feedback from parents/carers.
- Comprehensive police response to sexual exploitation.
- In complex cases there was evidence of professionals working together to try and find the best solution.
- Culture of learning, reflection, high support and high challenge.

Areas for Reflection

- Wider language used across the partnership could improve to use less child blaming language.
- Improving contact with exploitation teams outside of Stockport when children are placed out of area.
- Need to review support offered to parents in relation to risk outside the home was evident in all cases.
- Use of safety mapping and peer mapping tools would be beneficial.
- Consideration of using Achieving Change Together (ACT) model without this needing to be the ACT worker.
- Feedback mechanisms could be improved.

Partnership Reviewing Activity

Stockport's learning hub model is now established and there is a learning hub planned for October 2022 which will focus on complex safeguarding and transitions. This will be done jointly with adult social care and safeguarding agencies in Stockport. This will offer the opportunity to explore what is working well and what could be even better in relation to our offer for children and adults.

Complex Safeguarding - continued

Complex Safeguarding Independent Reviewing Officer (IRO)

The complex safeguarding IRO was appointed mid 2021. To date they have supported over fifty children and offered eight consultations to social workers. There have also been four drop in sessions with locality social work teams and auditing activity, which has taken place.

There has been a continuation of themes around safety plans and safety instructions, with a focus of developing comprehensive safety plans that focus on the journey victim and the children. Following from the some of the auditing activity and themes around effective safety planning, there has been a joined-up piece of work to embed initial safety instructions/advice and further safety planning documents with the children social care systems.

Drop-in sessions have been offered to all locality teams to help support in understanding of the role and understanding of the quality of the plans going to initial child protection conference. Moving into 2022/2023 the focus will be on the thematic areas, as well as increasing practitioners' confidence through consultation and reflective supervision.

Partnership Training

Understanding exploitation training is offered across the partnership for practitioners. Three sessions have been offered during the year, reaching forty practitioners. Unfortunately, only two of the sessions were run, due to a lack of participants for one of sessions.

Domestic Abuse Data

1009 referrals with domestic abuse is a factor in referrals to children's social care.
2046 early help referrals with domestic abuse as a presenting issue

64% of children on Child Protection plans have domestic abuse as a factor

2026 referrals made to domestic abuse providers in the community

1062 referrals were accepted

Highest demographic of victims were white, heterosexual females aged 20-40 years old.

There were a total of 792 Multi Agency Risk Assessment Conference (MARAC) cases heard.
497 cases featured children
429 were repeat cases (heard in the last 12 months)

110 Safe accommodation referrals made (Stockport Homes and Stockport Without Abuse)
94 (out of 110) offered safe accommodation

4894 domestic abuse incidents in Stockport attended by Greater Manchester Police
1470 Operation Encompass notices made
155 Clare's Law Disclosures made

Domestic Abuse - continued

Whilst domestic abuse is the statutory responsibility of the Domestic Abuse Partnership Board (DAPB), the safeguarding partnership data informs us that we require assurance to ensure appropriate activity is underway to reduce the harms of domestic abuse in our community.

The highest percentage of children on child protection plans are due to emotional abuse caused by the impact of domestic abuse (as seen in the domestic abuse data) There has also been a rising number of MARAC referrals over the past 12 months.

We said we will:

• Have oversight of data to develop quality audits to oversee the effectiveness of agencies' response to domestic violence and abuse

• Support the implementation of the Domestic Abuse Bill across the partnership via the Domestic Abuse Partnership Board (DAPB)

• We will support the domestic abuse operational group to deliver a training programme in relation to domestic violence and abuse

Progress has continued to be made and information on the following pages provides information in relation to the key deliverables.

Domestic Abuse - continued

The Domestic Abuse Bill gained royal assent on 29 April 2021 and is now enshrined in law as the Domestic Abuse Act (DA Act)

In response to the DA Act the safeguarding unit has developed and launched a Domestic Violence and Abuse Strategy 2021 - 2024 which has been published on the website click the link to view the strategy

The strategy identifies five areas of focus;

- Early Intervention and Prevention
- Responding Effectively to Perpetrators
- Working Together
- Appropriate Housing
- Post Abuse Support

Domestic Abuse Senior Practitioner

The Aspire service has a domestic abuse Senior Practitioner, who is also a caring dad's facilitator (see next slide), she has co-worked over 52 cases, all of which were high risk and complex.

There have been 149 support contacts, reflective case discussions and consultations offered throughout Stockport Family. In addition, 16 learning circles/training sessions have been offered.

Early Intervention

- 29 education staff attended drop-in session for Operation Encompass and Domestic Abuse Q&A.
- Safe Lives worker: has worked with 28 young people supporting them through incredibly difficult times including pregnancy and trauma. Whilst the cases are under the projected amount the complexity of the work requires longer involvement with the young people to build trusting relationships.
- Healthy Relationships sessions have been offered to 2192 students over the year, in addition to the Cut It Out programme, which has been delivered and will now form part of the offer with Trafford College group.

Domestic Abuse - continued

Caring Dads Programme

Caring Dads is a 17 week group intervention programme which aims to help fathers value their children. It engages fathers, to help them develop more child-centred fathering and to take responsibility for ending their abusive behaviours towards their children and their children's mothers.

There have now been two cohorts of the Caring Dad's programme run in Stockport. Cohort 3 will begin in August 2022.

There have been 62 referrals received in total (since the course began) and 46 fathers have been accepted onto the programme.

17 fathers have successfully completed programme. A further 23 fathers are due to start the programme in August 2022.

Feedback from fathers on the programme;

"Patience is key…the dads in the group might not get much attention off the social worker…. they concentrate more on mum. You had empathy not sympathy"

"Helped me be more focused on the needs of my eldest, helping me with my relationship with her and it has improved since this time last year"

"It makes you think, its education, I've learned about the children's emotions. I thought I wouldn't learn anything, but I have. My advice is listening to dads."

Domestic Abuse - continued

Themes during 2021-2022

- There has continued to be a steady increase in referrals whereby high and complex domestic abuse has been a common theme. There has been a notable change in the demographics of families needing support, as well as increased complexities.
- There has been an increase in so-called honour based violence (HBV) and Forced Marriage referrals, which has required further reflection, development, and training within the partnership. This has led to a task and finish group being set up to develop and strengthen our strategic response to HBV and Forced Marriage.
- Domestic abuse (DA) has been both a current and historic feature within the family's journey. Whilst DA is not the presenting issue for some families, it is later identified as a theme throughout the families' journey. Thematic areas include developing comprehensive plans and including fathers/stepfathers within assessments.
- The impact of the pandemic, current impact of poverty, and increased cost of living, fuel poverty, 'tolerating' and 'normalising' abuse, as well as 'generational trauma' continue to be key patterns and themes.
- There has also been an increase in complexities from learning needs of fathers, multiple trauma and complexities within families accessing services.
- Generational trauma, longer term impact of domestic abuse.
- Stability of staffing and recruitment to posts.

Audits

A review of MARAC cases has been completed which has highlighted areas to focus on for the next 12 months.

The first Stockport Learning Hub will take place in July 2022 and this will focus on the theme of 'hidden men.' This is a multi-agency audit which brings together practitioners to review the audits, identify key themes and learning. The audit tool has been developed from the learning of the National Panel report 'The Myth of Invisible Men – safeguarding children under 1 from non-accidental injury caused by male carers.

Children's Social Care have also focused a practice week on 'hidden males' to seek assurance fathers and men are included in assessments and interventions.

Assurance activities will continue throughout the next year.

Domestic Abuse - continued

Training

- Specialist domestic abuse training has been delivered to over 300 professionals within the partnership.
- There have been various learning circles throughout the year reaching 617 participants.
- 358 colleagues have received basic awareness domestic abuse training and DA Act training.
- Overall 1275 participants have attended training or learning sessions in relation to domestic abuse throughout the year.

Asking the "So what?" question

To try and better understand the impact of training, follow up discussions and questionnaire were completed with practitioners to review what difference this had made to their practice. Below some of the questions asked and answered given demonstrate the impact on practice.

Since attending the course has your practice/understanding changed when working with victims of domestic abuse?

"I found it a really useful course. It was delivered in a really accessible way. I feel as though I know the process more should I need to refer to it in the future"
"Yes it's given me more of an insight to support appropriate cases and to be able to offer correct advice and signpost to relevant services sting to other services"
"Most definitely reviewing approach and looking at safety plans and family law injunctions. I managed to secure a non-molestation order recently. We are working towards DA housing alliance accreditation"

Since attending the course has your practice/understanding changed when working with perpetrators of domestic abuse?

"More awareness of what to look for and being able to advise my staff"
"it has given me better awareness"
"…the training increased my knowledge around behaviours of perpetrators"

Provide any additional comments you would like to make about changes to your practice following attending training.

"I feel this has improved my practice as a professional"
"The training has definitely made me more open minded. I do not have much experience with DA cases so I would welcome any further training"
"Having the confidence to have difficult conversations and the impact it has on babies and young children. I am more aware of research evidence on children and how it impacts them"

Safeguarding Children in Stockport

Data Overview
April 2021 – March 2022

Annual Infographic depicting the picture of safeguarding within Stockport at the end of 2021/22 (unless dates otherwise stated)

236
Child Mental Health Presentations (21/22 Q4)
(▲20/21 Q4 = 193)

127
Families with Homelessness Relief Duty Accepted (21/22)
▲20/21=112

1470
Operation Encompass Referrals (21/22)
▼20/21=1565

Referrals

3806 Referrals to CSC
(▲20/21: 3424)

17,268
MASSH Contacts
(▲20/21: 13,058)

19.2%
Re-referrals
(▲20/21 19.0%)

Missing Episodes
Episodes - 1689
Young People - 452
(2020/21 – ▼ Episodes: ***1707***
▲ *young People:384)*

2445 Children in Need
(▼20/21: 2453)

448 Children in Care
(▲ 20/21: 411)

3,896(21/22)
Social Work Assessments
(▼20/21=4,028)

365 Looked After Children from Other Areas
(▲20/21: 326)

Youth Justice

2
Custodial Sentences
(10-17 year olds)
(20/21=2)

34
First time entrants to Youth Justice System
- age 10-17 Jan21-Dec21
(▼31 : Jan20-Dec20)

26.9% (GM 30.2%)
Re-offenders Annual Weighted Average
(age 10-17 for Jul19-Jun20) (▼Jul18 – Jun19 =28.3% vs. GM 30.1%)

Child Protection Plans

409
Children Subject to an Initial Child Protection Conference
(starting in period)
(▲20/21 219)

286
Children subject to an open Child Protection Plan
(end of period)
(▲20/21=156)

12
Subject to a plan over 2 years *(▲20/21=0)*

23
Subject to a Repeat Plan within 2 years (open 31.03.22) *(▼20/21=25)*

For open CPP end of year

Sexual Abuse **1 (▼** *20/21: 2)*

Physical **1 (▲** *20/21: 5)*

Neglect **81** *(▲20/21: 59)*

Emotional Abuse **203** *(▲20/21: 90)*

Sources:
SMBC Tableau
ONS 2021 Census
Public Health Profiles

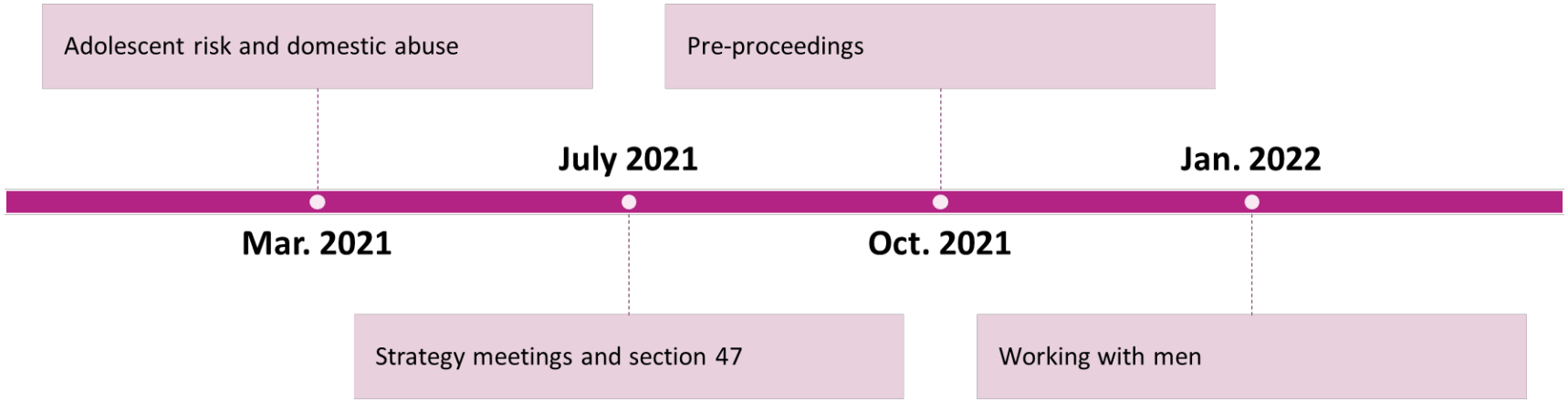
Core Business - This section gives an overview of the safeguarding picture in Stockport.

Starting Cohort Description	2020/21 Q1	2020/21 Q2	2020/21 Q3	2020/21 Q4	2021/22 Q1	2021/22 Q2	2021/22 Q3	2021/22 Q4	Trend
Early Help Episodes starting in Period	352	500	791	748	861	598	709	786	▲
Referrals starting in Period	654	961	951	858	998	926	893	989	▲
Child and Family Assessments starting in Period	836	1080	1121	1048	1128	1029	1048	1156	▲
Team Around Child Plan starting in Period	333	421	489	405	371	384	424	543	▲
Child Protection starting in Period	13	71	47	69	107	51	92	125	▲
Stockport CIC starting in Period	72	32	42	28	21	53	40	47	▲
Open Stockport CIC at the end of the quarter	*399*	*400*	*408*	*411*	*408*	*428*	*425*	*448*	▲
Missing starting in Period	435	384	462	410	464	451	416	357	▼
OLA CIC starting in Period	40	42	35	45	65	50	30	35	▲
Open OLA CIC at the end of the quarter	*403*	*332*	*320*	*321*	*349*	*356*	*357*	365	▲
Section 47s starting in Period	161	228	173	255	328	201	278	321	▲
Initial CP Conferences starting in Period	13	75	52	79	116	69	95	129	▲
Strategy Discussions starting in Period	375	622	429	527	672	519	620	729	▲
Education Health and Care Plans starting in Period	88	120	56	72	120	114	84	107	▲
EHM (Early Help Module) Contacts starting in Period	2535	3255	3615	3657	4656	4031	4041	4538	▲

Single Agency Assurance Activity – Childrens Social Care

Children's Social Care run a practice week every quarter to undertake reviews of practice, cases and supervision. Twice a year this is done across Stockport Family which includes practitioners from a variety of teams and services, including health visiting, fostering and adoption, MOSAIC (drug and alcohol service), Youth Justice Service and more.

Themes are selected based on national learning or themes that have been noted in data changes. The practice week themes for 2021 – 2022 are illustrated below.



Single Agency Assurance Activity – Children's Social Care

Other review activity taken place includes;

- Strategy meetings (multi-agency review)
- Cases where physical abuse is the presenting issue
- Child Protection Cases (multi-agency review)
- Impact and efficacy of Team Around the Child plans
- Children placed with their parents on Care Orders (multi-agency review)
- Monthly review of referrals from the MASSH (Multi Agency Safeguarding and Support Hub) that step up to social care.

Special Educational Needs and Disabilities (SEND)

Learning in Safeguarding

A Stockport child with Special Educational Needs and Disabilities (SEND) featured in a recently published CSPR Child F (click to read the report)

Learning from the report has led to action being taken to improve workforce knowledge of the Dynamic Support Database and referral process. There was also learning in relation to the availability of placements for children with complex needs and disabilities which has been highlighted as a national issue.

There is a national review being completed by the National Panel in relation to the concerns raised in residential education placements for children with complex needs. The learning from this review when it is available will be considered by the partnership.

We are committed to and engaged in improving this for our children in Stockport.

Data

The last year has seen a reduction in looked after children with Education Health and Care Education Plans (HCEP) Stockport has a lower average than our statistical neighbours and nationally.

There has been a reduction in the number of children and family assessment completed by the Children with Disabilities team in the last financial year (2021-2022). This was 37% less than the previous year (2020-2021) it's not clear what the reason is for this and it's important that we have greater clarity about the reasons behind it.

The data collected for children with SEND should be improved so that the safeguarding picture, trends and themes could be understood better in the partnership.

Data – Training

- Over 4,000 members of staff across the local area have completed the SEND E-learning
- Year on year the second survey shows an increasing awareness of SEND across the Stockport Family workforce.
- Since 2019, the percentage of people who are not confident in their knowledge of EHCP has dropped from 26% to 12% with none not confident at all.

Children in Care (CIC)

Data

There has been a continued rise in children in care (CIC) seen in the last 12 months of children who remain in the care of the council. Data from 31/03/2021 demonstrated 409 children were looked after in Stockport compared with 31/03/2022 where there were 447 children in care.

Stockport continues to have a high number of out of area CIC placed in the borough. There needs to be a consideration of the impact on services for Stockport as the host authority and also on local placement availability which has reduced. Local sufficiency of placements has therefore become a focus of the Local Authority who seek to improve this for children in care in the borough.

Remands and Custodial Sentences

During the last year there were 4 remand episodes relating to 3 young people. All children who are remanded into custody become children in care under the Legal Aid Sentencing and Punishment of Offenders Act 2012. None of the children were looked after before they entered custody.

There were three custodial sentences during the last year 2021-2022. All Children who receive a custodial sentence are subject to initial planning and regular reviews as per the Youth Justice Board's National Standards. All children who are assessed as a risk to themselves or others will have a plan in place to reduce the risk. There is regular contact between the secure estate and the Youth Justice Service for the period they are in custody

Resettlement starts at the earliest opportunity. Professionals involved from the start, have regular contact with the child in order to build their relationship and plan for release. We have seen this in the cases above where professionals across Stockport Family visit the young person and complete interventions whilst they are in custody, particularly around offending behaviour, exploitation and education provisions

Children In Care (CIC) Continued

Unaccompanied Asylum Seeking Children (UASC)

When UASC arrive in Stockport they are allocated a Social Worker immediately who undertakes the necessary assessments and support to ensure their safety.

In the last year, Stockport has gone from having one UASC in their care to 16. Some children have come to Stockport as part of the national scheme and a number have been spontaneous arrivals.

This has placed additional pressure on demand for looked after children and financial pressure on the Local Authority as the Home Office funding doesn't cover the cost of placements and what the children need. There are also now 17 care leavers who were UASC in Stockport who continue to be supported. This has been a challenge for other authorities across the country as more unaccompanied children enter the country.

Sufficiency of Placements

As the number of children in care have increased, this has placed pressure on the availability of local placemats and foster carers.

Sufficiency and quality of placements has now been raised in two CSPR's, this is a priority for the partnership to understand how to improve this.

There is also a Greater Manchester (GM) sufficiency group exploring how to improve placement availability across GM.

Improving Outcomes

The Corporate Parenting Group oversees the progress of services for cared for children and focuses on the themes, data trends and key issues for CIC.

The Named Nurse for Looked After Children has led on work to improve health outcomes for children.

There has been a rise in presentations of looked after children at hospital in relation to their mental health. The Named Nurse for Looked After Children is completing a health profile to understand why we are seeing this increase. There has also been a challenge for CAMHS (Child and Adolescent Mental Health Service) to recruit a Psychologist for children in care. This post has now been vacant for 18 months impacting on the service available to our children who are looked after.

The drug and alcohol service – MOSAIC, has seen a rise in referrals being made to support children who are looked after. This is something that will be further understood

Care Leavers

What has changed?

We are conscious that young people who are care experienced can be vulnerable when living independently in the community.

Ring door bells are given to leavers who have their own tenancies to increase their feelings of safety within the home.

There is now a digital Wi-Fi offer for free Wi-Fi given to care leavers which is provided by Sky. This offers 17GB of data s month and for those in need of more data, there is a limited offer for 50 people to have unlimited Wi-Fi for 18 months.

The new accommodation has now opened in Stockport offering 7 independent flats for care leavers to live in. This is accompanied by outreach support. There is a plan to offer further accommodation over the next couple of years to open 20 more flats.

Co-Production

A group of Care leavers are consulted on changes and practice developments to gain their views on what is needed.

Part of this work has led to the plan to develop a care club for care leavers so that they can use pool cares to get to work or to use ad hoc.

Much of the increased local offer has come from the feedback of care leavers asking for more support with those areas that are challenging to them.

The way that co-production is being championed and used with care experienced could be replicated in other services to enable co-production and the voice of service users.

Safeguarding Reviews

Working Together requires the safeguarding partners to make arrangements to review serious child safeguarding cases, and others where there may be learning, in order to prevent or reduce the risk of recurrence of similar incidents.

Rapid Review meetings are held within 15 days of the incident coming to the attention of the safeguarding partners. It gathers facts about the case, identifies whether any immediate action is required to secure the child's safety, whether there is immediate learning, and whether a local or national Child Safeguarding Practice Review (L)CSPR is warranted. In the year April 2021- to April 2022 three Rapid Review took place.

The learning themes from the Rapid Reviews:

One review heard of a child who was alleged she was sexually abused by her brother (also a child). Themes noted from the review were; professional understanding and pathways for responding to children who display sexually harmful behaviour, record keeping and language used to describe behaviours that indicate trauma and information sharing between agencies. This review led to a Local Child Safeguarding Practice Review being completed. This review will be published in the summer of 2022.

The second review heard of the death of a baby girl who drowned in the bath. Learning explored the issues of when families are out of routine and how this impacts on supervision of children.

The third review considered the death of a baby boy who died whilst co-sleeping with his mother. The review identified themes around the use of stepping down cases (as opposed to closure) the review considered learning from safer sleep which has been a former priority of the partnership. It was identified that safer sleep advice and guidance was given multiple times and this was not an area that practitioners could improve upon. The panel also explored the training offer for front line practitioners on understanding the impact of trauma on care giving.

Safeguarding Reviews continued

The National Safeguarding Practice Review Panel which oversees and gives advice on Rapid Reviews and Child Safeguarding Practice Reviews have commissioned a further National Report titled *The Myth of Invisible Men – Safeguarding Children under 1 from non-accidental injury caused by male carers.* You can read the report by clicking here

Stockport took part in this review due to having male carers who had harmed their children and are therefore cited in the document.

The Practice Improvement Partnership has considered the learning from the report and the first learning hub event is planned for July 2022 to focus on the themes from the report. It is hoped that this approach will offer assurance that all agencies are focusing on the learning and partnership. Learning events will also be planned to share any further learning.

The National Safeguarding Practice Review Panel is due to publish a further report in May 2022 following the review of the deaths of Arthur Labinjo-Hughes and Star Hobson. The Partnership will be reviewing this report and recommendations made to ensure that any applicable learning to Stockport is understood and embedded in practice.

Feedback from Children and Families

Children in Care Council (CiCC)

The group meets weekly, and the young people take part in a variety of activities. During Covid-19 The Children in Care Council members met via virtual meetings and these have now returned to meeting in person. Some of these activities concentrate on issues that are directly relevant to being a looked-after young person; some of the issues are relevant to all young people. The young people are encouraged to think about the issues through discussion, practical activities and by meeting with people who represent organisations relevant to issues. The young people are also encouraged to talk about what is going on in their lives and to get support from the other young people who are in a similar position. There are also opportunities to take part in social activities organised by the youth worker.

The group have recently sought to establish a challenge cards process whereby they can ask senior officers of the council questions and in return receive questions or requests back from their corporate parent.

There has also been work on developing life story tools for children entering care. The group have developed new 'into care boxes' that are given to children entering care.

Two members of the group also interviewed candidates for the Service Director posts in Stockport Family.

Youth Council

The Youth Council have been involved in consulting on the new children and young people strategy, 10 year plan and the One Stockport Health & Care Plan.

The group are currently developing work based on the results of 'Make Your Mark' (an annual nationwide consultaiton of young people) The top priority is mental health and wellbeing.

Autism Ambassadors

The group have been working on what support is given to Autistic children in schools, the community and on public transport.

They have also been involved in the development of the Autism Strategy.

Stockport Family Practice Weeks

During the practice weeks (held quarterly) feedback is gained from parents, carers and young people in relation to the service they receive, their relationship with their worker and to gather feedback for what is working well or what could work better. This is fed back to practitioners and leaders to contribute to the development of the service.

Feedback from Children and Families

Parents Reference Group

The group was established during the pandemic, initially meeting virtually and now face to face or hybrid. The group has five permanent members and are recruiting on a continual basis for more to join in.

All members are parents who have been through the Child Protection (CP) process with their own children, each wanting to use their own experience to shape how the service meets the needs of families going through CP process, and what we do well and what we could do better

The group meet quarterly and so far, they have helped with – designing leaflets for other parents (what is a core group, what is a CP plan/conference); redesigning conference literature; advising us about processes (confidential slot; who attends; timing of reports; pre-consultation with IRO); and giving feedback about the new location of the safeguarding unit (signage; furniture; resources; literature)

The group exists to also provide feedback on any wider developments around CP and the service can request their input/feedback on other developments as and when they arise

The creation of a peer mentor scheme has evolved from this group – it is in its infancy; however there have been three parents who have recently been trained as peer mentors and they will begin in their roles soon.

Areas for Improvement

There is limited feedback from children who are receiving services from safeguarding agencies.

Agencies within the partnership should improve the feedback gained from children and families. Action needs to be taken in response to gaining regular feedback.

This is a focus for the partnerships in the next year where assurance will continue to be sought.

Partnership Auditing Activity

The Partnership undertook a number of multi-agency audits throughout the year.

April 2021 → the **GCP2** desktop audit conducted in August 2020 was revisited. It found that numbers of completed GCP2 where children are the subject of CPP remain low. An action plan was drawn up to address this. A **dip sample** conducted in **Sept 2021** found only 20% of cases reviewed at CPP with category neglect had a GCP2 completed. However, the quarterly dataset is now showing improvement within this area.

June 2021 → the **Placement Planning** desktop audit was undertaken following the rapid review of Child F, to identify if there were similarities between this case and the cases of other children with similar multiple needs. The report concluded the circumstances of Child F were unique and there was typically informed decision making in around placement planning.

June 2021→ A **Families Recently Stepped Down from Child Protection Plans –** this desktop review was undertaken to provide assurance in relation to a question asked in September 2020 by the then undersecretary of state for Children and Families – Vicky Ford. The audit centred on families stepped down from May-Oct 2020. Contact was maintained with families and additional risk assessments were in place during initial lockdowns. Further the proportion stepped back up to CPP after step down was not disproportionate to pre-lockdown figures. For families who went on to have another child, 4 cases were identified and audited by Heath Visiting and Midwifery this provided assurance that universal services were engaged with families. The review highlighted the need for and benefit of communication and engagement with all services at the point of step down and in the TAC or other multidisciplinary processes is vital.

October 2021 → A desktop audit took place looking at the **TAC and Supervisions for the under 1 cohort** in relation to the Gracie rapid review. Data from both health and social care was received. The review found areas for improvement, and since the review the TAC policy has been updated and CSC have put in place a TAC quality assurance process which began in November 2021, and which is part of the regular data and quality reporting cycle. The audit will be revisited in 12 months to provide partnership assurance that changes made have been embedded in practise.

November 2021 → **Strategy Discussions and Outcomes** Multi Agency audit. Overall, the audit found that strategy discussions are proportionate, and decisions are appropriate. There is accurate recording, and in most circumstances the right people are attending. Actions from the review were linked to the overall strategy discussions plan held by CSC and included amendments to recording systems to enable a clearer record of minute sharing, and guidance for social workers to help them to select the most appropriate health professional to attend.

February 2022 → **Care Orders at Home** desktop audit. This audit focussed on attendance at meetings. The audit found discrepancies in the recording within minutes and invited/attended lists. Health professionals were not routinely invited to attend, although reports were sometimes sent in their absence. Both parents are not normally invited to the review, although there is often one parent/grandparent or carer invited. This audit is due to be presented at the QAP within September 2022.

Our shared strategic priorities 2021-22

Following the period of reporting in this annual report, the business plan and thematic areas of focus were reviewed.

In May 2021 both Children and Adults Safeguarding Partnerships came together to attend a virtual joint development day. The event was well attended and the purpose of the day was to review the strategic plan 2020-23.

There was a presentation from Sheila Fish from SCIE and Mark Gurrey from the National Safeguarding Practice Review Panel which helped to challenge the Partnership thinking for the year ahead.

The next Partnership development day will be held in September 2022.

Feedback was collated and the Partnership will continue to develop how we approach our new priorities in the coming months which will be reported upon in the next annual report.

The thematic areas of focus will be 2022-2023

- Neglect/Self Neglect
- Complex Safeguarding
- Domestic Abuse

Key Messages for the Partnership

- There is a good level of trust and positive relationships in the partnership
- A number of procedures have been reviewed and updated along with terms of reference for the executive and sub groups with partners
- GMP's increased focus of safeguarding and vulnerability has been welcomed
- The voice of lived experiences of children and families accessing services needs to be strengthened
- The data that is collected needs to be purposeful.
- We need a broader range of relevant data from all agencies, that offers a holistic safeguarding picture
- The progression of business plan priorities can be slow. There needs to be a greater focus on timely action
- All agencies need to support the practice review process that has been set up to monitor the delivery of actions to ensure that they are completed in a timely manner.
- There appear to be a limited number of professionals and agencies who contribute to the delivery of actions and priorities within the partnership. This raises questions about how all agencies prioritise effective safeguarding

Appendix –

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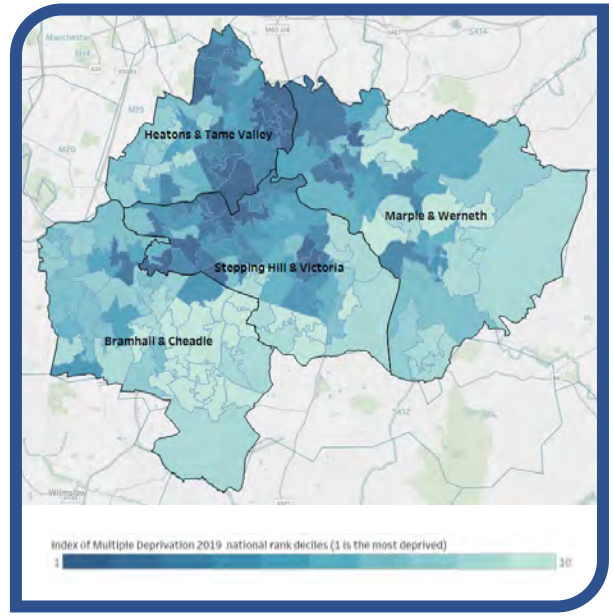
42 – The Town of Stockport Continued

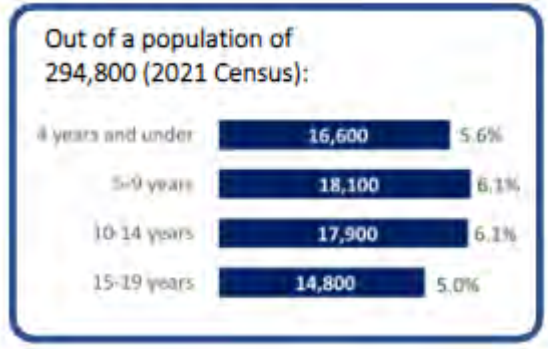
The Town of Stockport

Stockport is very polarised, with pockets of very concentrated deprivation contrasted with large areas where deprivation is relatively low. The 2021 census informs us that out of a population of 294,800, 23% (67,400) are aged 0-19. 11.7% of children and young people (8,500) in Stockport are living in low-income households (JSNA 2018). In Stockport, there are more areas that rank within 1% most deprived nationally than average, Stockport also have the most deprived electoral ward and GP practice within Greater Manchester. Birth rates have grown most rapidly in deprived areas, and population growth generally has been more rapid in these areas, although this may change with planned large scale housing developments in the less deprived areas, but significant growth is still expected in the town centre.



There are currently 127 schools in Stockport:

- 4 maintained nursery schools
- 85 primary schools
- 14 high schools
- 6 special schools
- 3 pupil referral units
- 9 independent schools
- 6 independent special schools.



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

The Town of Stockport continued

Ethnicity Data from 2011 Census;

Stockport was less ethnically diverse than the national average with 92% if the population identifying themselves as white compared to 86% nationally. People who describe themselves as Asian Pakistani are the largest Black or Minority Ethnic (BME) groups in Stockport, around 6,600 in 2011.

It can be seen that the younger population is slightly more ethnically diverse than the population as a whole, with 87% of people aged 0-19 identifying as white, compared to 92% over all ages.

Overtime the diversity of the population is increasing and the number of people identifying themselves as from a BME group almost doubled from 2001 to 2011 and is likely to have increased since. We are still awaiting the data from the 2021 census which for ethnicity is expected towards the end of 2022.