Safeguarding Partnership Yearly Report 2023/2024

Authors

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Purpose of the report

Working Together 2023 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 between April 2023 and March 2024. The partnership is required to report on the following:

- what partnerships have done as a result of the arrangements, including child safeguarding practice reviews
- how effective these arrangements have been in practice. In addition, the report should also include:
- the contribution of each safeguarding partner to the functioning and structure of the multi-agency safeguarding arrangements
- any themes emanating from aggregated methods of scrutiny, for example, reviews and scrutineer activity and multi-agency audits
- evidence of the impact of the work of the safeguarding partners and relevant agencies, including training, on outcomes for children and families
- an analysis of any areas where there has been little or no evidence of progress on agreed priorities
- an analysis of learning from serious incidents
- a record of key decisions and actions taken by the safeguarding partners in the yearly cycle, including in relation to implementing the recommendations from any local and national child safeguarding practice reviews and the impact this has had
- ways in which the safeguarding partners have sought and utilised feedback from children and families to inform their work and influence service provision
- the breakdown of costs in delivering the arrangements for that period, including the financial contributions of individual partners, any changes to funding and an assessment of the impact and value for money of this funding
- evidence of how safeguarding partners are ensuring the adequate representation and input of education at both the operational and strategic levels of the arrangements
- an overview of how data is being used to encourage learning within the arrangements and evidence of how information sharing has improved practice and outcomes
- a review of the impact and learning from independent scrutiny arrangements to ensure the leadership is strong and the arrangements are leading to the desired and necessary impact
- any updates to the published arrangement with the proposed timescale for implementation
- evidence that national reforms have been implemented, taking into account key decisions and actions taken by safeguarding partners in response to reforms, and any issues or concerns encountered within the yearly cycle.
- Where there is a secure establishment in a local area, safeguarding partners should include a review of the use of restraint within that establishment in their report, and the findings of the review should be reported to the Youth Justice Board, the Youth Custody Service, and His Majesty's Inspectorate of Prisons.

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 adults and children's safeguarding partnership is translated into a joint action plan through a three-year strategic business plan underpinned by a delivery plan. The current Strategic Plan (2023-26) was agreed in June 2023 and is based on five priorities which are reviewed and refreshed annually. Our report this year is written against our strategic priorities for 2023-2026, which are as follows:

- Improve partnership working and information sharing (joint priority)
- Effective transitions from childhood to adulthood (joint priority)
- Understanding complex trauma and assessing risk (joint priority)
- Working with men (children's priority)
- Working with adults to manage risk effectively and make safeguarding personal (adult's priority)

Chair's Introduction

Gail Hopper Independent Chair and Scrutineer

I have now held the role of Independent Chair and Scrutineer of the Children and Adult Safeguarding Partnerships in Stockport for over two years. It remains a privilege to hold this position and work with a Partnership that is committed to continual improvement and delivery of the most effective approach to safeguarding children and young people and supporting their families.

This report provides a concise and accurate account of the work undertaken by the Partnership over the last year. It mirrors many of the points that I have raised in this following introduction.

Progress is being made on delivering some of the agreed priorities and this is supported by the chairs of sub-groups and the Partnership, who closely review progress and acknowledge where more work is required. One of these areas is the joint priority of effective transitions from childhood to adulthood and complex safeguarding. This was a priority that was carried over from the previous business plan, due to limited progress and my challenge to both Partnerships is to ensure this doesn't happen again, through collective and focused action.

As part of my scrutiny role, I chair the meeting of sub-group chairs and use this opportunity to seek evidence about progress being made against the business plan priorities. It is a credit to the chairs that they are reflective and open in their assessment of progress and acknowledge the challenges that can impact on progress. They have been open to exploring other ways of working to increase progress and achieve success.

The Partnership continues to rely too heavily on data and information provided by the Local Authority and can only be strengthened by timely partner contributions. Work to address this is underway and I look forward to seeing a stronger and broader performance framework in the coming year that the Partnership can more confidently rely on.

As a Partnership, members have been open in acknowledging that a greater focus in required on addressing equality, diversity, and inclusion to fully understand and meet the needs of an increasingly diverse local population. This formed the basis of a productive joint partnership's development day in November 2023. Work is underway in some partner organisations to progress

this work, but it is acknowledged that it is early days and more work will be needed to evidence the major shift required if partners are to demonstrate that responses are meeting the needs of all parts of the borough, particularly for those who are minoritised.

I am aware that work is taking place in partner organisations to strengthen contributions made by children, young people and their families. One of my challenges in the coming year will be to see the evidence of that through the Partnership's work. At present it is not clear what impact this has.

I will continue to seek information from all partner organisations about their contributions to delivering the priorities of the Partnership, and to responding to information requests. It would be a significant step if this sharing of information became "the way we do things", rather than it being a positive response to requests made.

Partnership Arrangements

The Stockport Safeguarding Children Partnership (SSCP) and Stockport Safeguarding Adults Partnership (SSAP) are comprised of the three statutory safeguarding partners (Stockport Council, NHS Greater Manchester and Greater Manchester Police) alongside other agencies across education, housing, health and social care, and the voluntary sector.

The SSCP is comprised of two executive boards and several sub-groups, and these are detailed below. To promote a Think Family approach to safeguarding across Stockport, the SSCP and SSAP have their own executive boards *as well as* a joint board. This joined up working is additionally supported by two joint working groups - the complex safeguarding group and the training and development group.

The three statutory safeguarding partners, Stockport Local Authority, NHS Greater Manchester (Integrated Care Board) and Greater Manchester Police contribute most of the funding for the partnership to operate effectively. The detail of these contributions can be found in the section 'Partnership Funding and Expenditure'.

The SSCP, SSAP and Joint Executives

For the last two years, the executive boards of the SSCP and SSAP have been chaired by the same independent chair and scrutineer, Gail Hopper. In response to the changes outlined in Working Together 2023, the Director of Children's Services (DCS) will become the chair of the executive board of the SSCP from December 2024 onwards and the chairship will rotate biannually between the statutory partners. Gail Hopper will continue as independent chair and scrutineer of the SSAB and will offer independent scrutiny to the SSCP.

Practice Improvement and Assurance Partnership

This partnership group 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.
The group will scrutinise and challenge the work of partners by integrating a range of information and is underpinned by a delivery plan, quality assurance framework and dataset. This group is responsible for the moderation of all completed action plans for case reviews and oversees a programme of multi-agency auditing activity.

Complex Safeguarding sub group

This group is 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 sub group

This group is 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 partnership will continue to develop the learning hub approach in the next year to ensure learning is embedded routinely for the multi-agency workforce.

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 whether to progress to a rapid review in accordance with the criteria set out in Working Together to Safeguard Children 2023. If the criteria is met, a rapid review panel is convened to consider learning from the case, and whether a local child safeguarding practice review is to be commissioned. The rapid review panel is also chaired by the head of safeguarding and learning.

Learning from Practice Group

This sub-group is chaired by the safeguarding partnership business manager and brings together partners in a focused way to review progress against safeguarding review action plans. The work of this group is overseen by the practice improvement partnership and ensures there are no undue delays in delivering system improvements for the children, adults, and families of Stockport. Completed action plans will be reviewed by the children's executive board for assurance.

Safeguarding Children Education Subgroup

The partnership plans to launch an education subgroup in the autumn of 2024. This group will bring together partners from all education and early years settings. The group will report to the children's executive and will focus on partnership improvements in education settings.

Subgroup Chairs

A quarterly meeting of all sub-group chairs is convened in advance of each of the executive partnership meetings. This group has to date been chaired by the independent chair and scrutineer. Chairs are invited to contribute to the agenda setting for each partnership and this is where progress against the business plan is regularly monitored and challenged prior to progress reporting to the relevant partnership executive boards.

Strategic Priorities and Thematic Areas

As a joint adult and children's partnership we have agreed several areas that we want to concentrate our efforts on over next three years, our shared priorities for 2023-2026 are:

1. Improve partnership working and information sharing
2. Effective transitions from childhood to adulthood
3. Understanding complex trauma and assessing risk
4. Working with men (SSCP priority)
5. Working with adults to manage risk effectively and make safeguarding personal (SSAP)

Our shared values are**:**

- Co-production with children, adults and partners
- Non-discriminatory and inclusive practice at all levels
- Constructive and supportive challenge
- Culture of continual improvement across all agencies

Priority One – improve partnership working and information sharing

What did we achieve?

Several learning circles took place with various safeguarding professionals to highlight learning from reviews and reinforce the importance of information sharing and seeking.

A development day was held for the executive partnership in November 2023. The day focused on improving partnership working, relationships and equality, diversity and inclusion.

A 7-minute briefing on professional curiosity was produced and distributed across the partners to improve practitioner knowledge and learning in this area.

Enhanced training offer across the partnership in relation to information sharing.

We escalated a decline in health professionals attending strategy discussions to the executive, which resulted in a positive piece of work taking place which improved attendance rates.

What else do we need to do?

Strengthening attendance at multi-agency training to ensure practitioner receive key messages and learning.

Organise and deliver a development day for partners who attend the quality assurance and practice improvement partnership meetings.

Seek assurance from key partners and partner agencies in relation to inter-agency work to improve partnership working and information sharing.

Please see the appendix for a summary of a response from partners in relation to this priority area. This was put together as part of a scrutiny exercise of the joint partnership board.

Priority two – effective transitions from childhood to adulthood

What did we achieve?

A transitions learning hub was held in April 2023 which brought together practitioners from adults and children's agencies. Several cases were reviewed, and the learning hub event identified learning to take forward. The learning from the event has supported the shaping of the work plan that sits under the business plan.

We reviewed and refreshed MAARS (Multi Agency Adults at Risk) and Team Around the Adult guidance and processes.

What else do we need to do?

Improve the membership and frequency of the complex safeguarding sub-group to push forward the work plan and engage partners effectively. The actions of the co-chairs in attempting to move the complex safeguarding work forward is noted. However, changes made to the way the sub-group operates have not been effective and a meeting facilitated by the independent scrutineer has been planned to explore other options in April 2024.

Highlight gaps in progress with key partners.

The MAARS audits will take place 2024-2025 for assurance activity.

Seek assurance from key partners and partner agencies in relation to inter-agency work for effective transitions from childhood to adulthood.

Priority three – understanding complex trauma and assessing risk

What did we achieve?

Work is planned for this theme and will take place in the next schedule of reporting 2024-2025. This is in the form of two multi agency audits, completed in the learning hub model that will be facilitated by an independent author. There is an audit planned focusing on parental mental health which will be undertaken in July 2024 and a further audit planned in September 2024 which focuses on peer on peer abuse and mental health.

The review of Caring Dads was completed and disseminated across the partnership. This evidenced positive work with fathers and improved outcomes for victims and children of domestic abuse.

What else do we need to do?

An independent author has been commissioned to undertake a review of cases where parental mental health and complex trauma is a feature. This will take place in July 2024 and September 2024. The events will engage practitioners and senior leaders.

Seek assurance from key partners and partner agencies in relation to their plans to improve understanding of complex trauma and using this to effectively assess risk. This will be done through the practice improvement and quality assurance partnership.

There is a plan to introduce a weeklong introduction for all social workers joining Stockport Family and quality assessments will be included in this process, in addition, the development of a social work curriculum is also in progress. This will include a suite of mandatory training to ensure a high quality and consistent work force development offer regarding assessment and understanding trauma.

The partnership has a trauma conference planned agencies across the partnership in November 2024.

The caring dads programme will be rolled out in a more sustainable way. This will ensure the programme can continue to run effectively and with a wider reach for working fathers.

Priority four – working with men

What did we achieve?

The partnership has offered a robust programme of training for practitioners. Several learning circles took place titled 'working with fathers and men' and multiple training days took place titled 'marginalised fathers' with more are scheduled for 2024.

The named Doctor for safeguarding in Stockport and consultant paediatrician has delivered in a number of learning circles in relation to bruising in non mobile babies and s.47 processes. These will continue and will be a feature of regular training offered to all partnership agencies. This recognises the findings from the National Panel report 'The Myth of Invisible Men.'

The partnership continues to support the delivery of 'caring dads' which is a programme for fathers who have harmed their partners domestically.

A GP practice is trialling a new text messaging service to fathers of newborn babies to offer advice, support and guidance. If this is successful it will be rolled out across the borough.

Stockport family hub now includes a male worker from "dads matters" which enhances their offer for male parents and carers.

The partnership held a development day which focused on issues of equality, diversity and inclusion.

What else do we need to do?

Continue embedding the work plan and seek the views of fathers and male carers to continue to improve services.

To pro-actively seek the voice of fathers and men.

During the last 12 months, at each safeguarding adult partnership executive (or Joint Executive in the case of shared priorities), the progress made on a single business plan priority is highlighted as an agenda item. This ensures that all partnership members are aware of their responsibility to contribute to progress and can collectively hold each other to account. At the March'24 meeting of the Joint Partnership, the Independent Chair highlighted a concern that in the case of priority one, improving Information Sharing, there was an over reliance on the Safeguarding Unit and role of business managers in delivering progress. She challenged all partners in writing to provide evidence of how they were addressing this priority as single agencies. Response rate was 100% and provided some good evidence of progress.

Effectiveness of Arrangements

The partnership has developed a data dashboard which is reviewed in the practice improvement partnership meeting. The data set has been developed to be able to measure impact of the partnership business plan priorities. There is more work to do by partner agencies to contribute to the data set, as this is currently heavily reliant upon Local Authority data.

Development of the data set is a focus of the partnership for 2024 – 2025 alongside robust ways to be able to better evidence the effectiveness of arrangements.

The contribution of each safeguarding partner to the functioning and structure of the multi-agency safeguarding arrangements

- The three statutory partners attend the children's and joint executive board meetings.
- Following the changes made in Working Together 2023, the children's executive will be chaired by the Director of Children's Services. The chair will rotate every 12 months between the statutory partners.
- The quality assurance sub-group is chaired by the Associate Director of safeguarding and designated nurse safeguarding children.
- The practice improvement partnership is chaired by the Director of Children's Social Care.
- The complex safeguarding sub-group is chaired jointly by the head of social work services and practice improvement, children's social care and the head of adults social care

Themes emanating from scrutiny and multi-agency audits

The SSCP has undertaken two multi-agency audits in 2023-2024 and held two multi agency learning events which were facilitated by the independent chair and scrutineer.

The themes that have been identified are:

- Effective transitions for children to adulthood where there is vulnerability to exploitation
- Risk outside the home
- Professional knowledge and understanding of restrictive eating
- Importance of all agencies contribute to safeguarding children through attendance, sharing knowledge, expertise, offering support and challenge

The learning from practice group has been progressing action plans in relation to themes identified.

The independent chair and scrutineer has also carried out the following scrutiny actions:

- Challenge of Greater Manchester Police following the Child Q case, to seek information about number of strip searches carried out in the borough
- Led and chaired a multi-agency review of a decision to implement a child protection plan, that was challenged by the child's parents. The panel was unable to support the initial decision and required the initial child protection conference to be re-convened
- Scrutinised recommendations of the virtual and the Rapid Review panels that recommend if criteria is met to conduct a Rapid Review or a Child Safeguarding Practice Review and offer an independent view on these.

- Challenge of key partners on specific issues – such as accuracy and timeliness of information sharing

Impact of the work of the safeguarding partners and relevant agencies on outcomes for children and families

Due to the timing of Working Together 2023 being published in December 2023 and the scope of this annual report reviewing work between April 2023 and March 2024, the partnership has not had sufficient time to gather evidence for this new section within the last year. There is however North West regional improvement work planned for February 25, which is focusing on supporting partnerships to evidence their impact in safeguarding arrangements.

Analysis of any areas where there has been little or no evidence of progress on agreed priorities

The partnership chose a small number of priorities to progress over a three-year period from 2023 to 2026. It is therefore not our aim to complete delivery against all priorities within year one. The partnership has a yearly plan where each priority area will be a focus of the practice improvement and quality assurance group. This assists the partnership in identifying areas of slow or no progress, whilst also capturing the evidence and impact of progress made on agreed priorities.

There has been slow progress particularly on the priority area of effective transitions from childhood to adulthood and understanding complex trauma and assessing risk. Due to this the partnership has sought the support of the independent scrutineer who will review the arrangements with partners in April 2024. The partnership will be able to further update on this work in the next yearly report.

We have a development day planned for May 2024 to review the partnership subgroup arrangements and to further develop the improvement partnership to provide stronger rigour to the review of progress against agreed business plan priorities.

Learning from serious incidents

Working Together requires the safeguarding partners to ensure arrangements are in place to review serious child safeguarding cases, and others where there may be learning, 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. Rapid Reviews gather the facts about the case, identify 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 2023 to March 2024 two Rapid Reviews took place and two CSPRs were published.

Overview April 2023 to March 2024

Child Safeguarding Practice Reviews and Rapid Reviews Common Themes Identified

- Information sharing and seeking
- Use of chronologies to inform assessment of risk
- Neglect and child sexual abuse
- Children persistently or severely absent from education
- Understanding of parental complex trauma in assessing risk
- Working with men
- S.47 processes specifically in relation to bruising in non-mobile babies, roles and responsibilities

Child Safeguarding Practice Reviews (CSPRs)

The partnership has commissioned and published two child safeguarding practice reviews between April 2023 and March 2024. A summary of the reviews is available on the safeguarding partnership website, which can be accessed by clicking here.

In May 2023 the CSPR 'Molly' was published. The report identified nine learning points for agencies to consider and work on. The learning from practice group formed an action plan based on these learning points, which was completed by June 2024.

The work that took place included:

Learning to be shared with the National panel for consideration of placement sufficiency and safety. Safer recruitment processes needed for agency staff working in residential children's homes. This has also been raised with the national panel as a priority.

Transitions from secure placements for children and their efficacy in ensuring children's safety in the community.

In July 2023 the CSPR 'Dylan' was published. The report identified nine learning points for agencies to consider and work on. The learning from practice group formed an action plan based on these learning points, which was completed by July 2024. The work that took place included:

Work Completed:

- Quality assurance audits took place in the partnership to review cases where parental mental health was a concern.

Learning Identified:

- Working with men – the children's fathers were not included in social work assessments. Limited information was known about him.
- Information sharing and seeking between agencies – historical information particularly was not sought or known during strategy discussions and assessments of parental capacity which would have given a more holistic picture
- Practitioners' ability to understanding complex trauma in adults and the impact of this on their parenting was not robust within the intervention
- Multi-agency working and holding strategy discussions at key times.
- s.47 processes and procedures being initiated and followed within the GP practice

National Child Safeguarding Practice Review Panel

The National Safeguarding Practice Review Panel oversees and gives advice on Rapid Reviews and Child Safeguarding Practice Reviews. The panel published a National Review in April 2023 titled Safeguarding children with disabilities in residential settings following the review of the reports of abuse taking place in residential settings for children with disabilities and complex needs. The Partnership reviewed the report and recommendations made. You can read the report by clicking this link

In response to the report of the National Panel, the SSCP undertook an assurance activity of all Stockport children in similar settings to those considered in the report. The completed practice reviews assured the Partnership that the relevant children's needs were being met and that they were being offered a good level of care.

The National Safeguarding Practice Review Panel also published their national report for 2022-2023 in January 2023 which highlighted 6 key practice themes;

- Effective leadership and culture supporting critical thinking and professional challenge.
- Giving central consideration to racial, ethnic, and cultural identity and impact on the lived experience of children and families.
- The importance of a whole family approach to risk assessment and support.
- Recognising and responding to the vulnerability of babies
- Domestic abuse and harm to children – working across services.
- Keeping a focus on risks outside the family.

The practice improvement partnership group is exploring the learning from the report and completing a comparison exercise against our own learning. This will be presented at May's practice improvement partnership meeting.

Each of the decisions made by the Partnership about the outcome of Rapid Reviews, whether to undertake a Child Safeguarding Practice Review or not, and the outcome of those reviews that have taken place have been supported by the National Panel. The Partnership has not been asked to reconsider any of its actions or take additional ones during this period.

A record of key decisions and actions taken by the safeguarding partners

The partnership undertook a 'true for us' exercise following the National Panel annual report. This was completed by the Safeguarding Partnership Manager and was presented to the practice improvement partnership and children's executive. This exercise will be repeated annually to offer insight and benchmarking against national themes and trends.

Learning from the National CSPR published during the scope of this report was disseminated to partner agencies. The partnership training manager and safeguarding partnership manager ran several learning circles to deliver the learning to a wide range of agencies.

In response to the national panel report Child Protection in England following the murders of Arthur Labinjo-Hughes and Star Hobson, children's social care undertook a piece of quality assurance activity reviewing all referrals received in the multi-agency safeguarding support hub (MASSH) from family members. This activity assured them that referrals from family members were taken seriously, and that further information was gathered to ensure appropriate triangulation.

Additionally, the following steps have been built in as additional safeguards

- Service Leads review all contacts received for the 4th or subsequent occasion to consider whether there are emerging needs and a missed opportunity to support a family earlier.
- Family members who contact the MASSH, who often wish to remain anonymous will be spoken to by a senior practitioner to ensure all information they wish to give has been provided

Stockport NHS Foundation Trust named nurse for safeguarding chairs a CSPR group meeting six times a year. At this meeting single agency action plans relating to new and existing CSPRs are discussed. Drift relating to ongoing actions, is escalated to the Divisional Nurse Director for the Women and Childrens Division.

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

Children's Social Care Commission the independent charity Coram Voice to undertake "Bright Spots" surveys with both children in our care and care leavers on a bi-annual basis. The findings from the surveys are used to inform and refresh the corporate parenting strategy and service action plans.

Feedback is also gained directly from children and families by Children's Social Care as part of their quarterly Practice Week. Where possible, the children and families of all children reviewed during the week are spoken to by reviewers who are independent of the management of the case.

The Children's Safeguarding Unit runs a parent's reference group to seek the views of families who have lived experience of child protection processes. The group provides feedback that is used to improve service delivery and practice in this area.

The Local Authority has commissioned Listen Youth Alliance to offer feedback on council priorities, including issues relating to the safeguarding of children. The partnership is due to meet with the group following the current reports scoping period to gain their views on partnership work. Their first annual report can be read here

Stockport Family Hubs are committed to a co-production charter. This charter has provided the foundation the approach in the last year to revitalise and refresh the early help assessment document. Strategic leads have engaged with families and frontline staff to ensure their views in the design of the new documentation.

During 23/24 the hubs have expanded the scale and scope of engagement with families. This has included the development of initiatives such as QR codes for parents engaging in group work interventions and the Start Well Family survey.

Stockport NHS Foundation Trust has listened to the view of care experienced children and young people who wanted professionals to not use abbreviations such as looked after child (LAC) when referring to them. This has led to a change in title for their named nurse who is now referred to as Named Nurse Children in Our Care. Where possible, the term LAC has also been changed to Children in Our Care in Foundation Trust policies and guidelines and a section on language matters is provided in the safeguarding children level 3 training.

Partnership Funding and Expenditure

	Children's Partnership
Income	
SMBC	149,027
NHS GM	32,000
GMP	13,800
SNHSFT	4,000
Probation	2,274
Education	32,000
SSAB	17,000
	250,101
Expenditure	
Chair	15,858

Reviews	34000
Salaries	214,008
Sundries	11343
	275,209
Total	**-25,108**

The contributions of the key partners leaves the partnership underfunded at this current time. These concerns have been raised with NHS GM and GMP to consider increasing their contributions or sharing the cost of the partnership equitably with the Local Authority. Reserves of the Local Authority have been used to account for the underfunding, which is not sustainable for future funding.

There is an ongoing piece of work in Greater Manchester for leaders to review this together as funding varies across the region.

How data is being used to encourage learning

The SSCP is committed to using data to evidence and encourage learning and challenge partners when this is not evident. The dynamic data set is being refreshed and redeveloped for the partnership to improve the quality of the data available. Partners have contributed data that is available to them in relation to the business plan priorities and there is a core data set to review any trends or themes.

Data has been used as part of learning reviews, for example when a multi-agency audit was supported by the SSCP in relation to restrictive eating and ARFID (avoidant food intake disorder). Data held by the NHS FT Stockport, Pennine Care Stockport and the Children With Disabilities team in Stockport MBC was used to support the identification of the number of children with restrictive eating or ARFID. Assurance activity was completed to ensure children were nourished and receiving the appropriate care for their health. Data and learning from this assurance activity was shared widely across the partnership, including doctors, nurses and social workers to encourage learning in this area.

The business manager has used data from the National Panels annual report to support a piece of northwest work to identify learning trends and themes in the northwest. This was reviewed in comparison to the national picture, which enabled individual local authorities to work further on areas that were under or overrepresented.

The SSCP is committed to continuing to use data to encourage learning and this will be a continued focus for the next financial year.

Published arrangements

Our revised multi agency safeguarding arrangements will be published on the safeguarding partnership website in December 2024. You can access our website here.

National Reforms

The Partnership remains concerned by the slow nature of implementation of reforms and information sharing which makes it difficult for any partnership to respond to this as this stage. We are aware that some councils and partnerships have been identified as pathfinders, but partnerships are finding it difficult to access information from the progress made to date.

Stable Homes, Built on Love, was published in February 2023 has 6 ambitions of reform.

1. Family Help
2. Keeping children safe
3. Supporting families to help children.
4. Make better care for children in care and care leavers,
5. Children to have great social workers.
6. Improving the whole system for children and families.

As part of its reform programme, on 23rd December 2023 the government issued the following key strategies and statutory guidance.

1. Championing Kinship Care
2. Children Social Care National Framework
3. Working Together to Safeguard Children 2023
4. Digital and Data Strategy

In preparation for social work reforms, children's social care have moved six social workers into their family help teams, the teams are also managed by qualified social work team leaders. This means that they have social work expertise sat in the community, in their early help service, to prevent escalation to statutory social work and to support an unqualified work force to feel more confident in holding and managing risk.

Appendix

Information Sharing Response Summary;

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Plan%20scrutiny%20re

SSCP Business Plan

Final%20SSCP%20&%
20SSAP%20Business%