Safeguarding Children in Stockport

# Annual Report 2020/2021

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# Chair's Introduction

I am pleased to present the 2020 - 2021 Annual Report on behalf of all the agencies represented on the Safeguarding Childrens Partnership. 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.

In line with Working Together 2018 we changed the emphasis of our new arrangement from a Board to a Partnership to widen the scope of the responsibility; whilst it is the 3 statutory partners (Stockport MBC, GMP and NHS Stockport CCG) who have a key role in being accountable for how partners/agencies work together to safeguard and protect the most vulnerable children and their families in Stockport; all agencies have their own accountability and governance frameworks to adhere to.

**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'.**

# Chair's Introduction continued

One of the most significant challenges we have faced as a Partnership since March 2020 has been dealing with the impact of COVID-19 pandemic. However we continued the vital role in gaining assurance that both service users and the wider public were safeguarded during this period.

The Partnership has continued to offer the same level of safeguarding in line with the Coronavirus Act 2020 and the functions continued to operate by virtual conference calls with some areas of the business temporarily stepping down.

Moving to virtual meetings led to an increase in attendance due to the ease of partners joining meetings, which has opened up opportunities to explore smarter ways of working to improve engagement with professionals, service users and carers and families. However there was some disruption to audit schedules as a result of capacity and availability amongst professionals.

A positive use of MS Teams meant that multi-agency training moved online and resources have been made available via Stockport's learning pool.

During the year, we increased our publicity and developed a Covid -19 safeguarding website providing key safeguarding information, specific to Covid-19. Monthly bulletins were produced and disseminated to partners with highlights of service updates, along with guidance and useful resources for supporting and working with adults at risk during these times.

Key messages were also tweeted via our Social Media platforms and we expanded our reach to inform twitter users of the resources and services available within the local area, and at a national level too.

Communication was vital throughout the year and we introduced safeguarding weekly check in meetings aligned with colleagues from Stockport Adult Safeguarding Board to look at emerging themes and to share what was working well with partners.

We introduced weekly safeguarding check in meetings which were well attended and allowed for a wider sharing of changes to services and agency news. We saw excellent engagement from our partners that enabled us to oversee that the safeguarding response was co-ordinated. As the months progressed the meetings moved to fortnightly and have since evolved to monthly. This good practice has remained throughout the financial year and we will continue to meet at an operational level on a quarterly basis. I have to say a big thanks to all our front line workers for their excellent response during such unprecedented times. We will look at the learning from our response and build the positive learning into our structures for the future.

The COVID pandemic has had a significant impact in Stockport as in all other areas of the country. The Partnership had a vital role in gaining assurance that both service users and the wider public are safeguarded during this unprecedented period. The response to COVID-19 across the partnership has been astonishing – we saw an excellent response from all agencies working with vulnerable children and their families. A big thank you has to go to all schools and their staff for the creative ways that they engaged with children and their families during very difficult times; to ensure where possible they weren't hidden from view and were being provided with support.

# Chair's Introduction continued

The continuing challenge will be maintaining the progress of the last few years, through a time of policy change and new national priorities and a completely different way of working and engaging with professionals and families due to the Covid restrictions; without losing sight of what matters – the safeguarding of children in Stockport.

To conclude, I would like to thank members 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.

This is my last annual report as Independent Chair. It has been a pleasure and an honour working with colleagues in Stockport and I would like to wish Gail Hopper my successor all the best.

### Independent Scrutiny

As the Independent Chair I a crucial role in making certain that the Partnership operates effectively and can secure an independent voice. As chair I am independent of local agencies and in a position exercise the key role of challenge effectively. The SSCP maintains a discernible independence from the Stockport Family Partnership Board arrangements within Stockport whilst ensuring clear and consistent communication channels between the Boards. I attend the Corporate Safeguarding accountabilities meeting where the Chief Executive, the Leader of the Council, and the Executive member for children and families have the opportunity to hold the SSCP to account. These accountability meetings have continued throughout the pandemic.

The Head of Safeguarding and Learning has responsibility for both the Children and Adult Safeguarding Boards and the Deputy Chief Executive of SMBC has responsibility for the facilitation of Safer Stockport partnership.

One of our plans for 2020 -2021 was to look to recruit Lay Members to support the work of the Quality Assurance and Performance Improvement Partnerships. This would add an additional level of scrutiny to our arrangements; however, with the restrictions impose by the pandemic it has not been possible to progress this.

# Chair's Introduction continued

In our new partnership arrangement, we set out what independent scrutiny would look like for Stockport as we recognise that striving for effective multi-agency arrangements, the role of independent scrutiny would be critical to provide assurance in judging the effectiveness of services to protect children.

Our approach to independent scrutiny is part of a wider system which includes:

- Independent inspectorates' single assessment of the individual safeguarding partners and the Joint Targeted Area Inspections. During this reporting period we have sought assurance from GMP in relation to their HMIC inspection and also from Stockport NHS Foundation Trust in relation to their CQC inspection regarding the Emergency Department
- We have continued to use Independent Authors for Safeguarding Practice Reviews;
- Multi agency audit, page 20 of the report sets out the work we have done;
- We haven't been in a position to undertake front line practitioner visits, due to the restrictions, these are now included in the role of the independent scrutineer;
- Section 11 and Section 175 audits.#

As part of the role of Independent Chair I provide independent scrutiny and challenge to the effectiveness of the new arrangements, along with holding partners to account. I have set out below an overview of the independent scrutiny that has taken.

During 2020-21 we have undertaken a number of Rapid Reviews into Child Safeguarding Practice. More detail of these can be found on page 19 of the report.

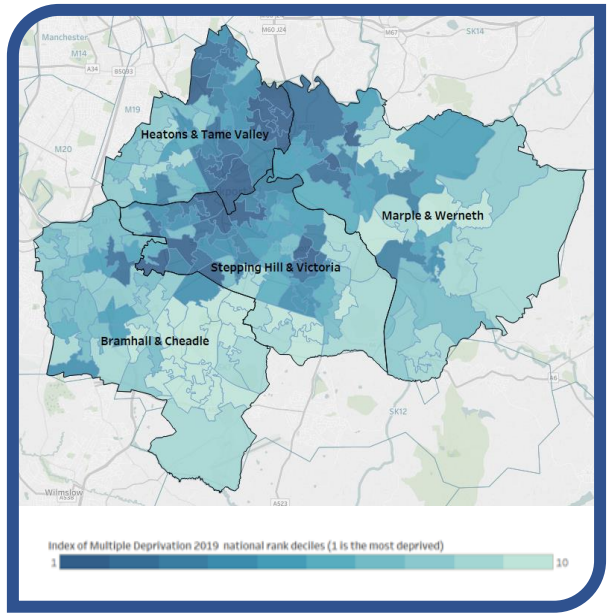
In Stockport I feel that we have a robust and timely system for notifying serious incidents and progressing to Rapid Reviews. These have been completed within the 15 day timescales and the decision made by the Rapid Review Panel has been endorsed at National level. Two things that will strengthen our approach to learning, will be the involvement of front-line practitioners in the rapid review process, an area that we considered pre-ovid and for the right reasons were not able to progress; and the Executive feeling confident and assured that actions from reviews are being progressed, learning embedded and the partnership being in a position to evidence the impact of that learning on practice and children and families. This will come down to agencies being able to provide the evidence of the impact and change they have made.

In 2021-21 the Partnership strengthen the role of the Independent Scrutineer and there is now a framework in place that outlines the role, function and expectations in relation to reporting of scrutiny activity. It includes attendance at the Practice Improvement and Quality Assurance Partnerships; front line service visits and hearing the voice of children and their families

The report recognised that Stockport was on a journey of improvement; and I have seen that journey continue with greater engagement with partners in partnership/subgroups and attendance at training; senior leaders driving the work of the partnership groups; a more robust business unit that underpins the work of the partnership. This was evidenced by the partnerships response to Covid 19, lockdown, school closures and services who traditionally worked with families having to work remotely. We saw excellent engagement from our partners in virtual weekly Covid safeguarding meetings that enabled us to oversee that the safeguarding response was co-ordinated. I have to say a big thanks to all our front line workers for their excellent response during such unprecedented times. We will look at the learning from our response and build the positive learning into our structures for the future.

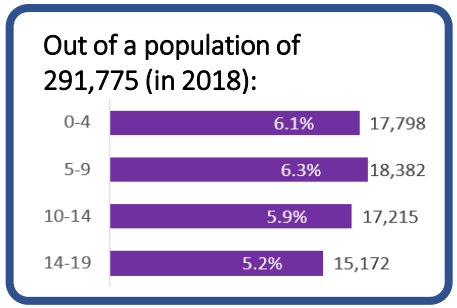
# The Town of Stockport

Stockport is very polarised, with pockets of very concentrated deprivation contrasted with large areas where deprivation is relatively low. Out of a population of 291,775,  23.5% (68,567) 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 125 schools in Stockport:

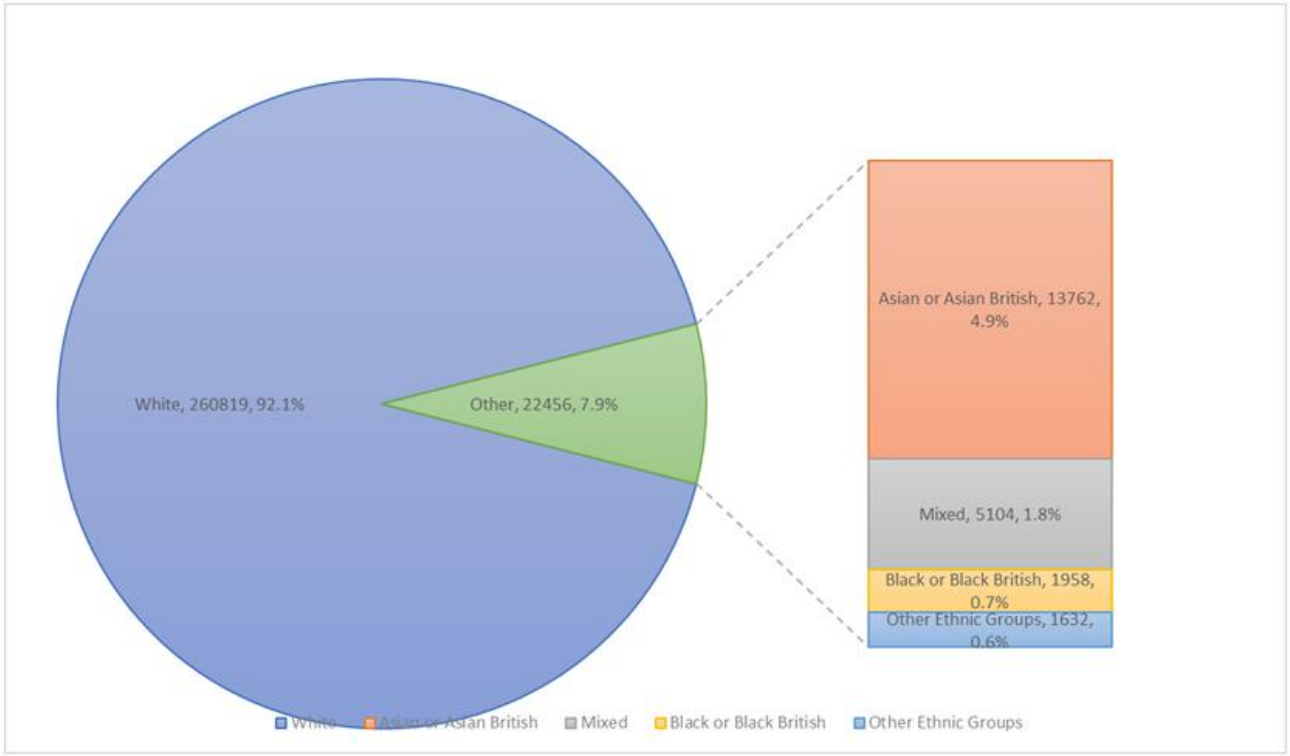
- 84 primary schools
- 13 high schools
- 6 special schools
- 3 pupil referral units
- 10 independent schools
- 9 independent special schools.




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 Women's Centre, Stockport without Abuse, Disability Stockport, Parents in Partnership, 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.

Overtime however 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.

# 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;**

- The report must set out what the Safeguarding Partners have done as a result of the arrangements, including on 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 looked-after children 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 2020 and April 2021

**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 is based on five priorities:

Transitions; Neglect/Self Neglect; Safer Sleep; Homelessness, the fifth added was on the Implementation of Liberty Protection Safeguards (LPS).

# How the Partnership Works

The Safeguarding Children Partnership 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 3 main groups: The SCP Executive. The Quality Assurance and Scrutiny Partnership and the Practice Improvement Partnership. This is supported by two joint working groups are. The Complex Safeguarding Group and the Training and Development Group.

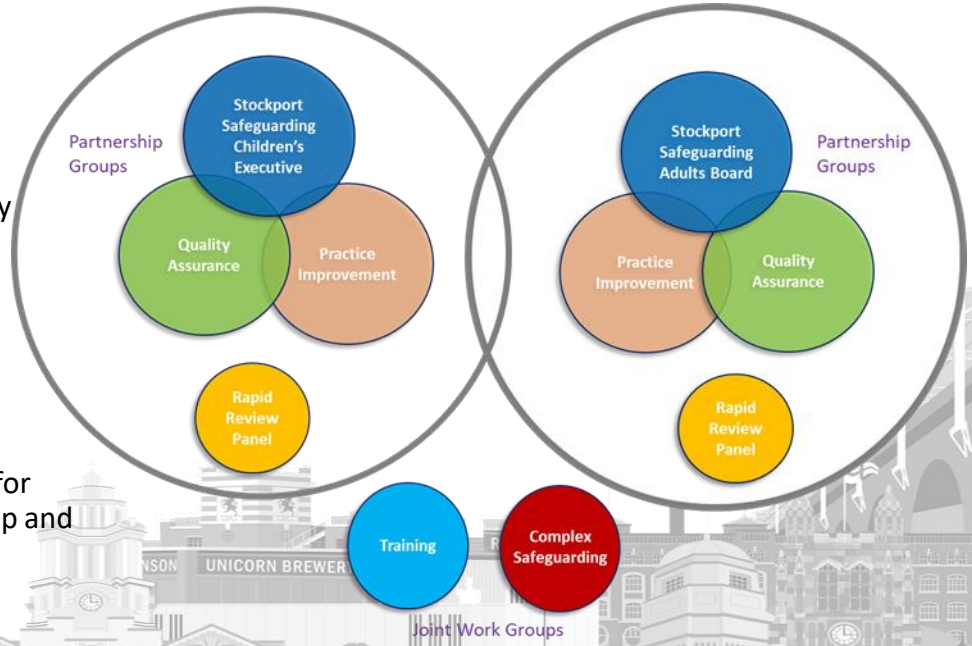
The three main Safeguarding Partners of Stockport Local Authority, Stockport Clinical Commissioning Group and Greater Manchester Police contribute the majority of the funding for the Partnership to operate effectively. The contributions can be found in the appendix.

**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 and Scrutiny 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 Steering Group**
Chaired by Detective Chief Inspector for the Stockport Borough, Greater Manchester Police
Develops and drives 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. The Domestic Abuse Steering Group will become a Partnership/Board from April 2021.

**Complex Safeguarding**
Co Chaired by the Practice Leader, Stockport Family and the Principle Social Worker, Adult Services. Stockport Council
Develops, implements and monitors the SSAB Complex Safeguarding Strategy and Action Plan to ensure there is a co-ordinated multi-agency response to Sexual Exploitation, Missing Adults, Modern Day Slavery/Trafficking, Female Genital Mutilation, and Honour Based Violence/Forced Marriage.

**Training and Workforce Development**
Chaired by the Service Manager for People and Organisational Development, Stockport Council
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 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 the pandemic.

**Rapid Review Virtual Panel**
This is generally chaired by the Head of Safeguarding and Partnerships 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 Independent Chair of the Safeguarding Partnership and will consider whether a Child Safeguarding Practice Review is to be commissioned.

**SAR Review Panel**
Chaired by the Head of Service, Safeguarding and Learning, Stockport Council
Considers serious safeguarding incidents and the potential for multi-agency learning through statutory Safeguarding Adult Reviews (SARs) or other non-statutory processes such as Multi-Agency Learning Reviews (MALRs).

# Strategic Priorities and Thematic Areas

**As a wider Adult and Children partnership we have agreed a number of 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 2020 – 21 were:**

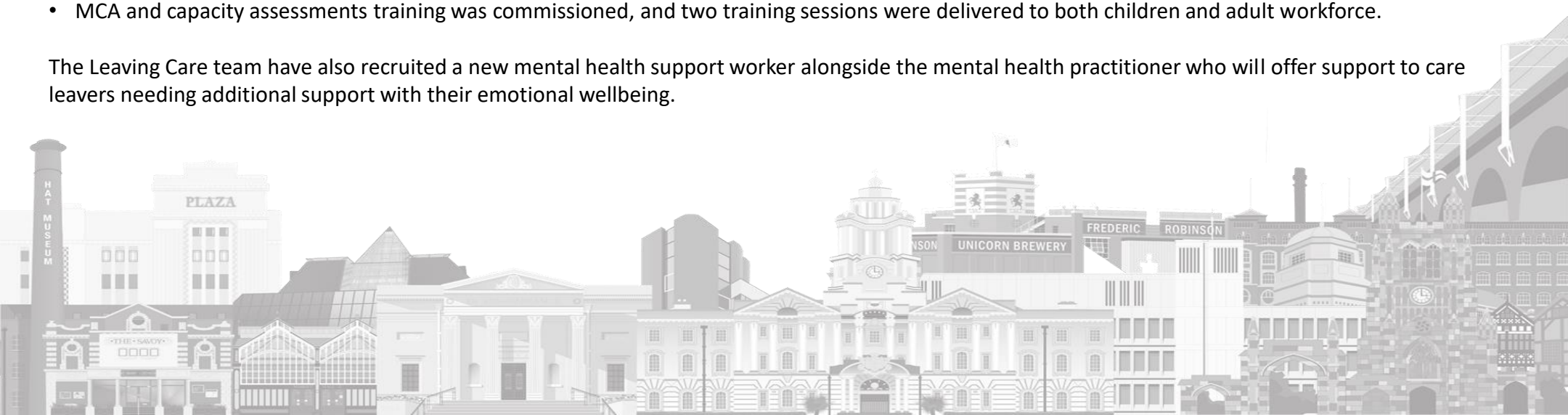
- Transitions
- Neglect/Self Neglect
- Safer Sleep
- Homelessness
- Implementation of Liberty Protection Safeguards (LPS)

# Transitions

The last annual report detailed how transition social workers have been employed in adult social care and planning now starts at 15 years old. The refresh of the Multi Agency Adults at Risk Panel has been successful and supports cases where vulnerable young people present chaotic lifestyles and are not eligible for adult social care support by developing a multi agency plan.  Achievements this year have been:

- The new SAB Multi-Agency Safeguarding Adults Policy has been published as a web-based resource hosted on the website.
- Transition plans for those with SEND are well embedded with SEND social workers sitting in the Learning Disability team.
- A few multi-agency safeguarding workshops have been held to review the Team Around the Adult (TAA) process to ensure that all agencies are taking a lead as appropriate in this process to embed in practice across the partnership.
- Feedback from the workshop sessions has enabled the commission of an external author to assist in drafting the revised procedures, and to incorporate a Think family approach across all practice.
- Think Family is being embedded into training programmes and offer extended across both children/adult workforce.
- A MAARS desktop review was completed to look at cases of young people's (17 to 25-year-olds) experiences.
- MCA and capacity assessments training was commissioned, and two training sessions were delivered to both children and adult workforce.

The Leaving Care team have also recruited a new mental health support worker alongside the mental health practitioner who will offer support to care leavers needing additional support with their emotional wellbeing.



# Neglect/Self Neglect

An all age Communication strategy was completed and approved by Practice Improvement Partnership in late 2020.

Private, Voluntary and Independent (PVI) guidance was completed and shared with the PVI sector.

Lead partner agencies have completed ownership and delivery off the adults self neglect Action Plan.

Links are being made across the PVI sector and with a range of safeguarding training being delivered forms part of the business-as-usual for SSAB.

Developed and strengthened our Data Performance Dashboard to extrapolate self-neglect data that has continued to report into the monthly check-in meetings.

There have been 7 Minute Briefing papers about Adult Grooming and Cuckooing, along with Scams, Fraud and awareness on Adult Safeguarding.

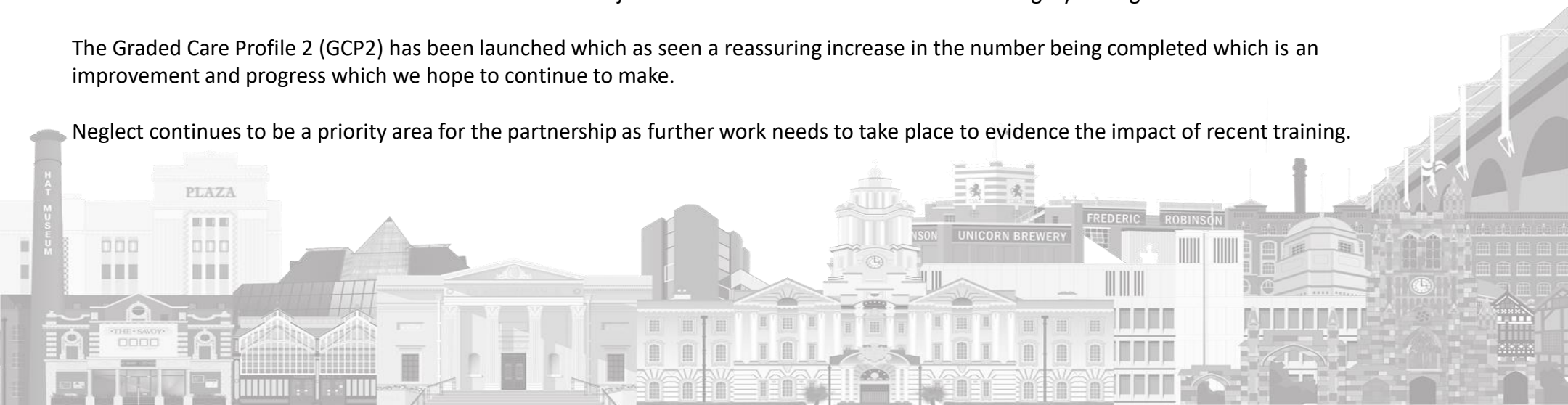
Social Media Campaigns throughout the year continue to raise awareness of Neglect/Self Neglect.

Recent data in April 2021 has seen an increase in the number of referrals made in relation to neglect of child to the MASSH comparison to the same period in 2020. This is a trend that has continued since 2019 where increasing referrals have been seen consistently through each year.

There has also continued to be an increase in children subject to Child Protection Plans under the category of Neglect.

The Graded Care Profile 2 (GCP2) has been launched which as seen a reassuring increase in the number being completed which is an improvement and progress which we hope to continue to make.

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



# SEND

In Stockport, our vision is for all children and young people with special educational needs and disabilities (SEND) to have the best start in life. We want all children and young people to be happy, prepared for adulthood and able to achieve their goals. We want families to feel supported, confident, resilient and connected to their community.

In 2018 Ofsted and CQC reviewed our SEND services and Council and CCG were required to provide a Written Statement of Action to address areas for significant improvement. One key area was the need to work more closely with parents, families and partners to ensure that the local SEND services continue to meet the needs of local communities.

It was clear we had not engaged closely enough with local families and our partnership working needed strengthening.

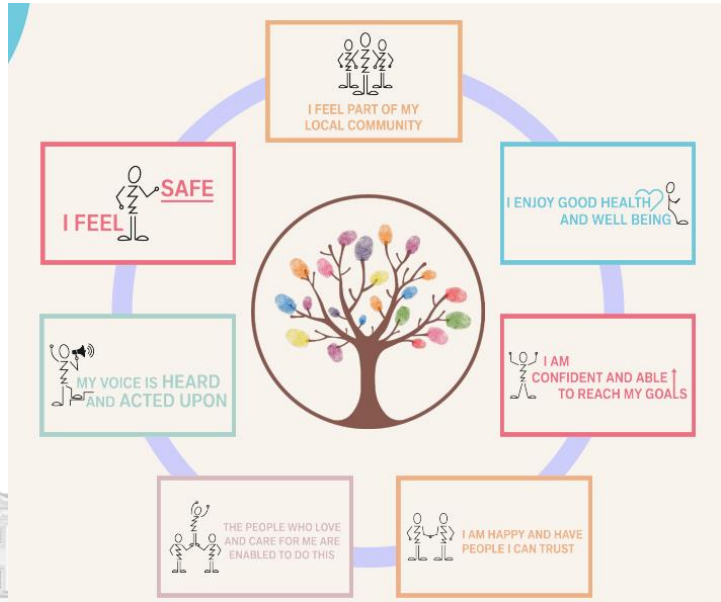
Our joint ambition was to meaningfully engage and co-produce with families and young people on a range of changes, including the development of an Outcomes Framework.

Stockport has been working with CDC under the DfE's Delivering Better Outcomes Together – learning from best practice across England.

We have worked together with parents, carers, young people and workforce across the local area to co-produce a set of Outcomes that we all want to achieve for children and young people. These are set out in our Outcomes Framework that was launched in November 2020.

The agreed statements are:

- I feel Safe
- I feel part of my local community
- My voice is heard and acted upon
- I enjoy good health and wellbeing
- I am happy and have people I can trust
- I am confident and able to reach my goals
- The people who love and care for me are enabled to do this



# SEND continued

In January, a dip sample took place of 8 children with an allocated social worker an EHCP and where the first annual review has taken place. Positive feedback was received, and the annual review ensured plans were effective and correct support was in place.

**Changes in practice across settings**

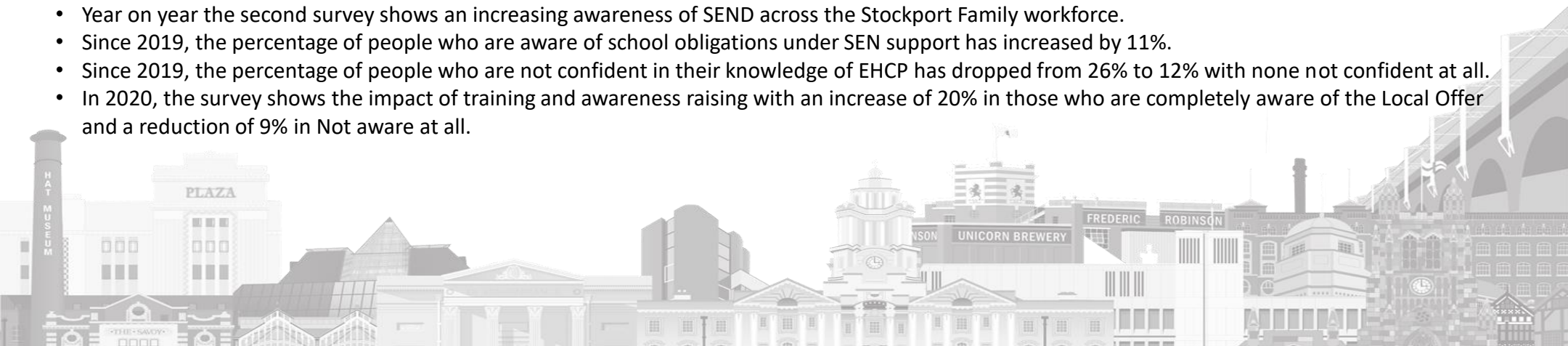
School improvement held 'one conversation' with all primary and secondary provision this provided some examples of changes in practise. SEND self-evaluation has improved in 24 schools, curriculum provision in 22 schools, SEND leadership in 21 schools, Quality First teaching (24 schools) and co-production in 24 schools. 29 schools have cited the Entitlement Framework as a key support tool and 19 have focussed upon developing a graduated response.

*"Teachers are held accountable for the SEND pupils in their classes and are able to articulate the progress, strengths, barriers, and gaps of all the children in their class and discuss in detail the interventions and adjustments to teaching they have put in place and highlight the impact and next steps. This is a result of teacher 'buy in to' and 'ambition for' the children with SEND across the school."* Westmorland Primary

*"The school is clear that aspirations are for all children to reach their own personal potential. Every adult connected to a child has to support all children in achieving their potential. Quality first teaching is imperative with every teacher understanding that they are a teacher of SEND. Learning environments must be accessible for all children and clear lines of communication with all adults who work with children must be in place. Removal of barriers to children's progress is vital."* Mersey Vale primary

**Data**

- 2388 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 aware of school obligations under SEN support has increased by 11%.
- 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.
- In 2020, the survey shows the impact of training and awareness raising with an increase of 20% in those who are completely aware of the Local Offer and a reduction of 9% in Not aware at all.



# Children Looked After (CLA)

There has been a continued rise in looked after children seen in the last 12 months of children who remain in the care of the Local Authority. Data from 31/03/2020 compared with 31/03/2021 identifies an increase of cared for children by 11% (42 children) This has understandably put pressure on services who support cared for children. There was a sharp increase of children entering care seen in the first quarter of 2020 in comparison to the previous year which led to analytical work being undertaken.

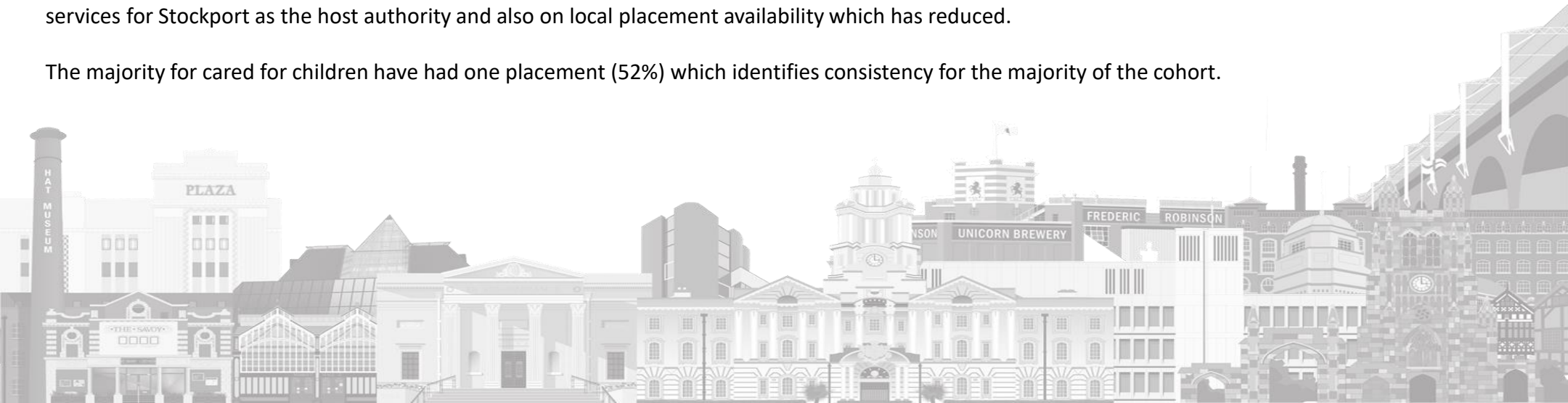
**Data**

After first lockdown period from 31/03/020 – 13/07/2020 There were 79 children who became looked after; which is an increase of 47% when compared to the same time period in 2019. A report conducted to look into this identified that Covid had impacted in some way for all children that entered care during that period (July 2020 – October 2020). The impact has been evident health services and placement availability. However and despite the surge of admissions during that first quarter on the whole admissions to care are less than in previous years now.

The analysis has highlighted that children are remaining longer in the care of the authority than previous years. Discharges have reduced from 178 in 2019 to 147 in 2020. The general monthly average has reduced. This is shaping future work for Childrens Social Care to understand why less children are being discharged from care as per previous years. It was also noted that 76% of children looked after are either staying with families and friends or are at home with parents (16% at home and 60% with family and friends) Further work will be completed to review care planning decisions to understand this and ensure that such a high level of intervention is needed. There is currently a of Care Orders at home for children with parents which will be shared with the partnership in the autumn of 2021 which will be reported upon in the next annual report.

Stockport continues to have a high number of out of area Children Looked After 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.

The majority for cared for children have had one placement (52%) which identifies consistency for the majority of the cohort.



# Children Looked After (CLA)

There has been a continued effort from Children's Social Care to further co-produce services with cared for children. A new and improved survey has been developed which will be launched in May 2021 to gain the views, thoughts and feelings of the children in their care. The feedback will form an action plan which can be reported upon in the next annual report.

Stockport is one of eight Local Authorities' involved with the New Belongings programme. This is a two year programme started at the end of 2019.

New Belongings was initially developed between 2013-2016, with support from the Department for Education. It has led to significant national improvements for care leavers, including the extension of PA's for care leaver to the age of 25 and the introduction of council tax relief. More information can be found by clicking the following link; New Belongings Programme - Coram Voice

During the initial lockdown period, laptops were provided for Children who were looked after to ensure they didn't become social isolated.

Stockport has continued to review and increase their offer to unaccompanied asylum seeking children (UASC) It was noted in the last year that 0.01% of CLA were UASC. This has led to the National Transfer Scheme being reviewed as Stockport was underrepresented in the number of UASC children they should be caring for.

There has been a GM dental pilot for CLA that Stockport has taken part in – indicators across the board for dental treatment was poor following Covid 19 and dentists only offering emergency care. As part of this joint work with health, a pathway has been identified for children that doesn't have a dentist to ensure they will be treated.

There has been continued work with Stockport Homes to improve the accommodation offer to care leavers. One provision of supported accommodation opened in April 2020 and was commissioned jointly by Stockport Homes and Children's Social Care. There is also work underway to open a further 7 independent flats in April 2021 to enhance this offer.

# Safeguarding Reviews

The previous annual report looked at Gracie which resulted in a legacy Serious Case Review from the previous Stockport Safeguarding Children Board. This case now has an action plan which is being progressed. A series of learning circles took place to support the workforce in understanding the issues from this serious case review. Bi-annual dip sampling of cases with similarities will be undertaken by agencies within the Partnership to evidence the impact of the learning.

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, held within 15 days of the incident coming to the attention of the safeguarding partners, will gather facts about the case, identify whether any immediate action is required to secure the child's safety, whether there is any immediate learning, and whether a local or national Child Safeguarding Practice Review (CSPR) is warranted. In the year 2020-21 there were four Rapid Reviews that took place.

**The learning themes from these Rapid Reviews were:**

How to work with children that involved in high risk activities such as stealing and driving cars and how as a partnership we can look at the contextual factors when children are not engaged with services. Attention was also given to children that have ADHD that are drawn into high risk activity.

There was also a review which related to a child that had experienced serious harm as a result of being shaken. There were a number of themes that needed to be taken forward by each agency in relation to tightening up processes. For example the advice given to parents on crying babies and non accidental injuries. It was noted that the national programme on ICON is in place and this partnership participated on the National Panels review in 2019 and are progressing an associated action plan. The general messages for practice, such as the benefits of the Graded Care Profile and importance of involving fathers in safe sleep discussions, can be shared more broadly via these means across the wider partnership.

A further theme that is being looked at by the partnership is the issue of placement provision for children with a number of different needs. It is acknowledged that there is a shortage of placements nationally and the partnership are to hold a workshop in relation to the issues in placing children in the right therapeutic home with support to address the identified needs.

# Safeguarding Reviews continued

The National Safeguarding Practice Review Panel which oversees and gives advice on Rapid Reviews and Child Safeguarding Practice Reviews have commissioned two further National Reviews. Both of these hold significance for Stockport as we have picked up themes in our own Rapid Reviews.

The National Reviews were:

- It was hard to escape – safeguarding children at risk from criminal exploitation
- Out of routine: a review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm, and

These reviews are of national and local importance and have provided a robust analysis of the issues which is useful for us to consider as part of the work programme. The out of routine review was particularly important as this was identified in the Gracie SCR and also one of the Rapid Reviews which was predominantly an adult partnership case but had pertinent issues for children's. The action plan for this case has been completed and learning embedded into practice and supported by training.

## It was hard to escape – safeguarding children at risk from criminal exploitation (March 2020)

There has been a focus on supporting partners to improve practice in relation to children vulnerable to or experiencing exploitation.

The majority of work in this area has taken place in the complex safeguarding sub group who offers assurance to the partnership that work is being progressed and learning is being embedded in practice.

This will continue to be a focus for the following year as some work was delayed due to the impact of COVID 19. The further works will be reported upon in the next annual report which will be available in September 2022.

# Safeguarding Reviews continued

## Out of routine: a review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm (July 2020)

In Greater Manchester, in 2018/2019, there were 18 sudden unexplained deaths of infants. In Stockport at that time there were 3 cases. One at 8 weeks, one at 4 weeks 6 days and one at 4 weeks.

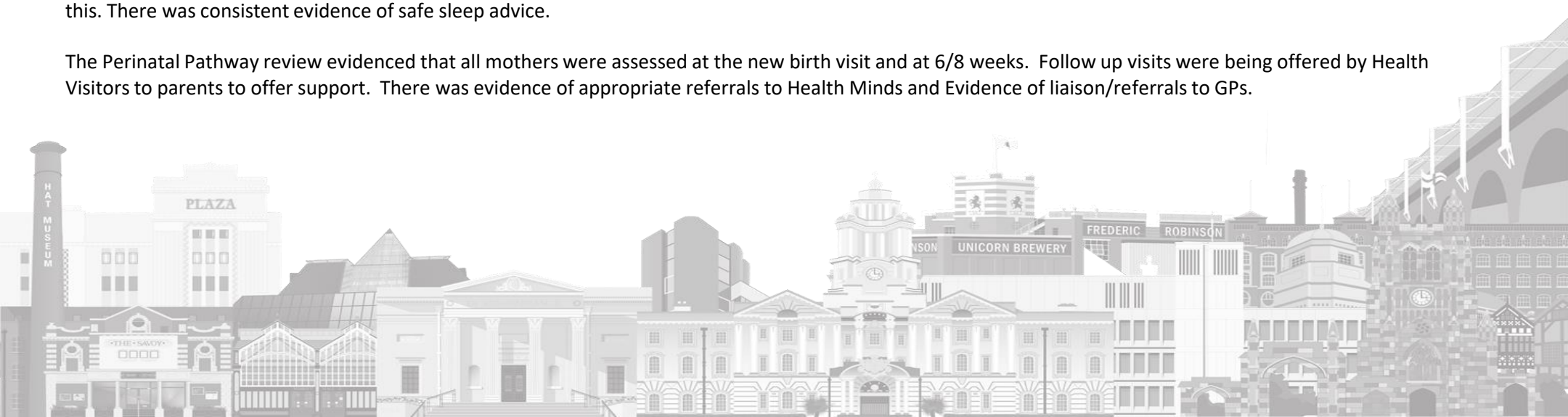
### What we did (please also refer to work undertaken on the following Safer Sleep page)

- Health led deep dive review to incorporate learning from other cases and developed a strategic action plan.
- Programme of awareness raising and training around safe sleep was delivered across the Safeguarding Partnership
- Review of recording processes and guidelines for safe sleeping advice
- 7 minute briefing papers were developed for safer sleep and vulnerable babies in mind
- Stockport Family Service Development days were held (to a 117 practitioners)
- Antenatal conference for midwife, family nurses and health visitors took place
- Stockport Family Practice Week November 2019 focused on Safer Sleep and assessment of vulnerable children to review impact of learning and offer assurance
- Services commissioned to address the strategic priority of reducing infant mortality/unexplained deaths in infancy

### Impact

Auditing activity in the partnership in 2019 evidenced that Social Workers were having safe sleep conversations with parents and understood the importance of this. There was consistent evidence of safe sleep advice.

The Perinatal Pathway review evidenced that all mothers were assessed at the new birth visit and at 6/8 weeks. Follow up visits were being offered by Health Visitors to parents to offer support. There was evidence of appropriate referrals to Health Minds and Evidence of liaison/referrals to GPs.



# Safer Sleep

A significant safeguarding theme across the country and locally is the risk factors associated with Sudden Unexpected Death in Infancy (SUDI) and this was no different in Stockport. There have been several developments in relation to SSCP safe sleep strategy with the creation of a task and finish group to work through what it means in practice for us.

Within Stockport we have had a safe sleep week, to reinforce the message around risk and best practice which went very well. During the year there was assurance that health visiting services were continuing to visit as per the visiting criteria for children and families and that the right families were being seen.

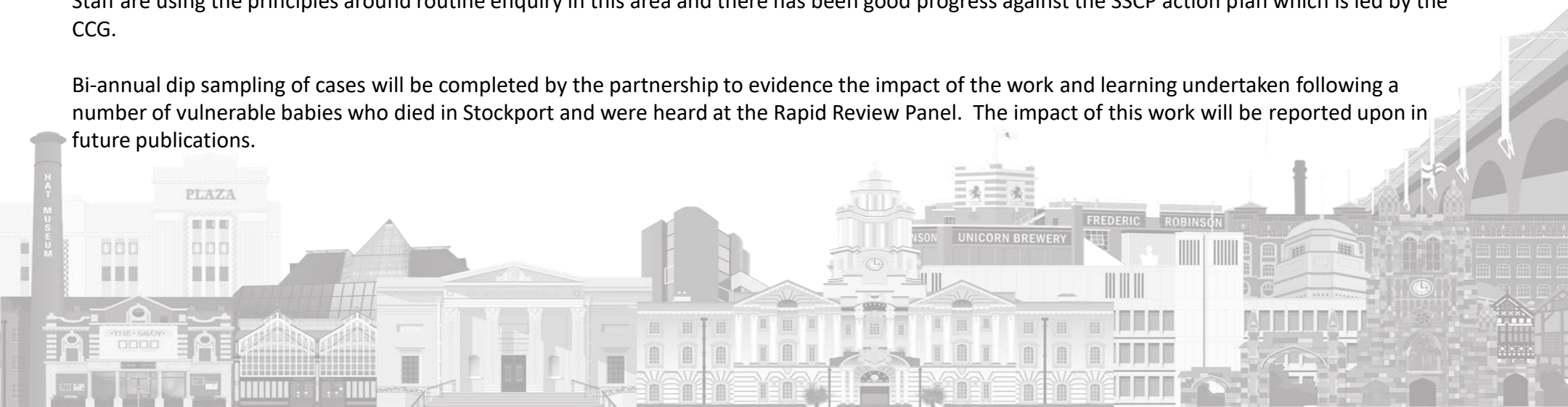
The continued implementation of the ICON programme (to reduce stress relief for parents with crying babies) is ongoing and is currently able to reach 87 % of all new parents at Stepping Hill Hospital. This is an important programme nationally and good to see it has been adopted within Stockport. Messages to frontline staff continue to be pushed so that practitioners are aware of what advice to give. ICON has been successfully implemented in a number of GP practices.

The threshold document is being revised and it is hoped that by using the Thrive model this will enable practitioners to know when it is right to refer for help and advice.

It is envisaged that as such progress has been made in this area which has been supported by health partners throughout Greater Manchester that this will no longer be a priority in the next year and become business as usual

Staff are using the principles around routine enquiry in this area and there has been good progress against the SSCP action plan which is led by the CCG.

Bi-annual dip sampling of cases will be completed by the partnership to evidence the impact of the work and learning undertaken following a number of vulnerable babies who died in Stockport and were heard at the Rapid Review Panel. The impact of this work will be reported upon in future publications.



# Safer Sleep continued

The Stockport GMP safeguarding lead set up a safer sleep steering group within GMP.  There was also liaison with the training school police officers. As part of the training they now have a safe sleep input which incorporated non-verbal children training, out of routine, being aware of where a child is sleeping, what they are sleeping in and sleeping patterns.

Training was delivered to Detectives and Detective Supervisors in regards to SUDC (sudden unexplained death in children) whereby the detectives have a full days input on safer sleep and go through the various points to consider such as those described above.

Training is also now given to Family liaison officers within the force including the Serious collision investigation unit so that they are all aware of various considerations around safer sleep.

# 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. 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.

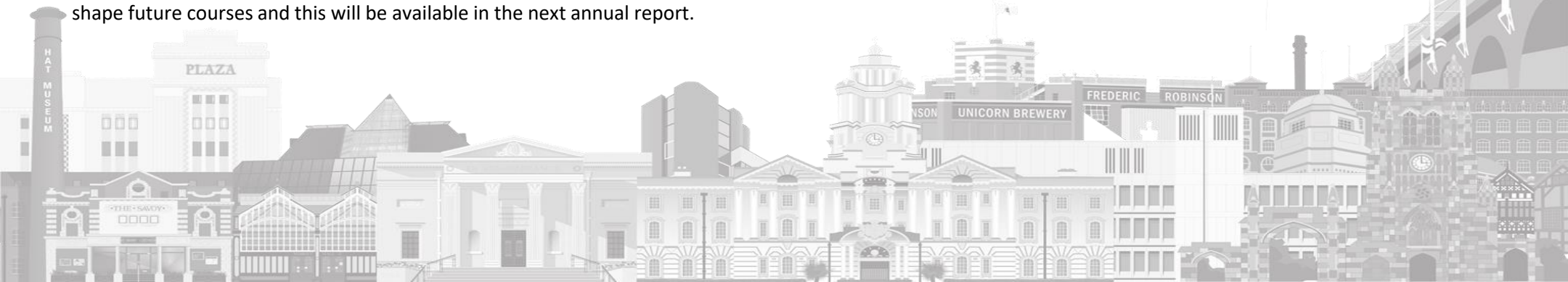
Every six weeks the young people have the opportunity to meet with senior managers and elected members to report on what they have been doing and to ask questions of these decision makers. The young people are also encouraged to be involved in a regional network of CiCC that meets three times per year in the Northwest. The Youth Worker supports them to attend this.

**SEND**
Building on more than 1000 comments gathered from the family listening events and input from professionals, the Co-Production Task and Finish Group developed a graphic illustrating:

- What really matters to families
- How do we change?
- The benefits of 'doing what matters'.

The Task and Finish Group also developed a Co-Production Charter and Co-Production Strategy, with the involvement of children and young people.
The co-production charter was re-launched in November 2020 which gave greater detail as to how we will work together to ensure co-production is strong across our local area. The charter was co-produced with families, children, young people and health, care and education colleagues. To view the charter and read more about this work please click the following link Co-Production Stockport

**Caring Dads**
The caring dads course has been run in Stockport for fathers who harm in relationships. The course has recently finished, and feedback is being gained which will shape future courses and this will be available in the next annual report.



# Partnership work

The Partnership is committed to work with all agencies to ensure that there is a highly coordinated approach to a range of adolescent risks that occur in contexts beyond the family home (e.g. neighbourhood, schools, local shopping centres, youth venues etc.). These risks include child criminal exploitation, child sexual exploitation, serious youth violence, peer on peer abuse, harmful sexual behaviour and other overlapping forms of harm.

The Partnership was pleased to see that a theatre company (Round Midnight) was commissioned to help young people in school to understand the risks and issues facing them outside of the home.  They used Virtual Reality head sets and run a virtual decisions programme for the young people and real life actors then have a conversation with the young person about why they made that decision at that stage etc as its teaching young people there's consequences to decisions that they make.

It is hoped that this can go beyond the 3 schools so far in the coming year.

**Stockport Family**

There has been a continued roll out of Social Workers being linked to schools and being based in footprints. This was following an evaluation of the Werneth and Brinnington Team pilot which was positively evaluated. The vision is that all Social Work teams will be linked to schools

During 2020 and the Edgeley primary school developments, the Head Teachers identified transition meetings for children into reception between school, health and social care was an area that required good practice development. The Edgeley Stockport Family team therefore worked up a model to trial between April 2021 and June 2021 with schools. Included were school nurse, health visitor and start well team leaders, social care and school age plus team leads alongside therapy services where they were able to attend.

Annual Infographic depicting the picture of safeguarding within
Stockport at the end of 2020/21 (data 2020/21 unless otherwise stated)

175
Hospital Admissions as a result of Self-Harm 10-24 (19/20)
*(19/20=180)*

65
Hospital Admissions for mental health conditions <18 (19/20)

12.0% children in absolute low income families (under 16's) (19/20)

*Distinct People Missing from:*
*Home: 249*
*OLA CLA: 80*
*Stockport CLA: 69*
*(19/20 Home=295, OLA CLA =95, Stockport CLA=91 )*

*411 Children in Care*
*(19/20=369)*

## Referrals

*3,424 Referrals to CSC*
*(19/20=3,365)*

*13,087 MASSH Contacts*
*(19/20=10,892)*

*2,453 Children in Need*
*(19/20=2211)*

*326 Looked After Children from Other Areas*
*(19/20=410)*

*648 Re-referrals*
*(19/20=640)*

*4,028 Social Work Assessments*
*(19/20=3,574)*

*2*
*Custodial Sentences*
*(10-17 year olds)*
*(19/20=5)*

*62*
*First time entrants to Youth Justice System*
*(age 10-17 , for Jan19-Dec19)*

*34.2% (GM 32.5%)*
*Re-offenders*
*(age 10-17 for 18/19)*
*(17/18=44.1% vs. GM 35.6%)*

## Child Protection Plans

***217***
*Children Subject to an Initial Child Protection Conference*
*(starting in period)*
*(19/20=384)*

**198**
*Children subject to an open Child Protection Plan*
*(starting in period)*
*(19/20=212)*

For open CPP 31.03.21
Bracketed 19/20.

**Sexual Abuse**
1.3% *(0.0%)*

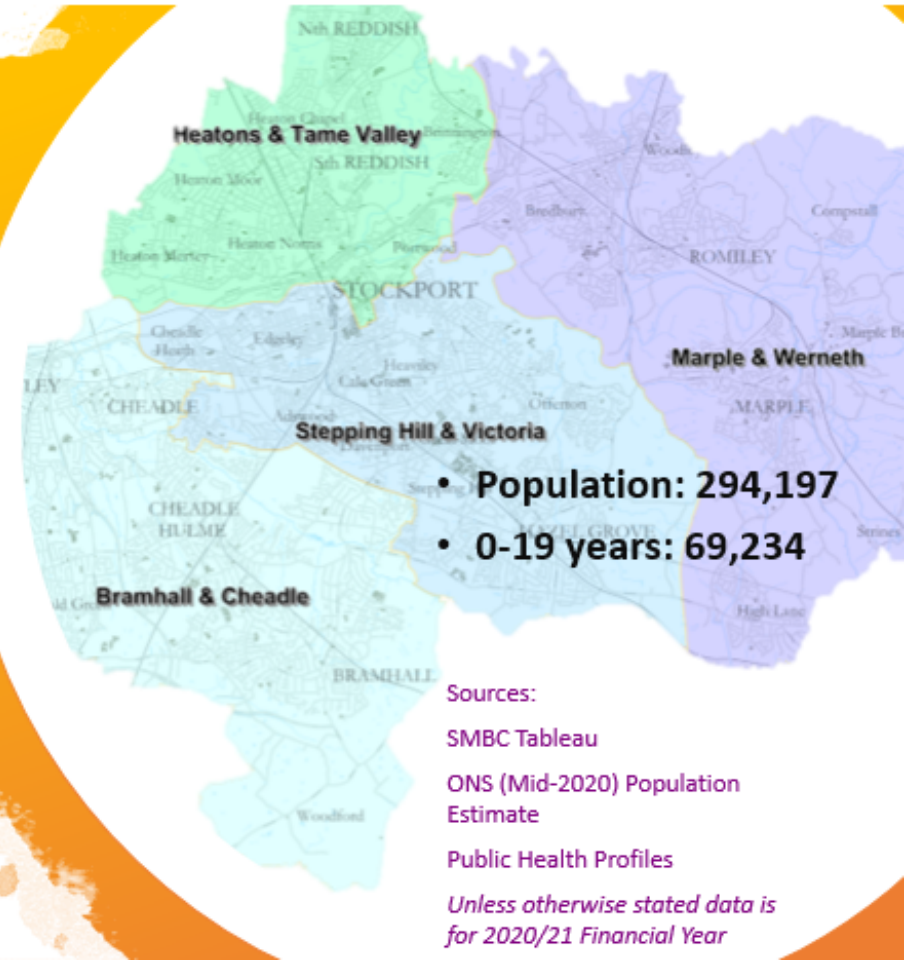
**Physical Injury**
1.3% *(2.8%)*

**Neglect**
38.5% *(39.4%)*

**Emotional Abuse**
59.0% *(57.7%)*

**7**
Subject to a plan over 2 years
*(19/20=10)*

**25**
Subject to a Repeat Plan within 2 years
(open 31.03.21)
*(19/20=16)*




- **Population: 294,197**
- **0-19 years: 69,234**

Sources:

SMBC Tableau

ONS (Mid-2020) Population Estimate

Public Health Profiles

*Unless otherwise stated data is for 2020/21 Financial Year*

# Audits

The Partnership undertook a number of audits throughout the year, although a full schedule of audits was not in place due to the pandemic.

**April 2020** → the partnership undertook an **EHCP and the IRO** desktop audit, this was repeated in August 2020. The desktop audit looked to see how the EHCP informed the IRO at CLA and CPP review meetings. Learning from the first review led to overall improvement in the use of the EHCP in the CLA reviews, although there was not a similar shift seen for the CP Reviews. The IRO team have used the review to identify ways to improve practice in this area and work is ongoing.

**November 2020** → **TAC and the GP** audit looked at the process of notifying GPs of TACs taking place. The audit highlighted improvements and methods were identified for improving the communication process, work is ongoing to complete this.

**December 2020** → Since there had been a limited number of Rapid Review notifications since the Covid pandemic began, the partnership sought assurance via audit that nothing was being missed. A **S47 and Notifiable Incidents** Audit took place, providing assurance that there were not missed opportunity for reporting.

**August 2020** → A **GCP2** desktop review was undertaken to identify how the process has embedded within practice since the roll out began. The results suggest that there is not sufficient evidence to show that the GCP2 is being routinely used or recorded for children where there is a child protection plan with the category of neglect. The report highlighted opportunities to refresh learning and, thinking about how to allocate cases to enable those trained in GCP2 to use the tool. It recommended a full audit take place to understand more fully the picture within Stockport, although noted the NSPCC are conducting a research project and it may be viable to tie in with this. A further desktop review was conducted in April 2021.

**November 2020** → **Pre-Birth Assessment** Multi Agency audit. Strengths that were identified included; good partnership work at the Front Door, evidence of some excellent single agency assessments, creative and thoughtful recording of observations as well as conversations, the tenacity of Health staff in contacting families and ensuring multi-agency partners were updated, and evidence of the development of robust multi-agency plans. Areas of improvement that were identified included; children's plans not being SMART, records from other Local Authorities not being reviewed, lack of clarity in use of PAMS, pre-birth assessments not being updated following completion and some health assessments lacking analysis around risk and over-optimism. Dip samples will be conducted moving forwards to ensure learning is embedded.

# 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.

We had 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.

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 2021-2022:**

- Neglect/Self Neglect
- Complex Safeguarding
- Domestic Abuse