South Tees
Safeguarding
Children Partnership

SOUTH TEES SAFEGUARDING
CHILDREN PARTNERSHIP (STSCP)

ANNUAL REPORT 2020/2021

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Foreword by the STSCP Independent Chair Edwina Harrison

The South Tees Safeguarding Children Partnership (STSCP) was set up in 2019 in response to the changes to multi-agency safeguarding arrangements which were introduced in the Children and Social Work Act 2017. This formal partnership is between the two South Tees Local Authorities (Middlesbrough, Redcar and Cleveland), Cleveland Police and NHS Tees Valley Clinical Commissioning Group. The partners share the ambition to improve the lives of the most vulnerable children in their area, many of whom face multiple disadvantage.

This is the second report of the STSCP and covers the period from April 2020 to March 2021.

The report demonstrates the work of the STSCP throughout the year and aims to show the challenges which will be addressed during 2021-22.

The response to my appointment as Independent Chair in March 2021 has been very positive and I have observed the commitment of the members across the South Tees Safeguarding Children Partnership to make the changes which are needed.

The word "unprecedented" has been over used during this year of the COVID19 pandemic but the impact has been felt by children, families and communities in ways which are becoming clearer day by day. We need to understand the impact, and to learn from the different ways in which work has taken place, including the increased use of technology for meetings and communication with children and families.

The report has tried to address the issues which were highlighted in the report by the Child Safeguarding Practice Review Panel (May 2021) which suggests that the newly formed Safeguarding Children Partnerships are not identifying "stubborn challenges" in their areas. This report has tried to do so, at the end of a year in which the work of the partnership has inevitably been affected by a number of reviews of serious cases. These reviews are complex and difficult but the processes have been thorough and the report identifies some of the learning and how that is intended to bring about changes in practice in safeguarding children.

2021 will be another year of significant change for South Tees Safeguarding Children Partnership which will need to be ready to adapt in response. The intention to do so is evident. The challenge will be in turning that intention into action on behalf of the most vulnerable children and families across the South Tees.

Our vision and values-this is what we are working towards

A partnership committed to keeping children safe and working together to achieve the best possible outcomes for children and families.

Edwina Harrison
STSCP Independent Chair

IMPACT OF COVID 19 - **SOUTH TEES ACTIONS**

In March, overnight both council's and partners had to change the way many of its services were delivered, to keeping schools open for key workers' children and vulnerable children, to working out how to keep services running without face to face contact, to ensuring key workers are able to operate safely within Personal Protection Equipment (PPE) and safeguarding requirements.

As a result of the national emergency in March 2020 the STSCP Partners identified that children and young people would be spending significantly more time at home, potentially placing them at increased risk of harm and that opportunities to spot abuse and neglect may be reduced or for them to access support, in turn increasing their vulnerability. The key partners worked together and met on a weekly basis and quickly developed new ways of working and systems to support vulnerable children during this time. A few examples of what were done are:

STSCP circulated

- A bulletin containing a range of information that all partners could access.
- Updated national guidance on serious incident notifications, rapid reviews, serious case reviews and local child safeguarding practice reviews in light of coronavirus.
- The Children's Commissioner children's guide to coronavirus to help explain the situation.

Also, a detailed guidance note was provided to children's social care staff about new working arrangements. These continue to be update and included:

- Decision making flowcharts for face to face visits.
- Safety advice during visits.
- COVID19 risk assessment guidance.
- Guidance on virtual visits.
- Domestic Abuse.

Council staff in both Middlesbrough and Redcar & Cleveland were directed to public health advice on the Council intranets.

Council executives provided online briefing for staff on a weekly a basis. A dedicated section was set up under the COVID section on the Cleveland Police website which included signposts to a list of resources e.g. 'It's Not Okay' and 'Trapped' on Facebook and Twitter.

INTRODUCTION

Working Together 2018 describes the features of effective multi-agency safeguarding partnerships:

This local arrangement supports and enables local organisations and agencies to work together in a system which places the child at the heart of the process and aims to ensure that:

- **Children are safeguarded and their welfare promoted.**
- **Partner organisations and agencies collaborate, share and co-own the vision for how to achieve improved outcomes for vulnerable children.**
- **Organisations and agencies challenge appropriately and hold one another to account effectively.**
- **There is early identification and analysis of new safeguarding issues and emerging threats.**
- **Learning is promoted and embedded in a way that local services for children and families can become more reflective and implement changes to practice, which informs our local approach to prevention.**
- **Information is shared effectively to facilitate more accurate and timely decision making for children and families.**

What is the South Tees Safeguarding Children Partnership?

Throughout the period covered by this report the arrangements included:

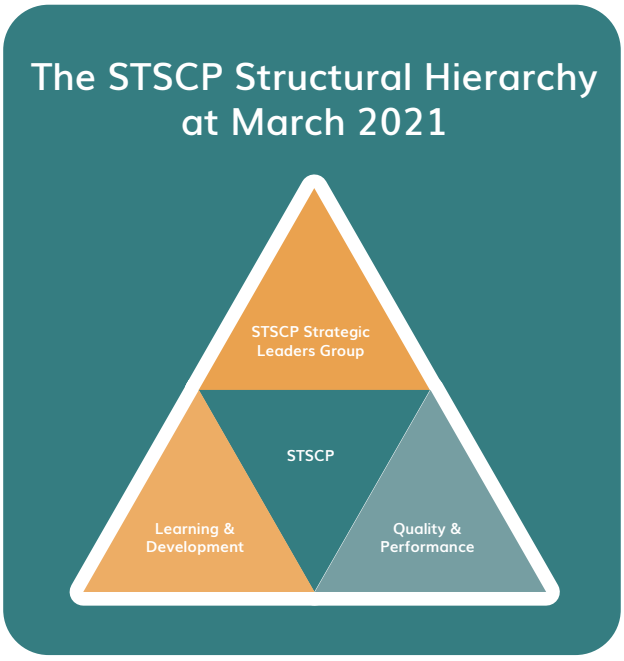
- **Meetings at Executive level to set the strategic direction for the partnership.**
- **Partnership meetings attended by the executive leads of the four statutory partners and the broader partnership and chaired by an Independent Chair.**
- **Sub groups and task and finish groups.**

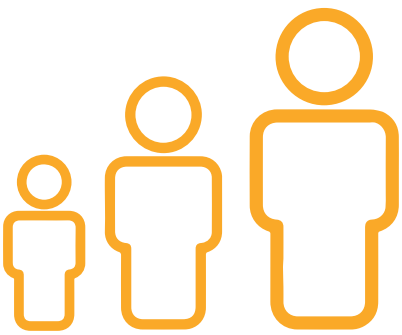
Middlesbrough Council is the host for the STSCP, as outlined in the legal agreement which established the partnership. The STSCP Executive is the key decision-making body and consists of the executive leads of the four statutory partners.

Initially there were some challenges in obtaining full attendance at partnership meetings but this improved during the latter stages of 2020 and early 2021.

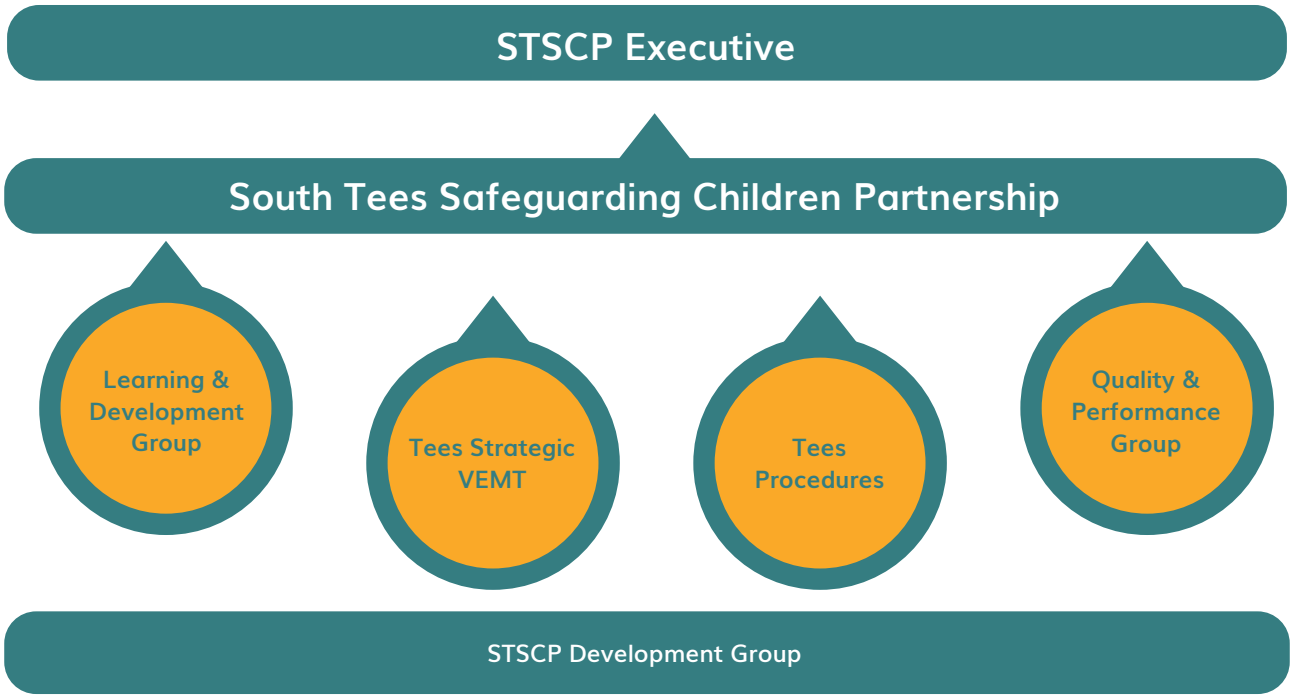
The published arrangements, which were reviewed in 2021, can be found through the website link below:

Key documents | South Tees Safeguarding Children Partnership stscp.co.uk





STSCP GOVERNANCE STRUCTURE



Links to Relevant Strategic Partnerships

Children & Young Peoples Partnership (R & C)

Children's Trust (Middlesbrough)

Corporate Parenting Boards

Strategic MARAC

Strategic MAPPA

Youth Justice Board

Community Safety Partnerships

South Tees Health & Well Being Board

Tees Safeguarding Adults Board

MBC Scrutiny Panel

Middlesbrough Improvement Board

COMMENT FROM THE INDEPENDENT SCRUTINEER

One of the major changes which was introduced in the Children and Social Work Act 2017 was that the responsibility for the safeguarding arrangements moved to the three statutory safeguarding partners, identified as the Local Authority, the Police and the Clinical Commissioning Group.

These partners were very much involved in the work of the multi-agency safeguarding arrangements when I took up the role in March 2021. However, I did not think it was clear enough that there is a difference in legislation and guidance between these partners and the broader partnership.

There is now a separate Executive meeting. There has also been a useful Chief Executive level meeting with a further meeting planned for November 2021.

A consultation is taking place with the agencies of the broader partnership about what they would find useful and the future arrangements will depend on the responses. They have been very committed to the work of the partnership and they have a key role to play in keeping children safe so it is important that we listen to what they have to say.

2 LOCAL SAFEGUARDING CONTEXT ACROSS SOUTH TEES

Although Middlesbrough Local Authority and Cleveland Police have had challenging outcomes from inspections, there is a strong commitment to improve and make progress. Both Middlesbrough and Redcar & Cleveland local authorities have high aspirations for their children and young people. Equally, both areas have significant challenges to address, as can be seen from the following information.

THE INCOME DEPRIVATION AFFECTING CHILDREN INDEX (IDACI)

The Middlesbrough IDACI score for 2019 was 32.7% of children living in income deprived households, highest in England;

The Redcar & Cleveland IDACI score for 2019 was 29% of children living in income deprived households, 13th (highest) in England.

LOCAL SAFEGUARDING DATA APRIL 2020 - MARCH 2021

MIDDLESBROUGH

4,436 referrals for the year (a rate of 1,353 per 10,000).
32.4% were re-referrals within the previous 12 months.
1,700 Children in Need in Middlesbrough.
570 children were subject to a Child Protection Plan, up 50% from previous year.
46% of children who were made subject of a Child Protection Plan due to neglect.
571 Children in the care of the Local Authority, a decrease of 7.8% on the previous year.
6 children were in Private Fostering arrangements during this period.
65 children and young people were reported missing from home in Middlesbrough more than once.
106 young people were discussed at Vulnerable, Exploited, Missing, Trafficked practitioner group.
4 Rapid Reviews were completed in this period.
141 referrals to the Local Authority Designated Officer in Middlesbrough.

REDCAR & CLEVELAND

1,878 referrals for the year (a rate of 680 per 10,000).
20.1% were re-referrals within the previous 12 months.
1,691 Children in Need in Redcar & Cleveland.
261 children were subject to a Child Protection Plan, an increase of 0.4%.
86% of children who were made subject of a Child Protection Plan were made so due to neglect.
316 Children are in the care of the Local Authority, a decrease of 9%.
9 children were in Private Fostering arrangements during this period.
68 children and young people were reported missing from home more than once.
159 young people were discussed at Vulnerable, Exploited, Missing, Trafficked Practitioner Group.
2 Rapid Reviews were completed in this period.
58 referrals to Local Authority Designated Officer in Redcar & Cleveland.

South Tees Key Health Facts

MIDDLESBROUGH:

- Ranked 1st out of 152 LA's for the highest teenage conception rate (2018) with rate of 39.4/ 100,000.
- Ranked 1st out of 152 LA's for children deemed not to be school ready (2018/19) with rate of 63.1%.
- Ranked 4th out of 152 LA's for children living in low income families (2018/19) with rate of 30%.
- Ranked 10th out of 152 LA's for breastfeeding 6-8 weeks (2019/20) with rate of 32.6%.
- Ranked 29th out of 152 LA's for childhood obesity year 6 (2019/20) with rate of 25.2%.
- Ranked 2nd out of 152 LA's for the highest rate of children in care (2020) with rate of 189/10,000.
- Ranked 55th out of 152 LA's for MMR vaccination coverage for two doses 5 years old (2019/20) with rate of 86.7%.

REDCAR & CLEVELAND:

- Ranked 6th out of 152 LA's for the highest teenage conception rate (2018) with rate of 34.6/ 100,000.
- Ranked 61st out of 152 LA's for children deemed not to be school ready (2018/19) with rate of 71.1%.
- Ranked 42nd out of 152 LA's for children living in low income families (2018/19) with rate of 18.1%.
- Ranked 4th out of 152 LA's for breastfeeding 6-8 weeks (2019/20) with rate of 27.6%.
- Ranked 41st out of 152 LA's for childhood obesity year 6 (2019/20) with rate of 24%.
- Ranked 12th out of 152 LA's for the highest rate of children in care (2020) with rate of 126 per 10,000 to 136/10,000.
- Ranked 113th out of 152 LA's for MMR vaccination coverage for two doses 5 years old (19/20), rate 91.8%.

CLEVELAND POLICE DATA:

- Child sexual abuse represented half (52%) of sexual offences.
- 21% of the 3,018 reported Missing from Home incidents were of children in care.
- 59% of child sexual exploitation crimes had a cyber-element.
- 5,534 children have been present during a Domestic Abuse incident.
- 9,562 incidents recorded as alcohol related.
- 9,560 incidents recorded as drugs related.
- Cleveland has the 9th highest homicide rate in the country.
- Cleveland has the 4th highest knife crime rate in the country (year to December 2020).

Children's Social Care

National indicators are used to monitor the performance of Children's Social Care. This information is presented to the STSCP as part of Tees Performance Management Framework.

CHILDREN IN CARE

Middlesbrough has a significantly higher rate of Children in Care than its regional, national and statistical neighbours, placing it in the top 10 local authorities in England for the rate of children per 10,000 under 18 population. The number of Children in Care in Middlesbrough at the end of March 2020 was 619 reducing to 571 at the end of March 2021, an decrease of 7.8% in the last year. This has now further decreased in 2021-2022 period.

Redcar & Cleveland also has a higher rate of Children in Care than its regional, national and statistical neighbours, for the rate of Children in Care per 10,000 under 18 population. The number of Children in Care in Redcar & Cleveland at the end of March 2020 was 348, falling to 316 at the end of March 2021, a decrease of 9% in the last year.

What children and young people in the care system in Middlesbrough and in Redcar & Cleveland said about being in care.

Young people wanted a "Have Your Say Group" newsletter

Health assessments are too intrusive and too long. Young people are asked personal questions in front of Carers and seeing a professional of the opposite gender can be awkward.

Listen and show you are listening

"Whilst in care my social worker has listened when I needed someone to talk to and helped me appreciate myself more"

"It's nice to be able to build a positive relationship with an adult"

"I didn't like that my social worker kept changing however that's better now and now I'm happy"

Child Protection

The number of children and young people in Middlesbrough subject to a child protection plan at the end of March 2020 increased on the previous year from 379 to 570 as at March 2021, an increase of over 50%. The majority were classed under the category of neglect.

The number of children and young people in Redcar & Cleveland subject to a child protection plan has remained static over the last year, from 260 at the end of March 2020 to 261 as at March 2021, a moderate increase of just 0.4%. The majority were also under the category of neglect.

STSCP IMPACT:

- Audit of CP meetings from SCR Pippa action plan, monitor compliance and performance.
- Hidden males in families, practitioner questionnaire circulated from CSPR Stork, to raise profile of hidden males in line with domestic abuse cases.
- Assessments quality challenged across the review process, to monitor quality of assessments and use of specialist assessment tools.

CHILDREN IN NEED

(The definition of children in need from the Children Act 1989 are children with disabilities and those whose needs relate to social and economic deprivation).

Middlesbrough identified 1,644 children and young people as Children in Need at the end of March 2020, this figure increased to 1700 as at March 2021, an increase of 3%.

Redcar & Cleveland identified 1758 children and young people as Children in Need at the end of March 2020, this figure reduced to 1691 as at March 2021, a decrease of 3.8%.

COMMENT FROM INDEPENDENT SCRUTINEER

Regular and comprehensive performance information is obtained through an arrangement across the four South Tees authorities. It has been recognised that this information is not used by STSCP as effectively as it could be to challenge poor performance and to improve outcomes for children using a multi-agency performance framework. A task and finish group has been set up to make sure that this does happen.

3 IMPACT ON STRATEGIC PRIORITIES for 2020-2023

These are the priorities that were agreed by the partnership and that we have been working on during the year.

PRIORITY 1: Vulnerable, Exploited, Missing, Trafficked (VEMT)

The aim is for children/young people to be free from the risk and harm of exploitation, from going missing and/or being trafficked

The STSCP will promote the safety and wellbeing of children and young people with a particular focus on those suspected of being at risk.

WHAT HAS BEEN DONE?

- The STSCP is effectively represented on key partnerships, including the South Tees Health & Well Being Board, the Middlesbrough Children's Trust and the Redcar & Cleveland Children Partnership;
- The STSCP has improved communication with the general public regarding key aspects of the work of the partnership through the stand-alone STSCP website: https://stscp.co.uk which is monitored by the STSCP business unit;
- There is increased intelligence around Missing From Education/ Permanent Exclusions / Elective Home Educated;
- There has been campaigns around National Child Sexual Exploitation Awareness Day;
- Awareness sessions have been held on County Lines; exploitation involved sex working; and how CSE affects boys and men;
- The Philomena Protocol has been launched. Its aim is to protect children who go missing from care homes;
- Cleveland Police has completed a comprehensive review on how Cleveland Police respond to Child Exploitation;
- Cleveland Police has completed a Tees-wide Child Exploitation Problem Profile and this has been presented to key partners and professionals;
- Barnardo's Tees Valley has completed a video about how they will support children and young people who have been subject to exploitation. A copy of the video can be seen at https://vimeo.com/user140651615

IMPACT

This year has seen a refocus on Criminal Exploitation, including a number of multi-agency development sessions supported by the Office of the Police & Crime Commissioner. The Tees Vulnerable, Exploited, Missing and Trafficked (VEMT) Strategic Group sponsored a workshop to review processes and understanding of VEMT issues across the Tees region. This has led to a review of the Tees VEMT Strategy and action plan. Refer to recent event and multiagency engagement.

NEXT STEPS

- Embed and strengthen the understanding and impact of VEMT across Tees;
- Promote the Tees VEMT Strategy;
- Continue to raise the profile of and promote the understanding of child exploitation.

PRIORITY 2: Neglect

The aim is to reduce neglect, reduce the impact of neglect and ensure help and support is provided at the earliest opportunity.

The STSCP will work with partner agencies to promote early help and recognise and respond to the neglect of children and young people.

What has been done?

- The Neglect Strategy has been reviewed and updated with the Signs of Safety approach being rolled out across service areas;
- Multi-agency task and finish groups are making progress around child exploitation and Adolescent Neglect, for example a transitions to adult services model has been developed and an Adolescent Neglect Framework has been produced;
- Participated in the Oxford Brookes University survey. This involved questions about whether the STSCP has implemented a Neglect Strategy; what type of tools, if any, are advocated by the partnership in the assessment and/or identification of child neglect.

IMPACT

The understanding of neglect and the importance of prevention and early help has been increased, with training available to professionals and staff working in Middlesbrough and Redcar & Cleveland. The Tees Safeguarding Procedures website is recognised by the inspectorate as a reliable and useful source of information and is well accessed by a diverse variety of people. The Tees Procedures group has reviewed and updated the Neglect section on the website as a result of the recent work undertaken.

Recently published serious case reviews have identified that "the risk of drug using parents actively giving drugs to their children" should be covered in all relevant multi-agency training. Public Health have co-ordinated and delivered multi-agency training which includes the signs and symptoms in children of drug ingestion, and clarity about what professionals should do if they suspect this is happening.

NEXT STEPS

- Embed and strengthen the understanding of Neglect including Adolescent Neglect by launching the Adolescent Neglect Framework in June 2021;
- Fully support the review of how key partners are dealing with Neglect;
- Review the Neglect Strategy.

PRIORITY 3: The Voice of the Child/Young Person

The aim is to create a clear focus on the needs and experience of young people.

The STSCP will develop and implement effective communication strategies with a focus on the participation of children and young people.

What has been done?

- Return home interviews collect and collate the views of the child/young person which is fed back via the quarterly reports to managers and professionals;
- The recently updated Tees VEMT referral forms now collect the views of the child/young person;
- A Voice of the Child section is now included in all multi-agency audits and findings fed back to the STSCP and partner agencies;
- Operation Encompass – relaunched internally renamed Cherish;
- Philomena Protocol launched, collecting the views of young people in care.

IMPACT

As a result of the multi-agency VEMT audit, the voice of the child/young person is collected via the VEMT Practitioner Group referral process. The Voice of the child is now part of all STSCP multi-agency audits and is reported directly back to partner agencies. Services are actively collecting the Voice of the Child.

NEXT STEPS

- Embed and strengthen the collection of children and young people views to inform planning and practice;
- Fully use the views already collected by agencies to fully inform the partnership about what it is like to be a child growing up in South Tees;
- The STSCP will increase engagement with children and young people via events both virtual and in person.

Children/Young People said:

"feeling listened to and understanding what was happening" (is important to me).

"Young people reported that their learning needs are often not met in school and that this has a major impact on their lives".

Taken from Barnardo's consultation with Young People.

PRIORITY 4: Working Together

The aim is to achieve excellent partnership working across all areas.

The STSCP will work with partner agencies to improve the link with other services in particular those services working with domestic abuse, parental mental health and substance misuse.

WHAT HAS BEEN DONE?

- The Tees Thresholds Document was reviewed in late 2019 to reflect the new Partnership arrangements for both South Tees Safeguarding Partnership and the Hartlepool, Stockton-on-Tees Safeguarding Partnership. The Thresholds document was reviewed in 2021 and due to the findings in the Middlesbrough inspection in 2020 and the improvement journey Middlesbrough agreed to an addendum document;
- The eLearning training programme has seen a substantial uptake from professionals working within children's and adult safeguarding;
- The STSCP has overseen the development of the Multi-agency Children's Hub (MACH) arrangements for both the Middlesbrough MACH and the Redcar & Cleveland MACH;
- The domestic abuse project SafeLives supports the development of the response to domestic abuse across Tees;
- Philomena Protocol implemented with all residential homes;
- The review of CDOP arrangements has been completed;
- A number of multi-agency audits have been completed and learning shared with the partnership;
- A number of rapid reviews and CSPR have been completed, confirming the growing strength in partnership working across the South Tees.

IMPACT

The STSCP training programme reflects the safeguarding priorities. This includes training around child sexual abuse, domestic abuse, neglect including adolescent neglect. ELearning is now accessible to professionals working in both adults and children's services as well as the voluntary and community sector. Learning from audits and reviews is impacting on planning and service delivery by changing procedure and practice (see Section 7 below).

It should be noted that, since the COVID restrictions from March 2020, the range of courses offered has reduced and face to face training has been replaced with remote learning.

NEXT STEPS

- Embed and strengthen the application of the revised thresholds across the partnership, to provide assurance that children receiving support as a child in need, receive focused intervention in a time appropriate to the child;
- Further improve Information Sharing, understanding the barriers to local information sharing and mitigating issues.

4 WORKING WITH OTHER PARTNERSHIPS

THE SOUTH TEES PARTNERSHIPS

The Partnership links strongly with other key bodies and the Relevant Agencies are listed in the new arrangements to be found at https://stscp.co.uk.

The arrangements include connections with the following:

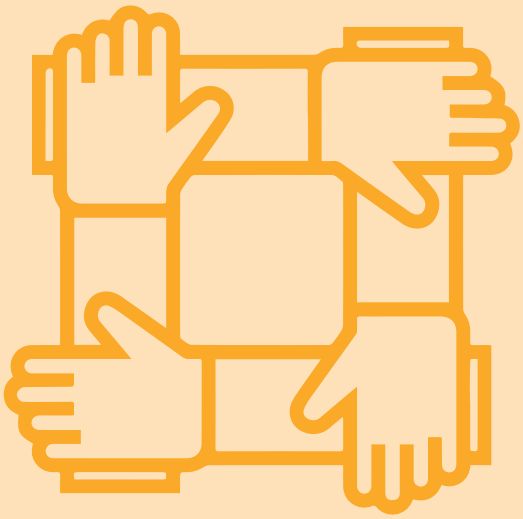
- The Tees Adult Safeguarding Board, with active discussion of inter-generational themes;
- Decision-making bodies and governance mechanisms working in both commissioning and provider organisations across:
  - Education across all ages and in all settings, whether publicly funded or not, and including Further Education provision.
  - Youth organisations in the public, private or voluntary sectors, including sporting and other citizenship organisations.
  - Both commissioner and provider bodies in health, in both physical and mental health settings. (The Clinical Commissioning Group are a Statutory Partner, providers being Relevant Agencies.)
  - All levels of social care provision, including early help and multi-agency safeguarding teams, those working with children in need, on child protection plans, involved in care proceedings or already in care, care experienced and care leaving.
  - Faith and other community bodies.

The Governance framework captures the business of the new partnership, how audit and data analysis captures progress and areas for development or renewed focus, and how the partnership relates to Middlesbrough and Redcar & Cleveland's other governance structures. This means that the partnership is clear about how and with whom it communicates agendas, decisions, priorities, successes, warning signs and lessons to be learned. Its reach covers a wide landscape across South Tees, the wider North East region, and then to national bodies.

The STSCP arrangements include the Elected Members for Children's Services and Education for both Middlesbrough Council and Redcar & Cleveland Council. Partners are called on to assist the STSCP in ensuring the voice of the community is heard in the partnership.

The importance of relating to children and young people and their representative and advocacy bodies is also considered in the way the partnership operates. Children and Young People are considered integral to the work of the STSCP and as such they will feature in the STSCP business plans and annual reports. The STSCP aims to actively engage and involve children and young people in all aspects of the partnership.

The STSCP aims to engage with peer review processes to enhance practice and procedures. The STSCP will continue to undertake routine multi-agency audits, reviewed by the partnership.



The following partnerships have a specific focus:

The Children and Young Peoples Partnership for Redcar & Cleveland and the Children's Trust for Middlesbrough - Both work to ensure effective services are delivered in the most efficient way to improve the lives of children, young people and families.

The Health and Wellbeing Board - Promotes integrated working between commissioners of health services, public health and social care services, to improve health and wellbeing.

The Community Safety Partnerships for both Middlesbrough and the Redcar & Cleveland - Tackles crime, disorder, substance misuse, anti-social behaviour and to reduce re-offending.

We have strengthened our joint working with a range of partnerships on shared or similar priorities. Examples include:

- Greater integration of the mental health and wellbeing agenda with the Health and Wellbeing Board and the development of a range of support aimed to reduce self-harm and suicide and to recognise the signs of adolescent neglect.
- Joint working with the Children and Young Peoples Partnership/Children's Trust to increase the voice of the child through work that includes supporting and helping to capture the voice of the child/young person.
- Working with the Community Safety Partnerships in respect of domestic abuse, alcohol misuse, substance misuse and counter terrorism (PREVENT duty). Aligning and improving work within sexual violence, sexual exploitation and female genital mutilation.

5 INDEPENDENT SCRUTINY

In establishing our arrangements for independent Scrutiny we have used the relevant guidance and the Six Steps for Partnership Arrangements (Pearce 2019) to ensure that we have a range of routes to understanding the impact of our work.

Independent scrutiny provides assurance in judging the effectiveness of the multi-agency arrangements to safeguard and promote the welfare of all children, including arrangements to identify and review serious child safeguarding cases. Whilst the decision on how best to implement a robust system of independent scrutiny is made locally, safeguarding partners should ensure scrutiny is objective, acts as a constructive critical friend and promotes reflection to drive continuous improvement.

Key duties are as follows, in compliance with Working Together 2018:

- Assess how well organisations work together to safeguard and promote the welfare of children and to hold each other to account for effective safeguarding.
- Contribute to the content of the safeguarding children partnership's annual report on the effectiveness of safeguarding arrangements, their performance and the effectiveness of local services.
- Assess the effectiveness of the help being provided to children and families including through universal and early help services.
- Assess whether the Four statutory safeguarding partners are fulfilling their statutory obligations.
- Scrutinise the quality assurance activity (including reviewing statutory and local reviews, the results and findings of multi-agency case file auditing, and Middlesbrough and Redcar & Cleveland's processes for identifying lessons to be learned from tragedy and crises in children's lives).
- Scrutinise the effectiveness of training, including multi-agency training, whose aim is to equip staff to safeguard and promote the wellbeing and welfare of children.
- Assess the effectiveness of safeguarding arrangements.
- Provide a rigorous, evidence based and transparent assessment of the extent to which partners and relevant agencies are fulfilling their statutory duties to keep children safe.
- Evaluate arrangements for the operation of the safeguarding partnership and attend a range of meetings and activities including visits to partner and relevant agencies.
- Support the implementation of findings and outcomes from safeguarding reviews.
- Assess whether effective performance management, audit and quality assurance mechanisms are in place within partner organisations which will support the four safeguarding partners to fulfil their statutory objectives, and which will enable the partnership to identify and measure its success and impact.
- Ensure that the voices of children, young people and their families are appropriately represented and heard in the work of the partnership.
- During the last year we have invited independent scrutiny of our business as follows:
  - The elected members for children have attended the partnership meetings.
  - Independent authors have been appointed for the Child Safeguarding Practice Reviews
  - Independent auditors have undertaken multi- agency case audits
  - An Independent Chair was appointed in March 2021 and a number of changes such as revised governance structure and work program were made immediately and are ongoing.
  - An independent agency has been involved in the evaluation of training.

THE INDEPENDENT CHAIRS WORK FOR 2021-22

As well as chairing the Executive and leading two Partnership days per year, the Independent Chair will also use the Minutes from meetings, and the contents of a wide range of plans and reports, to help to form a comprehensive and informed view of the progress being made on embedding the multi-agency safeguarding arrangements.

The Independent Chair role involves providing feedback on key documents commenting on effectiveness and what has been working well; for example, the importance of more effective multi-agency ownership and a shared understanding of neglect; the revised case review processes; the importance of a joined up approach to listening to children and young people through the listening standards.

The Independent Chair has provided independent advice on case reviews including communication and liaison with the national Child Safeguarding Practice Review Panel and read and commented on reports and notes from the Learning & Development Group and the Quality & Performance group and commented on the evidence provided and current performance.

6 KEY PRACTICE THEMES AND MESSAGES - THE 'STUBBORN CHALLENGES' AND WHAT WE ARE DOING ABOUT THEM

RECOGNISING AND BUILDING ON GOOD PRACTICE

The STSCP have identified some key actions and themes for development through the CSPRs undertaken this year. For instance:

- The introduction of a quality assurance framework; although impact of COVID and capacity on audits has been an issue;
- The development of a new framework/ guidance to address adolescent neglect, we plan to revise the Neglect strategy with a view to a Tees approach, providing further training and guidance;
- Agreed the adolescent neglect guidance;
- The professional challenge and escalation guidance has been updated in response to learning from Case Reviews;
- The Head Trauma in Infants procedural guidance has been reviewed and updated in response to learning from Stork Child Safeguarding Practice Review;
- The Tees VEMT Strategy has been updated, bringing it in line with the latest agendas such as criminal exploitation and modern day slavery;
- The STSCP has increased learning opportunities e.g. using virtual events and online briefings.
- As a result of the CSPR learning the guidance on how to complete chronologies and ecograms for all agencies has been updated and provided.
- The Learning & Development group led by the Principal Social Worker for Middlesbrough are reviewing the learning across all the recent Child Safeguarding Practice Reviews and a report will be produced later this year.
- As a result of recurring themes in some reviews a challenge process is being developed to review historic reviews and how well the learning was embedded, this work will commence summer 2021.
- We are also planning the establishment of a challenge process at the point at which CSPR action plans are signed off as being achieved. This will be a supportive process and will look at the impact on children and families and ensure that STSCP is compliant with Working Together 2018.
- The use of the electronic Survey 123 to allow feedback and evaluation of training is planned for roll out in July 2021.
- Barnardo's Tees Valley have created a video about how they will support children and young people who have been subject to exploitation.
- Both MBC and RCBC LAs were challenged by Ofsted on the implementation of their shared threshold document (ILACS 2019) therefore in response we have reviewed the Threshold of Need "Providing the Right Support to Meet a Child's Needs" across Tees. Middlesbrough has now adopted an addendum to the Tees Threshold document in order to strengthen its improvement journey. Redcar & Cleveland are remaining with the Tees model as it meets their practice needs.

7 LEARNING FROM REVIEWS

In compiling this report we have used the National Child Safeguarding Practice Review Panel Annual Report 2019 -2020 which says:

"Safeguarding partnerships may wish to examine their use of written agreements and assure themselves that they function in the way in which they are intended. Also, continue to focus on key themes e.g. risk assessment and decision making, information sharing, late or no escalation of concerns, over optimistic thinking, parental mental health or substance misuse."

In this year, STSCP has led eight Rapid Reviews, six CSPR and one Learning Review (LR). The reasons for the Rapid Reviews were around Neglect (lack of supervision), Adolescent Neglect, Head Trauma in Infants and Criminal Exploitation.

Practitioner learning events were held for each review and 95 practitioners attended in total (see table below for multi-agency attendance information):

CSPR	Practitioner Attendance	Agencies Represented
Stork	10	Health Visitor, R&C, BPAS, School Nursing & Health Visiting , Specialist Nurse, STHFT, DCI, Cleveland Police, Service Manager, R&C MACH,
Daniel	22	Social Worker, Redcar & Cleveland Children's Services Assistant Team Manager, Liaison & Diversion Team, TEWV Safeguarding Lead Education, Redcar & Cleveland Operations Manager (Redcar), South Tees Youth Offending YOS Worker, National Probation Service School Nurse, Redcar & Cleveland's SN & HV Service Detective Inspector, The Complex Exploitation Team, Police
Liam	21	Middlesbrough CAMHS, Tees Esk & Wear Valley NHS Foundation Trust Detective Constable, Child Abuse / Vulnerable Adults Unit, Cleveland Police Interim Designated Nurse LAC/CIC, NHS Tees Valley Clinical Commissioning Group Team Manager, Middlesbrough Children's Services Specialist Nurse, Safeguarding Team, South Tees Hospitals NHS Foundation Trust Family Casework Team Manager, Stronger Families, Middlesbrough Council Locality Manager, School Nursing & Health Visiting, HDFT Health Visitor, 0-19 Service, Harrogate & District NHS Foundation Trust Locality Manager, Health Visiting & School Nursing Services, HDFT
Fred	25	Case Manager, South Tees Youth Offending Service South Tees Hospitals NHS Foundation Trust Social Worker, Hartlepool Children's Services Assistant Team Manager, Stronger Families, MBC Team Manager, Middlesbrough Children's Services School Nurse, Harrogate & District NHS Foundation Trust Child Abuse/Vulnerable Adults Team, Cleveland Police Social Worker, Hartlepool Children's Services Senior Practitioner, Early Help, Middlesbrough Council Doctor, Forensic CAMHS, TEWV Senior Practitioner, Early Help, Middlesbrough Council Principal Social Worker, Hartlepool Children's Services Risk & Resilience Manager/Chair of Middlesbrough VEMT
Kingfisher	19	Social Worker, Safeguarding & Care Planning, Middlesbrough CSC Work Readiness Practitioner, Children's Care/Early Help, Middlesbrough Health Visiting/Locality Manager 0-19 Service, HDFT Practice Business Manager, The Coulby Medical Practice Team Manager, Pathways Team 2, Middlesbrough Children's Services Detective Sergeant, Child Abuse/Vulnerable Adults Unit, Cleveland Police Doctor/General Practitioner, The Coulby Medical Practice Professional Development & ASYE Manager, Middlesbrough CSC Independent Reviewing Officer, Review & Development Unit, Middlesbrough Doctor/General Practitioner, The Prospect Surgery
Total	95	

FROM THE RECENT REVIEWS WE HAVE NOTED THE FOLLOWING:

REVIEW 1 - KEY LEARNING CSPR STORK

The South Tees Safeguarding Partnership commissioned a child safeguarding practice review (CSPR) to consider systems and practice within and between partner agencies in the South Tees area specifically with regard to the assessment and safeguarding of infants where there are few known pre-disposing risks or vulnerabilities. The headline learning was in regard to bruises in non-mobile babies, involving fathers, late identification of pregnancy, and professional objectivity.

The review looked in detail at two babies in different families. Both were 14 weeks old when they received head injuries. Baby 1 lived with both parents and a sibling. Around two months prior to the injuries a bruise was observed on the baby's forehead. Baby 2 was in the care of their father at the time of the incident. The parents were no longer in a relationship. The mother told the midwives and health visitor that there had been controlling behaviour from the child's father in their relationship.

FATHERS/CO-PARENTS

- Advice in key areas such as safe sleeping and safe handling needs to be provided and reinforced to both parents, including parents who do not live with the baby if they are to have contact.
- Fathers need to be seen as equal parents in order to ensure that the needs and risks to a child are met and known. Professionals need to give separate consideration to how they can meaningfully engage with fathers, including those who do not live with the child. This is a challenge in universal cases.
- Professionals need to be aware of research on the impact of having responsibility for a new baby on fathers as well as mothers.

INFORMATION SHARING AND OBJECTIVITY

- Without information being shared directly when the responsibility for a new baby transfers to a health visitor, it cannot be guaranteed with current systems that potentially important information will be known by them.
- Professional curiosity is essential when there are issues in a case that may lead to additional needs or risks, and professionals should have an open mind to ensure they do not make assumptions about how a family will cope.
- The benefits of employing support workers from within communities need to be balanced with the risks when there is a potential child protection issue for someone living and working in the area.

BRUISING/MARKS IN NON-MOBILE BABIES

- Family members should not have unsupervised contact with their child in hospital if a non-accidental injury may be the reason for the attendance.
- When professionals are aware of even a small bruise on a very young child, they need to recognise it might be a warning injury. They need to take action and make appropriate referrals, explaining to parents that they HAVE to do this and follow the Bruising in Non-Mobile Babies policy. https://www.teescpp.org.uk/specific-issues-that-affect-children/bruising-on-non-mobile-babies/

WHAT IS THE PARTNERSHIP DOING?

- The current policy in regard to Concealed Pregnancy is being reviewed to consider what professionals should do if a mother presents very late in her pregnancy, and what needs to happen if the delay in identifying the pregnancy means that a planned termination cannot take place.
- Consideration is being given to how the partnership can influence the necessary cultural and systemic changes across all partner agencies regarding the need to better consider fathers and secondary carers in families.
- Asking partner agencies to consider whether professionals have the knowledge of and use the Injuries in Non-Mobile Babies policy.

REVIEW 2 - KEY LEARNING CSPR DANIEL

Daniel was a child in the care of Redcar and Cleveland Borough Council when, aged 17 years old, he was the victim of a shooting, believed to have been made in retaliation for an assault committed by Daniel a few days earlier. Daniel was taken to hospital where, as a result of his injuries, his left leg was amputated below the knee.

Between 2016, when Daniel was accommodated by the local authority and March 2020, when he sustained his life-changing injuries, interventions by key agencies were not able to keep Daniel safe; professionals struggled to engage Daniel and he persistently rejected services aimed at reducing the risks to which he was very clearly exposed.

WHAT DID WE LOOK AT?

The review team identified five lines of enquiry, which provided a framework around which the review team could appraise practice and safeguarding systems:

1: How well did agency assessments contribute to a collective understanding of Daniel's needs and vulnerabilities and the risks to which was exposed.

2: To what extent were interventions and plans effective in meeting Daniel's needs and keeping him safe?

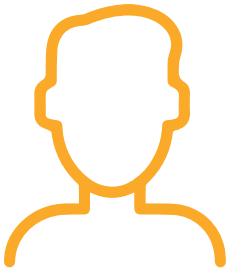
3: How did professionals manage and respond to Daniel's refusal to engage with them and the services they offered?

4: How well did agencies collaborate and work together?

5: To what extent were national and locally agreed pathways effective in keeping Daniel safe?

WHAT ARE THE MAIN THINGS WE FOUND: CHILDREN/YOUNG PEOPLE

- Experiences and trauma in children often affects behaviour in adolescence.
- Risk assessments must include the risks posted by past experiences as well as by current behaviour.
- Knowledge of the evidence base of risk indicators for adolescents who die or are harmed by their own actions is needed if professionals are to identify risk and respond accordingly.
- Children's plans must have SMART objectives and be regularly scrutinised, to ensure they are effective and reduce vulnerability.
- Being part of a 'gang' can create a sense of belonging and safety which cannot always be provided by professionals.
- Adolescents at risk need professionals who want to understand their world and the decisions they make.



WHAT ARE THE MAIN THINGS WE FOUND: PROFESSIONALS

Professionals are skilled at communicating and gathering information but need more help with analysing and evaluation.

- Curiosity and inquisitiveness should be part and parcel of professional practice.
- Robust managerial oversite helps prevent drift.
- Multi -agency systems to record and share significant events are needed to support decision making.
- Multi-agency meetings must well chaired, structured, and purposeful to avoid a false impression of progress.
- A shared responsibility.
- The young persons lived experience is not always well understood by professionals.

WHAT ARE THE MAIN THINGS WE FOUND: FAMILIES

- All men in a child's life are important and need to be included in assessments. Some will pose risks, some may be assets to the family and some may incorporate aspects of both. This is true of birth related and non-birth related men.
- Professionals need to be able to identify what needs to change for a child and if parents/ carers have the ability to make and sustain that change.
- Coping with challenging and aggressive behaviour in young people is scary and tough for families and professional support is not available around the clock.

WHAT HAVE WE DONE?

- Developed and implement a multi-agency framework for work with vulnerable at-risk adolescents.
- Ensured that all partners provide, support and supervision to their staff as well as training on adverse experiences in childhood, trauma and Criminal Exploitation
- Made sure that meetings, LAC reviews and Child Protection meetings are robust and lead to improved and timely outcomes for children and young people.
- Create opportunities to listen to what YP say they need.

REVIEW 3 - KEY LEARNING CSPR FRED

"Fred" is an older teenager who was found unconscious in the street after what is believed to be an accidental overdose. Fred lived with Mother and Stepfather. Until 6 months before this Fred had been living with Paternal Grandparents under a Special Guardianship Order due to longstanding concerns about neglect. The relationship between Fred and his grandparents had become strained, which prompted him to move to live with his mother.

We looked at four areas;

1. Responding to mental ill-health, domestic abuse and substance misuse
2. Engaging, safeguarding and supporting teenagers
3. How practitioners and agencies worked together; referrals, assessments and plans
4. Assessing the role of extended family members

WHAT ARE THE MAIN THINGS WE FOUND: CHILDREN/YOUNG PEOPLE

- It is helpful for practitioners to be aware of research findings about the main barriers to children making disclosures: emotional discomfort; worry about the family knowing; underestimating the seriousness of the concern; threats; fear of not being believed and fear of loss of control over decisions.
- Both the individual and cumulative impacts of incidents of domestic abuse and/or adult substance misuse or overdoses on children of all ages should always be considered especially when a child is directly affected.

WHAT ARE THE MAIN THINGS WE FOUND: PROFESSIONALS

- Professionals sought and responded to Fred's expressed views including when these changed
- Emotional abuse and neglect of adolescents tends to be less readily recognised by professionals than that of younger children
- When children subject to Special Guardianship Orders return to the care of their parents, consideration should be given to calling a strategy meeting

WHAT ARE THE MAIN THINGS WE FOUND: FAMILIES

- Children and extended family members may each need advice, support and encouragement to repair relationships; this should be given early consideration and kept in mind where the relationship is a significant one.
- It is important to obtain information from GP records about all adults involved in children's care; when undertaking S47 enquiries, preparing for Initial Child Protection Conferences or conducting assessments (when consent maybe needed).

WHAT HAVE WE DONE

- Ensured any plan to safeguard a child starts from their perspective on what being safe physically and emotionally means to them.
- Promote the use of evidenced based tools to help practitioners better understand family dynamics and support for children.
- Raised awareness about the legal implications of Special Guardianship Orders; parental responsibility and potential eligibility for support services.
- Ensured information about parent figures is obtained from GP records at all stages of the child's journey.
- Ensured that local response to neglect adequately focuses on the needs of adolescents.

REVIEW 4 - KEY LEARNING CSPR LIAM

Liam, nearly three years old, who presented at hospital having ingested multiple substances including cocaine. Liam's father had had been at home caring for Liam. Paternal grandmother brought Liam to the hospital and claimed that he had fallen from a ladder. Tragically, whilst Liam was in the hospital Father took his own life. Liam along with his siblings was subject to a child protection plan at the time of the incident. He recovered and was discharged into the care of the local authority.

There had been significant agency involvement since 2005, Mother had seven children, four living in family home. Neglect was a concern, as was ASB and criminal activities. Liam had a health condition and development reviews identified concerns. Domestic abuse was evident which may have impacted parenting capacity. Both parents misused drugs and alcohol for many years. Mental health issues were a factor for both parents. The detailed history was considered by the review.

MAIN THEMES FROM THE REVIEW

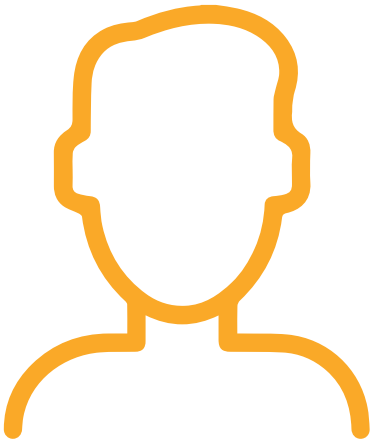
- Embedding learning from previous similar reviews.
- Prioritising the voice of the child and lived experience.
- Understanding and professional curiosity of the impact of abuse upon Mother and parenting capacity.
- Identifying, assessing and responding to parental substance and alcohol abuse.
- Ineffective multi-agency working.
- Missed opportunities in identifying risk indicators and not recognising the cumulative picture or contextual risk factors.
- Disproportionate focus on the risks and issues of parents and other siblings, and lack of professional curiosity in establishing Fathers parental status.
- Missed opportunities for collective oversight and joint decision making at key points.

WHAT WAS FOUND

- How learning from previous reviews and this review will be embedded into practice.
- Processes, assessments, thresholds and care plans to include:
  - the voice of the child and their lived experience should be evidenced and prioritised.
  - involve relevant partner information, including historical context and all cumulative and contextual risk factors.
  - changes to parenting capacity takes into account historical information and the impact of impact of mental illness, domestic abuse, drugs/ alcohol, trauma and bereavement.
- Protocols and guidance for future cases around safe storage, safe use and the risks of ingestion of drugs to ensure adequate management, discussions, assessments by parents and partners.
- Multi-agency meetings involve all partners and information is effectively shared between and within organisations.
- Develop guidance and raise awareness with regard to:
  - cumulative and contextual factors when interpreting the voice and lived experience of the child and involves wider partners.
  - extend learning to increase awareness of the patterns and impact of domestic abuse to facilitate safe and open conversations with victims of abuse.
  - Professional curiosity and responding to disguised compliance, parental coping mechanisms and failure to engage with partners.
- Management oversight evidences professional scrutiny and challenge and the difference both make to outcomes for children is evidenced.

WHAT ARE WE DOING

- The CSPR's over the past two years are being reviewed and a challenge process is being developed.
- Assessment of males in families is being reviewed and questionnaire has been circulated as part of another review.
- Review of the communication and training regarding ingestion of illicit substances is being implemented.



REVIEW 5 - KEY LEARNING CSPR KINGFISHER

This child safeguarding practice review (CSPR) was to consider systems and practice within and between partner agencies in the South Tees area specifically with regard to the neglect. The headline learning was in regard to knowing and considering the parent's history and vulnerabilities, recognising and understanding the causes of neglect, pre-birth assessment, involving fathers, the role of pathways workers, professional challenge and impact of COVID

The review looked in detail at two children in different families that met the criteria for a CSPR. The children are to be known as Lucy and Mia. Lucy was two years old when she was injured in an accident that may have been contributed to by parental neglect. Her mother was receiving support as a care leaver and Lucy was on a child in need (CIN) plan at the time of the incident. Mia was less than a month old when she died. The cause of death is not yet known. Mia was on a child protection plan (CPP) due to neglect concerns for her older siblings. Her father misuses a number of drugs and is on a treatment programme.

KEY LEARNING

- When assessing if children require additional support or if they are at risk, it is important to always consider the parent's history and on-going vulnerabilities and the impact on the children.
- A pre-birth social work assessment should be undertaken in cases where there are predisposing risks and vulnerabilities that warrant involvement from children's social care. This includes if there is involvement with the parent or other children in the immediate family. All professionals need to be aware of this procedure and should challenge a lack of assessment. If no assessment is to be undertaken when the parent is receiving a service from pathways, as could be appropriate, there needs to be clear reasons recorded about why this is the case.
- Clarity is required regarding the roles of all professionals involved with a family and assumptions should not be made. If a parent is receiving support from a Pathways worker, this does not mean they will be providing support to the care leaver's child or specifically monitoring their wellbeing. They may have no contact with the child.
- It is important that professionals understand the need to meaningfully consider and involve fathers in assessments and plans in respect of their children.
- Professionals need to use specific neglect tools and ensure that they understand the root causes of neglect and the impact on a child over time.
- There is a need for transparent and sensitive management of auditing activity in local authorities with improvement plans. There also needs to be a system in place to consider the outcome of actions from audits to ensure they have achieved what was required.
- Professionals need to be supported to robustly challenge themselves, each other and parents/carers when it comes to managing cases of neglect.
- Covid-19 has led to additional challenges locally for this complex area of safeguarding.

WHAT ARE WE DOING?

The STSCP is currently reviewing its Neglect Strategy and will relaunch it shortly.

Cooperation with the corporate parenting board to discuss the concept of 'Corporate Grandparents' to encourage a more positive view of support when care leavers have children of their own.

Consideration is being given to how they can ensure that a child's father is always considered and involved.

OVERALL ANALYSIS OF **REVIEWS AND PROCESS**

Analysis of the partnership recommendations from reviews over the last year has identified that the practice areas highlighted in partnership recommendations were:

- Managing Risk (ten recommendations).
- Neglect (nine recommendations) effective child protection practice i.e. changes in practice introduced.
- Children's Mental Health & Emotional Wellbeing (one recommendation).
- Disguised compliance and/or non-engagement of Families and or young people.

Recent referrals and reviews have highlighted the following new emerging issues:

- Age assessments
- Appropriate support for young people who have/are being exploited
- Hidden males
- Placements for at risk teenagers

Referral Reason	2019-2020	2020-2021
Neglect	1	2
Adolescent Neglect	1	1
Criminal Exploitation	0	1
Head Trauma in Infants	2	0
Child Death	3	3
Child Substance Ingestion	0	1

Of the eight referrals for consideration as CSPRs in 2020-2021, one was not known to Children's Services and seven were known to Children's Services in Middlesbrough or Redcar & Cleveland at the time of the incident. Three of the young people were Looked After by the Local Authority, two of the children were the subject of a Child Protection Plan, one was previously the subject of a Protection plan and one was a Child In Need.

Status	2020-2021
Looked After by the Local Authority	3
Child Protection Plan	2
Previous Child Protection Plan	1
Child In Need Plan	1
Not Known to CSC	1
TOTAL	**8**

Learning is shared via a range of methods e.g. seminars, conferences, 7 minute briefings (see website) reflective discussions and STSCP newsletters.

Number per Year	2019-2020	2020-2021
Referrals	7	8
Rapid Reviews	3	7
Learning Reviews	2	0
SCR/CSPR	3	6
NHSE Review	1	0
DHR involving Child	1	0
Average spend on Lead Reviewer per review CSPR/LR	7,237	4,705

Cost: Although the average cost of a Lead Reviewer has decreased compared to the last financial year, the Business Unit/Learning & Development Group has managed to reduce further the overall costs of the reviews without any reduction in the quality of the learning by undertaking themed reviews such as the Stork Review on head trauma in infants and the Kingfisher Review on a theme of neglect.

Time: The length of time taken to complete a review has increased in 2020-21. Once again, the use of the Learning & Development subgroup members has had an impact on reducing the number of days taken to complete as their availability and flexibility has to be noted.

The NEPO (North East Procurement Organisation) process did not work initially for the reviews as the process rendered no reviewers available and permission was therefore sought for the STSCP to seek procurement outside of this arrangement. Reviewers were found on recommendations from the other North East Partnerships.

COMMENT FROM THE INDEPENDENT SCRUTINEER

It is clear from my discussions that every effort was made to engage reviewers who could write the concise, clear and solution focussed reports which are required. Every effort was made to comply with timescales despite the challenges of lockdown restrictions.

STSCP welcomes the approach being taken by the National Child Safeguarding Practice Review panel including the appointment of links at local level.

The reviews which have been referred to have been signed off by the STSCP Executive. Each review is accompanied by an action plan which is being monitored by the Learning and Development sub group, with an emphasis on making sure that change has taken place to reduce the risk of a recurrence.

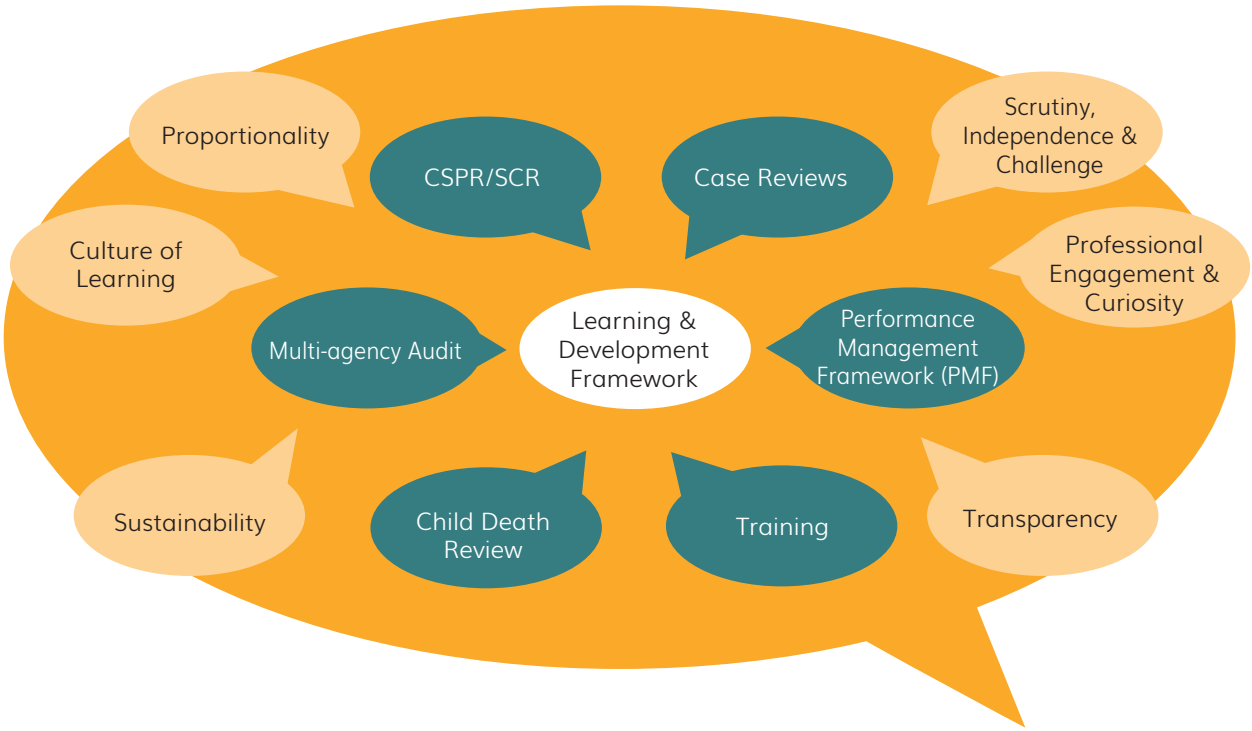
A report is being written which analyses any themes which may be evident across these serious cases and which looks at how STSCP can assure itself that action has been taken.

The work of undertaking reviews on serious cases is very time consuming and demanding of the professionals who take part in the process as well as of the authors. It is really important that the effort that has gone into the reviews makes an impact on multi-agency front line practice. I have seen evidence of that taking place in two events for practitioners which were attended by over one hundred people. On Child Exploitation and one on Adolescent neglect. Both events included powerful presentations from adults who had been groomed and abused as children and also contributions from local experts. The discussions among practitioners were captured and were very positive, provided evidence of the impact on practice of high quality multi-agency events of this nature.

8 LEARNING & IMPROVING PRACTICE

We have reviewed and implemented the STSCP learning and improving practice framework and the subgroups of the partnership will oversee this.

STSCP Learning & Improving Practice Framework



ENHANCING OUTCOMES IMPROVING PRACTICE

The STSCP Learning and Improvement Framework sets out the structure within which the South Tees Safeguarding Children Partnership delivers its priorities. It is underpinned by two main aims:

1. To make the voice of the child central to everything that they do,

2. To achieve the two outputs of:
   - Enhancing outcomes for children/young people, and
   - Improving practice.

These aims will be achieved by:
- Consolidating what works well, and
- Improving what needs to improve.

Principles
1. Culture of Learning
2. Proportionality
3. Scrutiny and Independent Challenge
4. Professional Engagement and Curiosity
5. Transparency
6. Sustainability

The STSCP Learning & Improving Framework can be found on the STSCP website on the following link:

Key documents | South Tees Safeguarding Children Partnership stscp.co.uk

There is a multi-agency scorecard of key performance measures, charts and a short narrative for each measure is produced on a quarterly basis. An outcomes summary is produced for the Safeguarding Children Partnership and Executive.

9 WORK OF THE STSCP SUB GROUPS

LEARNING & DEVELOPMENT GROUP (L&D)

The L&D oversees the quality assurance of all Serious Case Reviews/Child Safeguarding Practice Reviews and other Learning Reviews to monitor and evaluate SCR/CSPR/Learning Review action plans and to advise the STSCP Key Partners if the criteria for commissioning a CSPR, as outlined in Working Together to Safeguard Children, may have been met.

WORK TO DATE:

- The STSCP has commissioned six reviews over this reporting period and the L&D has had an overview of the process from initial decision making to implementation of review recommendations.
- L&D is monitoring the multi-agency action plans pursuant to the reviews and reviewing single agency action plans progress.
- Monitored the outcomes of national reviews of relevance to Middlesbrough and Redcar & Cleveland

QUALITY & PERFORMANCE GROUP (Q&P)

The group monitors child protection and safeguarding activity on an inter-agency basis on behalf of the STSCP in order to identify areas of concern to the Board and promote continuous improvement.

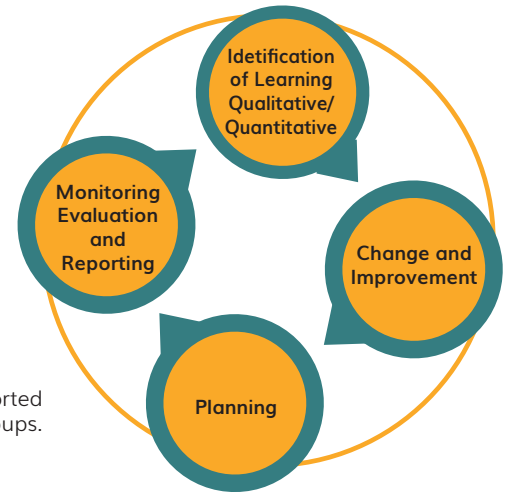
WORK TO DATE:

The group has reviewed and responded to the Tees Performance Framework and reported to the STSCP.

- Q1, Q2, Q3 and Q4 data reviewed
- Q1, Q2, Q3 and Q4 summary reports reported to the board

The Q&P group has coordinated the list of audits below and has provided oversight of the associated action plans developed in response to the audit findings:

- Middlesbrough JTAI Themed Exploitation Audit May 2020
- Section 11 audit completed, moderation process planned for Sept 2021
- Audit of Child Protection meetings
- Audit of Children in Care meetings
- Audit of VEMT Practitioner Group meetings



The work of the STSCP is supported by a number of sub groups.

TEES-WIDE GROUPS

TEES-WIDE POLICY & PROCEDURES GROUP

This group is responsible for reviewing and amending existing policies and procedures and for developing new ones based on experience, research findings, government and professional guidance and the recommendations of case reviews. There is a clear and effective structure and process in place which has resulted in a productive year.

Procedures agreed or reviewed during 2020/21 so far are as follows:

- Bruising on non-mobile Baby
- Early Help
- Transfer In / Out
- North East Regional Transfer Protocol for CIN Modern Slavery / Human Trafficking Assessment
- Child Living at Home Subject of Interim or Final Supervision Orders
- Philomena Risk Assessment (Forms)
- National Referral Mechanism (NRM) Guidance
- Tees-wide Child Exploitation Screening Tool
- Tees Child Death Review Process
- Neglect
- Child Protection Plan & Core Group
- Think Family Guidance (from TSAB)
- Child's Chronology - Policy, Procedure and Practice Guidance on Single-Agency and Multi-Agency
- Partnership Information Form (Police)
- Safer Referral Form
- Accessing Help and Services page
- Tees Multi-agency Information Sharing Protocol
- Professional Challenge and Resolution of Professional Disagreement
- Safeguarding the Unborn Baby Procedure

The Tees Safeguarding Procedures website continues to be monitored and updated as appropriate.

TEES CHILD DEATH OVERVIEW PANEL

The purpose of the Child Death Overview Panel (CDOP) is to review and/or analyse in order to identify any matters relating to the death, or deaths, that are relevant to the welfare of children/young people in Tees Valley or to public health and safety, and to consider whether action should be taken in relation to any matters identified - See Section 11 What Happens when a Child Dies.

TEES VULNERABLE, EXPLOITED, MISSING AND TRAFFICKED (VEMT) GROUP

This is a STSCP priority area and takes a strategic overview of this key area of work and directs the implementation of complementary strategies across the local operational groups.

WORK THIS YEAR:

- Membership and terms of reference reviewed and refreshed.
- Four task and finish groups have been set up in line with the four key areas in the strategy these are:
  - Conceptual Safeguarding
  - Communication Group
  - Training Group
  - Transitions Group
- The VEMT Strategy and Action Plan has been reviewed and updated.
- The VPG Screening Tool has been updated.
- The Tees Missing from Home and Care Protocol has been refreshed.
- Tees Performance Management Framework data in relation to VEMT has been reviewed to ensure consistency across Tees and enable improved analysis.
- Voice of the Child increased focus with Barnardo's "Tees Youth Take action project" and the Blossom Project questionnaires, changes to the audit tool to include voice of the child, obtaining the views of those exiting the VEMT process.
- An audit regime of VEMT cases in place to inform best practice and learning.
- CSE virtual training were held with attendance of 62 people from a wide range of agencies, whilst 504 professionals completed e-learning courses across the Tees.

TEES PERFORMANCE MANAGEMENT FRAMEWORK

In 2016 the Tees Performance Management Framework (Tees PMF) was introduced across the Tees to enable the review a much broader range of data on a quarterly basis.

The Tees PMF dataset contains a number of key indicators covering a wide range of subjects including:

- Child Protection Activity.
- Children In Care.
- VEMT (Vulnerable, Exploited, Missing, Trafficked).
- CAMHS (Children and Adolescent Mental Health).
- Accident and Emergency.
- Domestic Violence.

The data is divided into the following sub sections:

- Enable children/young people to live healthy lives.
- Providing the right support for children/young people.
- Ensuring children/young people are safe.

The dataset and summaries are shared with STSCP via updates at the partnership via the Quality & Performance report and updates by the TPMF team to the Quality & Performance group meetings and is used to:

- Identify any changes, patterns or trends that require either a single or multi-agency response.
- Identify what actions agencies may need to take in relation to changes in data.
- Identifying priorities for the STSCP multi-agency audit schedule.

OTHER TASK-LIMITED WORKING GROUPS

The STSCP appointed task and finish groups in this period for specific tasks
such as:

- Deep Dive into Teenage Pregnancies.
- Review of the Tees Threshold Document in line with the Middlesbrough threshold addendum.
- Review the Governance and membership of the STSCP.
- The development of the STSCP scorecard.

10 PERFORMANCE MONITORING & QUALITY ASSURANCE

The STSCP continually monitors the quality, timeliness and effectiveness of multi-agency practice through the Tees Performance Management Framework.

Where gaps are identified, implications for the STSCP are considered and any agreed actions are monitored through the STSCP.

The STSCP Quality and Performance group (Q&P) have an agreed work program and are developing a performance scorecard. Performance and progress is reported at the Q&P group level and collated through the Q&P up to the STSCP to monitor and challenge.

ONGOING QUALITY ASSURANCE

- Monitor partner compliance with the statutory requirement to have effective safeguarding arrangements in place (Section 11);
- Carry out multi-agency audits and identify lessons to be learned and make recommendations for future improvement and feeding into STSCP training;
- Multi-agency audit reports to inform the STSCP of the quality of work being undertaken and its impact on outcomes for individual children and young people;
- Overview of findings and action plans from multi-agency audits to monitor and review practice;
- The use of the STSCP performance scorecard

Serious Case Reviews/Child Safeguarding Practice Reviews are published on the STSCP website for a period of 12 months.
Outcomes and findings feed into our performance structures to promote a culture of continuous learning and improvement across the partner agencies of the STSCP.

The Tees Child Death Overview Panel share their key learning from child deaths. They monitor and challenge agencies for the completion of recommended identified actions and publish a separate CDOP annual report.

MULTI-AGENCY AUDITS

The Section 11* audit conducted in May 2020 took the form of a self-assessment format.

To free up resources to support the JTAI audits, the STSCP agreed to conduct Section 11 audits on a two-yearly cycle with the next Section 11 audit to be completed in 2022/23.

Other multi-agency audits undertaken in 2020/2021:

- JTAI Exploitation Audit
- CP Meeting Audit
- Child in Care Meeting Audit
- VPG Meeting Audit

*Section 11 Audit is an audit of key partners safeguarding compliance in line with Working Together.

11 TRAINING & COMMUNICATION

TRAINING

Under the new arrangements, the training function of the partnership is coordinated by the L&D group.

The L&D group must therefore ensure that appropriate high quality multi-agency training is provided for statutory agencies that reflect STSCP policy and procedure, enhances knowledge and skills and promotes joint understanding of child protection work.

In light of the restrictions caused by the COVID19 lockdown, all taught courses were cancelled from March and resumed via a virtual model in October 2020. This is proving successful.

The new eLearning product MeLearning was launched in May 2020 and is also proving popular.

WORK TO DATE:

In total from April 2020 to March 2021, 712 candidates attended virtual training sessions. The new Melearning product has enhanced the online training experience for professionals and to date over 15,000 online courses have been completed.

Multi-agency Threshold training has been delivered to 64 candidates; Child Sexual Exploitation training was delivered to 62 applicants; and 476 individuals undertook Core 3 training in this period.

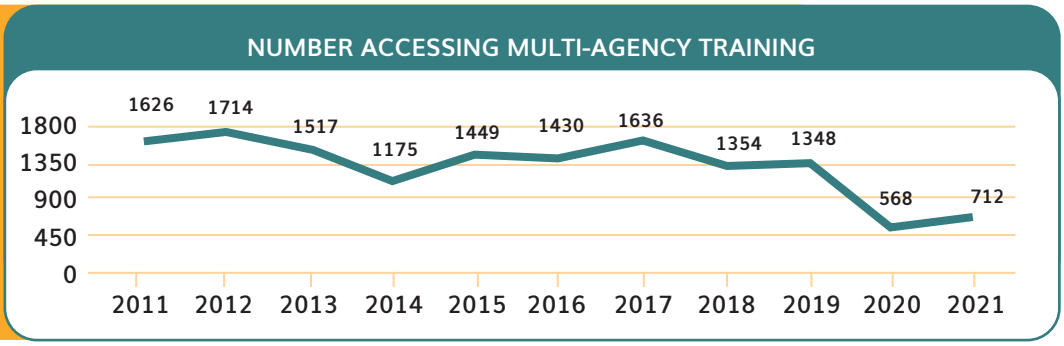
The STSCP delivered 10 Core 3 safeguarding courses and 12 Core 3 update courses and 2 CSE courses in 2020/21 as part of the multi-agency training program before COVID19 lockdown. The training courses received very positive feedback, with 93% of attendees marking the training as good or excellent.

E-LEARNING COURSES

The STSCP provided access to a full range of e-learning courses this allows partners the ability to offer up-to-date safeguarding training to all staff through the unlimited licenses available for each course. Courses include:

- Safeguarding Children and Young People from Abuse by Sexual Exploitation
- Domestic Abuse
- Awareness of Child Abuse and Neglect
- Collaborative Working: A Whole Family Approach

CHART 1: TRAINING ACCESS 2011-2021



Note: Due to the impact of Covid no face to face training was delivered in this period.

TRAINING IMPACT

Candidates were asked to list three ways that this training will influence your future practice?

CANDIDATE 1

1. I know how to challenge now when I don't agree with something.
2. I know I am able to report a person in trust and where to go to do so.
3. To get the full picture when making referrals and involve as much information as possible not just simple descriptions i.e smelly, dirty include the scent and how the clothes are dirty and how long it has been happening for.

CANDIDATE 2

1. A reminder on the importance/ benefit/ significance of the Tees CP website for referrals and Toolkits.
2. Information around Annie in pharmacy; domestic abuse.
3. A reminder that bruises on a non-mobile baby is a pathway to CP.

CANDIDATE 3

1. Make me more confident discussing any concerns with other professionals.
2. Allow me to change my writing style so it doesn't "blame" the child.
3. Allow me to feel more professionally comfortable /knowledgeable on the subject.

CANDIDATE 4

1. Able to see signs of any harm within families more.
2. More aware of in-depth information sharing and why.
3. Able to understand when I need to step a case up or close a case more clearly now and the goal posts around this.

CANDIDATE 5

1. The web site that was given looks very useful.
2. The work that was sent out will help.
3. In general this training has given additional ideas when looking at the families I work with.

12 TEES CHILD DEATH OVERVIEW PANEL

The purpose of the Child Death Overview Panel (CDOP) is to review and/or analyse in order to identify any matters relating to the death, or deaths, that are relevant to the welfare of children/ young people in Tees Valley or to public health and safety, and to consider whether action should be taken in relation to any matters identified.

Nationally, responsibility for the Child Death process has transferred from the Department of Education to the Department of Health, which is an acknowledgement that the overwhelming majority of child deaths nationally (approx. 80%) have a medical cause. Working Together 2018 moves responsibility for Child Death Review arrangements away from Local Safeguarding Children Boards and to the 'Child Death Review Partners' i.e. the Local Authority and Clinical Commissioning Groups. Revised statutory guidance in relation to child death reviews was also published during the year. This passed responsibility for the review of child deaths from the LSCB to the 'Child Death Review Partners '.

The Child Death Overview Panel has been reviewed and is compliant with new Working Together to Safeguard Children guidance 2018. Membership has been reviewed to include a GP at each meeting, and lay member engagement during thematic reviews. To ensure robust scrutiny and challenge, Public Health England has agreed to work across four CDOPs in the North East of England, undertaking thematic reviews of: suicide and deliberate self harm; sudden unexpected deaths; trauma and neonatal deaths. In addition, Tees Valley CDOP will share joint learning with County Durham and Darlington CDOPs via twice yearly challenge review meetings.

CASES REVIEWED BY CDOP 1 APRIL 2020 – 31 MARCH 2021

During 2020/2021 Tees CDOP reviewed 10 Middlesbrough child deaths and 8 Redcar & Cleveland child deaths. The Tees Panel met 6 times during the year.

The table below shows the respective ages of the children who were reviewed by CDOP when they died.

STSCP	Neonatal <4 Weeks	4-52 Weeks	1-4 Years	5-9 Years	10-14 Years	15 up to 17 Years	Total
Middlesbrough	1	8	0	0	0	1	10
Redcar & Cleveland	1	1	2	0	3	1	8

TOTAL CHILD DEATHS 2016 to 2021

The table below shows comparative numbers of total child deaths for the current and previous 4 years.

	2016/17	2017/18	2018/19	2019/20	2020/21
Middlesbrough	13 (2)	14 (8)	9 (5)	10 (3)	10 (6)
Redcar & Cleveland	9 (4)	7 (3)	13 (7)	5 (3)	8 (3)

(*) Numbers in brackets denote unexpected deaths

JOINT AGENCY RESPONSE (JAR) MEETINGS

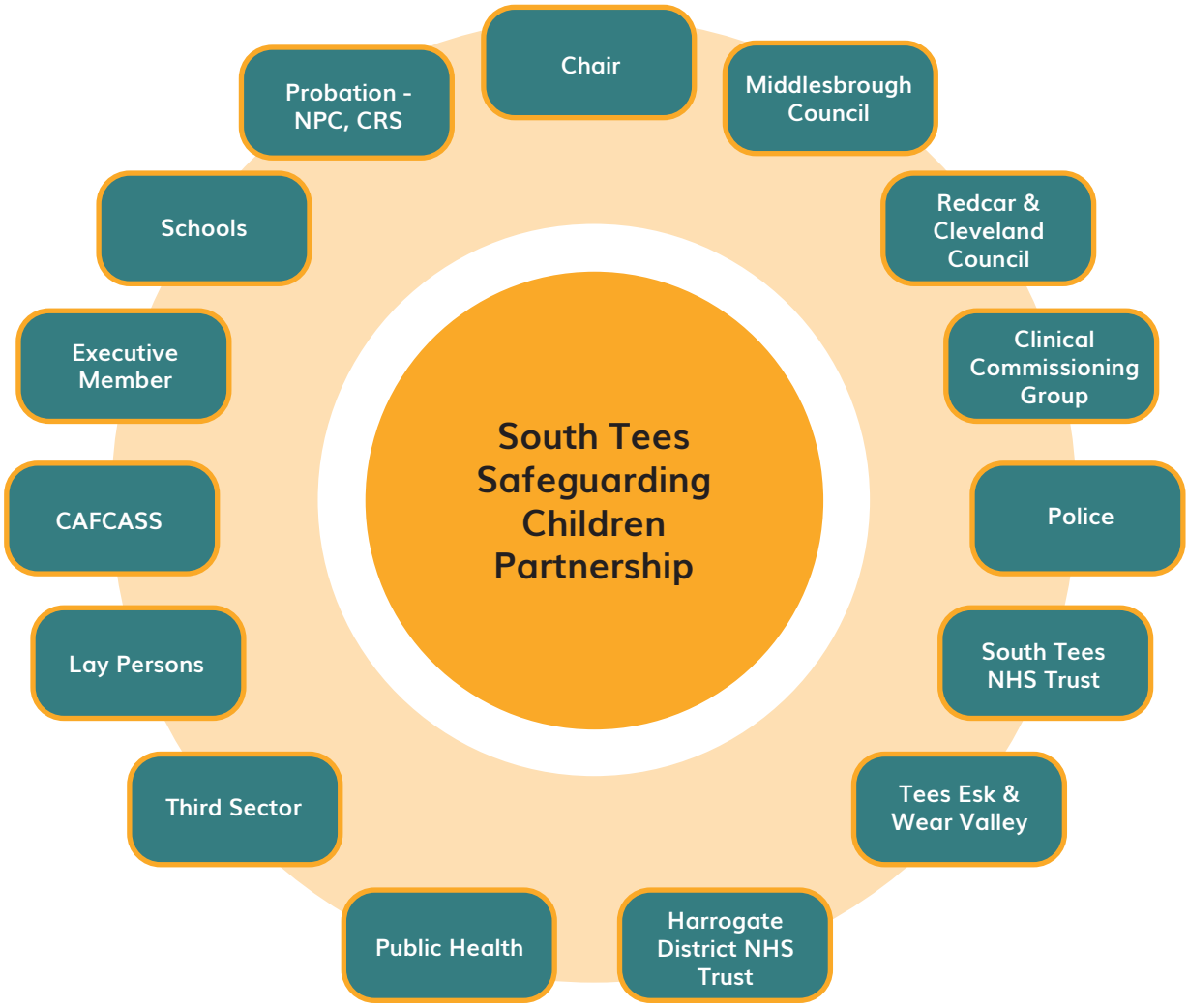
A Joint Agency Response meeting, formerly known as Rapid Response meetings, is held following unexpected deaths (with the exception of Neo-natal Deaths).

A total of 9 joint-agency response meetings were undertaken in 2020/21 across South Tees; 3 in Middlesbrough and 6 in Redcar & Cleveland.

CDOP have noted the following:

- Tees CDOP Safety Leaflet –This leaflet provides information and guidance to help prevent childhood injuries and deaths and is given to all parents/carers at the first home visit by the Health Visitor.
- Links with the Coroner – improved arrangements are in place to ensure greater support and information is provided to bereaved families/carers.
- Child Bereavement UK - A particularly good working relationship has been formed between Child Bereavement UK and James Cook University Hospital who have been receiving Bereavement Awareness training on a regular basis.

APPENDIX 1: STSCP EXECUTIVE MEMBERSHIP AND RELEVANT PARTNERS



APPENDIX 2: STSCP PLAN 2020 - 2023

STSCP VISION: 'A partnership committed to working together to achieve the best possible outcomes for Children and Families.'

WHAT ARE OUR PRIORITIES? (OBJECTIVES)

VEMT
The aim is for children/ young people to be free from the risk and harm of exploitation, going missing or being trafficked

Neglect
The aim is to reduce neglect, reduce the impact of neglect and ensure help & support is provided at the earliest opportunity

The Voice of the Child/Young Person
The aim is to create a clear focus on the needs and experience of young people

Working Together
The aim is to achieve excellent partnership working across all areas

WHAT ARE WE TRYING TO ACHIEVE? (KEY MEASURES)

1. *Track the number of children/ young people subject to exploitation.*
2. *Reduce the number of children/young people who go missing more than once.*
3. *Increase the % of return interviews completed within agreed timescales.*

1. *Reduce the number of children who are the subject of a child protection plan for Neglect.*
2. *Increase the % of outcomes achieved in a family plan.*
3. *Reduce the % of Neglect cases which involve Domestic Abuse.*

1. *Children/Young People feel confident to make contact with an appropriate adult if they have safeguarding concerns.*
2. *Improved opportunities for Children/Young People 'Engagement' with Safeguarding issues.*
3. *Increase the influence of the Voice of the Child in child protection processes.*

1. *Partners provide quality referrals that are referred appropriately for timely focused intervention.*
2. *Increase the number of initial Health Assessments submitted for LAC within timescales.*
3. *Effective information sharing across the partnership.*

WHAT ARE WE GOING TO DO? (PLANNED INTERVENTIONS)

Prepare - Strengthen the identification and assessment of those at risk of all types of exploitation, missing, trafficking.

Prevent exploitation - Making it more difficult to exploit children and young people.

Protect children/young people from exploitation

Pursue perpetrators of exploitation – identifying, disrupting and prosecuting offenders

Understand Neglect - Understanding the local picture of neglect, to raise awareness of neglect and the thresholds for intervention.

Early Identification - improve the recognition and assessment of neglect.

Effective Provision - Refine effective and successful interventions that reduce neglect before statutory intervention.

Domestic Abuse - Improve the recognition of the impact of domestic abuse leading to the Neglect of children and young people.

Voice of the Child - That every child has a voice within the child protection process.

Empower Young People - That every young person can recognise abuse and feel confident to report concerns.

Appropriate Support - Ensure that services are child focused.

Visibility - Ensure that all staff obtain the child's story and that every child is seen.

Peer Support Develop skills for young people to support other young people.

Thresholds - Strengthen agreed shared thresholds across the partnership.

Focused Intervention - Be assured that children receiving support as a 'child in need' receive focused intervention in a time appropriate manner.

Remove Barriers - Understanding the lessons learned and improving outcomes. Improve Information sharing - Understanding the barriers in order to mitigate issues.

Management Grip - Be assured that there is robust management accountability in cases across the partnership.

KNOWLEDGE MANAGEMENT
Understand the local issues in both Middlesbrough and Redcar & Cleveland.

PRACTICE STANDARDS
Identify and promote key guidance and toolkits while continuing to upskill practitioners.

YOUNG PEOPLE
Young People's experience and voice are at the heart of services keeping young people safe.

PRACTITIONERS
The voice and experience of practitioners is heard and barriers removed to assist with practice.

APPENDIX 3: STSCP BUDGET

BUDGET FOR 2020/2021

The financial contributions from partner agencies are as follows:

Funding Agency	2020-2021
Middlesbrough Council	65,000
Redcar & Cleveland Borough Council	65,000
Cleveland Police	65,000
ST CCG	65,000
National Probation Service	1,158
Durham Tees Valley CRC	1,000
ST YOT	6,239
	268,397

The STSCP acknowledges, in addition to financial contributions, there is a significant amount of 'in kind' contributions that partners provide through the support they give to the work of the standing groups and leading on task and finish groups, other pieces of priority work and the delivery of training.