Hartlepool and Stockton-on-Tees Safeguarding Children Partnership Annual Report 2021-22

Executive Summary

As the newly appointed, Independent Chair and Scrutineer for the Hartlepool and Stockton-on-Tees Safeguarding Children Partnership (HSSCP), I am pleased to introduce this annual report for 2021 - 2022.
The HSSCP is led by the Executive Group and Statutory Partners from both Hartlepool and Stockton-On-Tees Borough Councils, Cleveland Police, Tees Valley Clinical Commissioning Group, in partnership with key and relevant agencies across the two local areas.

Much work has been done by the HSSCP, building upon a strong and well-established partnership, to further develop and deepen effective multi-agency working throughout a whole system, to safeguard children and young people.
This includes the establishment of my post, strengthening effective governance arrangements, to provide independent scrutiny and assurance; the commissioning of a whole system review into domestic abuse across Cleveland and, establishing a Multi-Agency Child Exploitation Hub (MACE).

The report reflects upon the progress and impact against last year's priorities:

Partnership Effectiveness, Governance and Engagement;
Domestic Abuse;
Contextual Safeguarding;
Learning from Reviews and Best Practice.

As we look back, it is a testament to leaders, partners and practitioners across the HSSCP that so much has been achieved, against the unprecedented challenges over the last two years, not least due to the global pandemic.

The annual report also shares the system wide learning from Local Child Safeguarding Practice Reviews that were undertaken for Child O and Child Q and crucially, how this learning has been taken forward and most importantly, what has been done to improve practice by the partnership.

The multi-agency thematic case audits, build upon our active learning approach and the partnerships commitment and aspiration, to achieve the shared vision and objectives for every child and young person in Hartlepool and Stockton-On-Tees: to feel safe, secure and protected from harm, enabling them to reach their full potential.

As well as remaining sighted on continued and new emerging needs, our over-arching priority for 2022 - 2023 is Neglect. Central to our focus is to understand the child's world and daily life, their lived experience, so that as a partnership we can better understand, identify, prevent and respond to children living in neglectful circumstances.

Mel John-Ross
HSSCP Independent Chair
and Scrutineer

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HSSCP MEMBERSHIP

HSSCP Safeguarding Partners

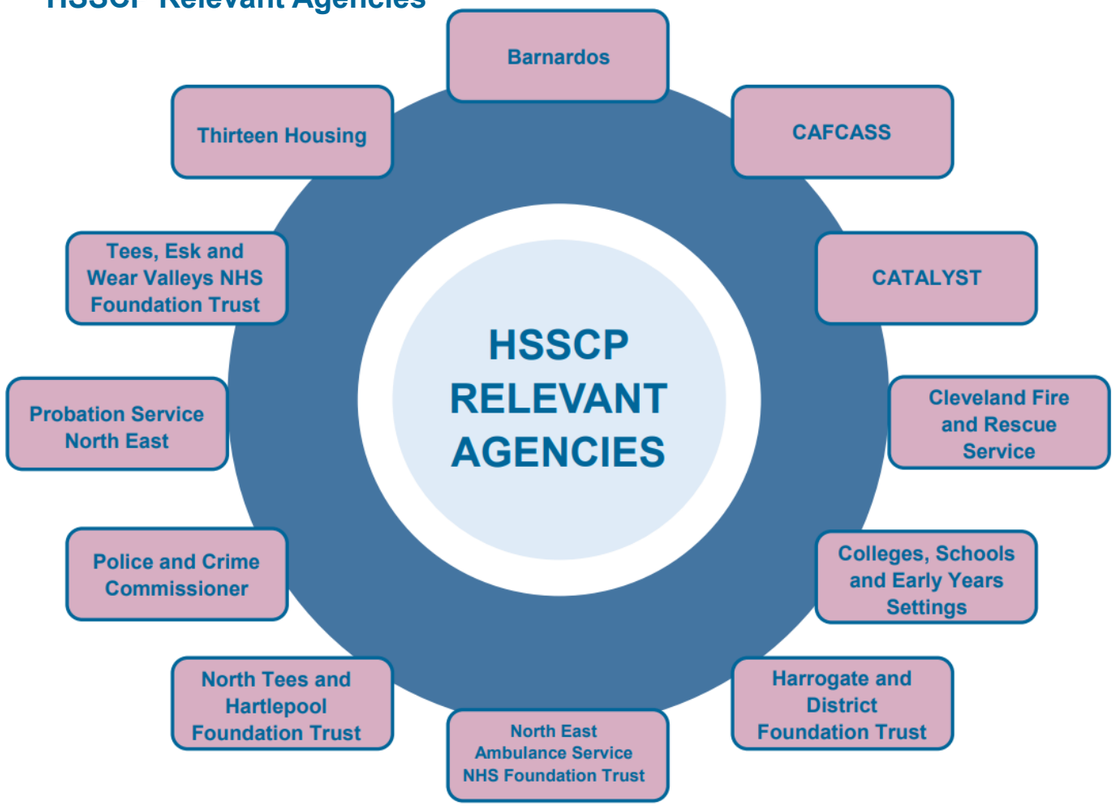
HSSCP covers the two local authority areas of Hartlepool and Stockton-On-Tees Borough Councils, with a co-terminus Clinical Commissioning Group and Police force. The four statutory safeguarding partners of the Hartlepool and Stockton-On-Tees Safeguarding Children Partnership, in accordance with Working Together 2018 (and Children and Social Work Act 2017), therefore include:

- Hartlepool Borough Council
- Stockton-On-Tees Borough Council
- Tees Valley Clinical Commissioning Group
- Chief Officer of Cleveland Police

The four safeguarding partners retain an equal and joint responsibility for local safeguarding arrangements. They agree on ways to co-ordinate safeguarding services; act as a strategic leadership group in supporting and engaging others; and ensure the implementation of local and national learning. In situations that require a single point of leadership, safeguarding partners will decide on which partner will take the lead on relevant issues that arise.

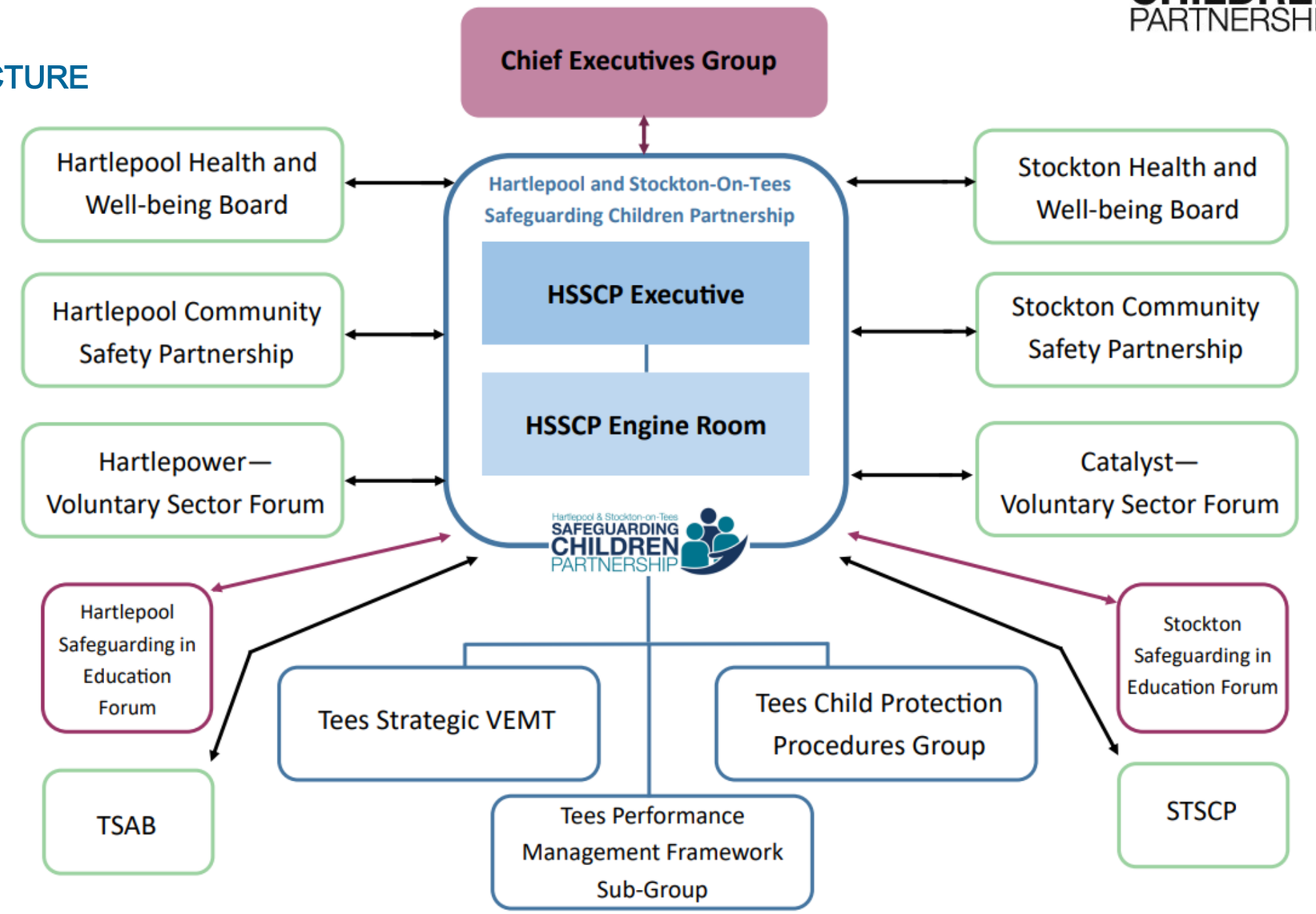
The safeguarding partners have identified other agencies that are required to work as part of the HSSCP's arrangements to safeguard and promote the welfare of local children. These agencies are referred to as relevant agencies and have a statutory duty to cooperate with the HSSCP's published arrangements.

HSSCP Relevant Agencies



N.B: The full list of relevant agencies can be found in HSSCP's published arrangements.

HSSCP GOVERNANCE STRUCTURE



The HSSCP Executive

The HSSCP Executive, made up of representation from the four statutory safeguarding partners, meet bi-monthly to provide strategic leadership and oversight to the partnership arrangements. The Executive is accountable to the Chief Executives Group and is responsible for ensuring delivery of the HSSCP business plan and priorities.

The Executive:

- Share and co-own the vision for how to achieve improved outcomes for vulnerable children
- Ensure that services are commissioned in a co-ordinated way; through liaison with other key partnerships and Boards
- Oversee core safeguarding functions of the partnership arrangement
- Scrutinise reports on learning activity presented to them by the 'engine room'
- Provide further challenge where necessary when seeking assurance, evidencing impact and improvement
- Liaise with other key local partnerships and boards; feeding back any relevant information to the 'engine room'
- Ensure all statutory function and requirements are met; and
- Approve the appointment of reviewers for local case reviews

The HSSCP Engine Room

The Engine Room, made up of representation from the four statutory safeguarding partners and selected relevant agencies, meets every 6 weeks and is accountable to the HSSCP Executive. The functions of the Engine Room carried out on behalf of the Executive include:

- Planning and undertaking learning activity; including Rapid Reviews, learning reviews and multi-agency audits
- Identifying and commissioning training following findings from review activity
- Identifying and ensuring dissemination of learning and good practice
- Identifying task and finish groups needed to deliver work on behalf of the partnership
- Impact testing – monitoring and reviewing change for improvement / learning
- Reporting learning and impact to HSSCP Executive

HSSCP VISION, AIMS AND OBJECTIVES

Every child in Hartlepool and Stockton will feel safe, secure and be protected from harm, enabling them to reach their full potential.

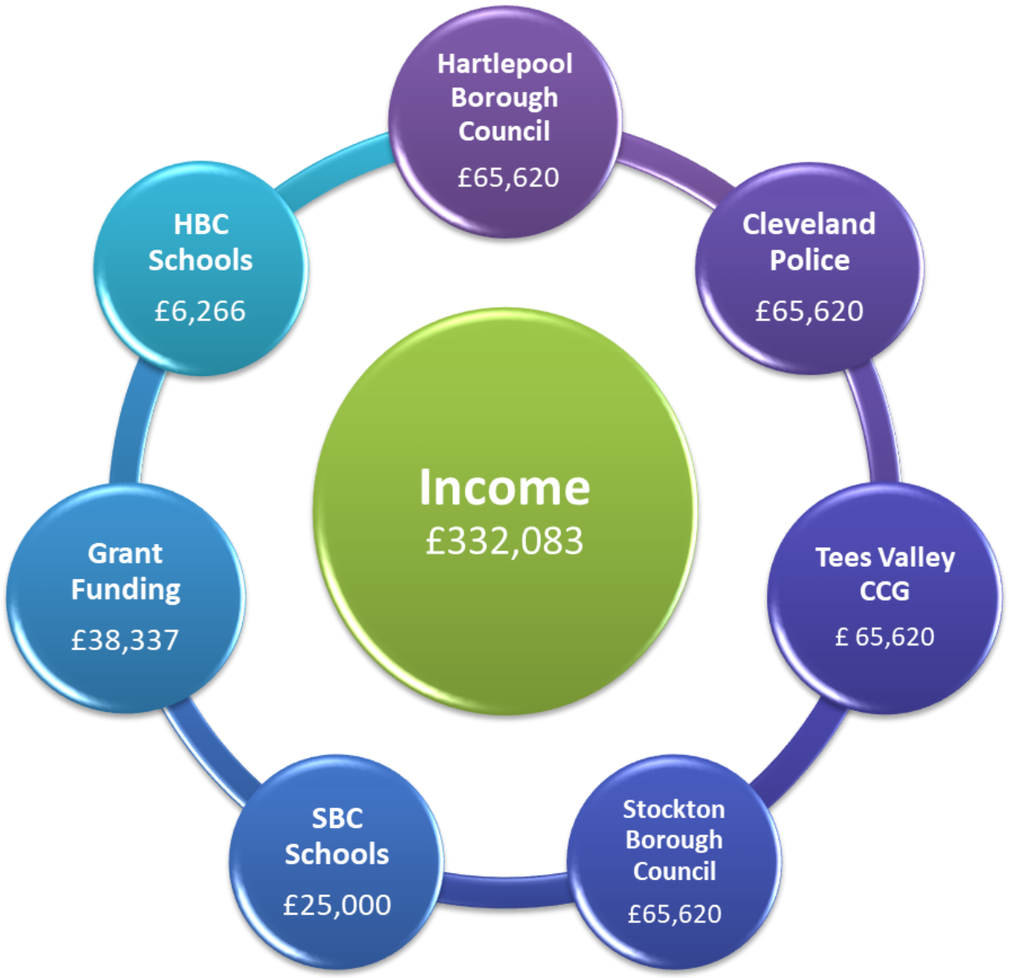
HSSCP's vision is to ensure that **"Every child in Hartlepool and Stockton feels safe, secure and protected from harm, enabling them to reach their full potential"** and aims to ensure that everyone who works with children across Hartlepool and Stockton-on-Tees has the protection of vulnerable children and young people at the heart of what they do.

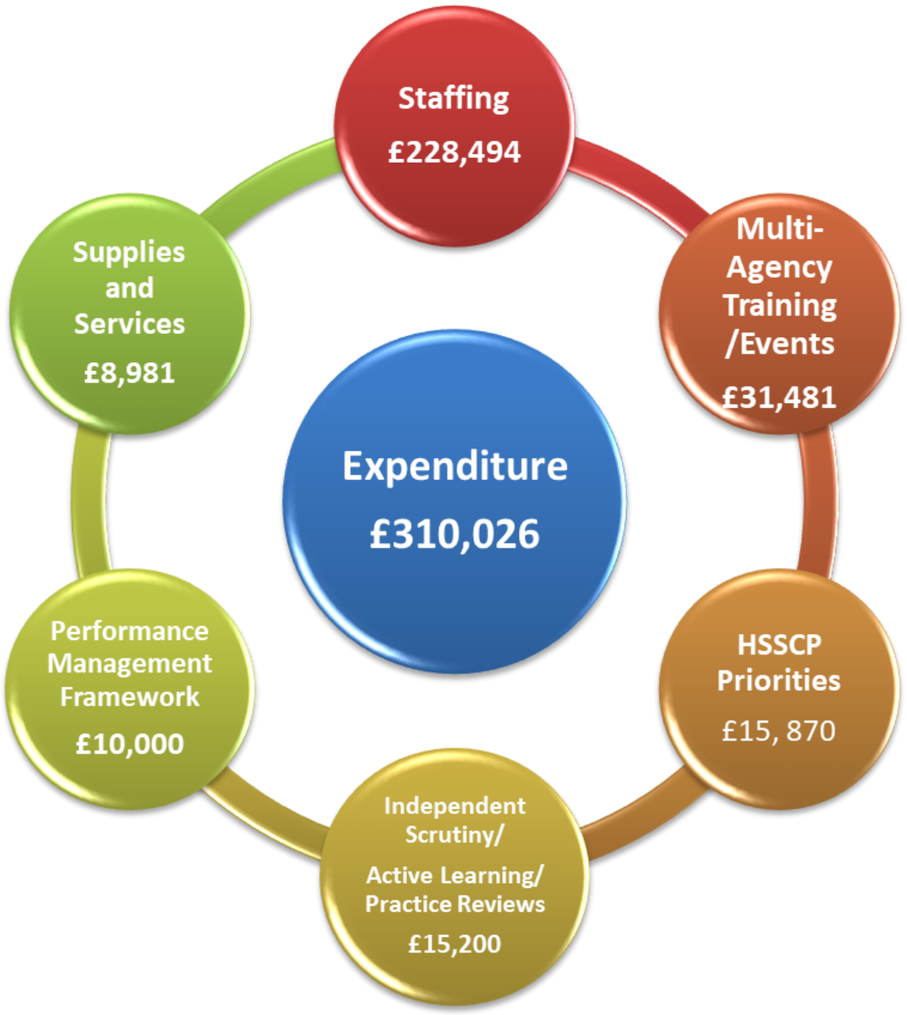
In order to achieve this the Partnership aims to understand what is working well in its collective safeguarding practice, to identify what needs further development and to ensure effective and co-ordinated multi agency working across our whole system. This 'Active learning' approach has the child at its core and harnesses the importance of working with practitioners to influence front line safeguarding practice in order to learn and improve together.

The Partnership's Objectives are to:

- achieve the best possible outcomes for children and families and provide the right services that meet need in a co-ordinated way;
- improve safeguarding practice across all partners thus impacting positively on the lives of children;
- improve safeguarding practice, via identification and analysis of issues/ threats / barriers to effective multi agency working;
- enable shared learning with front line staff across all partner agencies;
- establish and embed peer challenge as a process for learning and improvement;
- embrace a culture of challenge with organisations and agencies holding one another to account;
- share information effectively to facilitate more accurate and timely decision making for families; and
- deliver on key elements that inform the basis of effective safeguarding practice i.e.:
  - ◊ Effective governance
  - ◊ Quality assurance and intelligence; and
  - ◊ A culture of learning and improvement

FINANCIAL ARRANGEMENTS





Hartlepool & Stockton-on-Tees
SAFEGUARDING
CHILDREN
PARTNERSHIP

About Hartlepool

HARTLEPOOL DEMOGRAPHICS

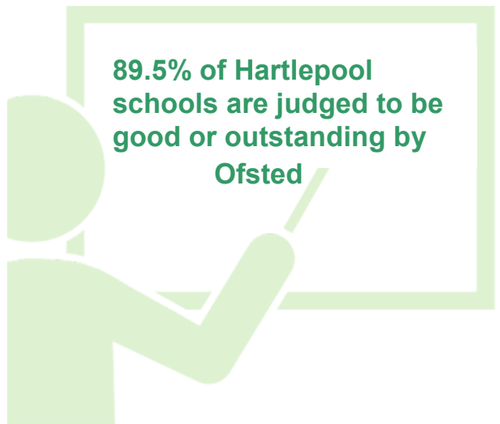
Hartlepool has a population of 93,836 living in...

With...

20,108 children under 18

and...

6,864 children in poverty



Hartlepool Context

There are **39 schools** in Hartlepool with 30 mainstream primary, 5 mainstream secondary, 2 special schools (one primary, one secondary), 1 Independent School and 1 Pupil Referral Unit. With **89.5%** of Hartlepool schools judged to be good or better by Ofsted, the potential for children achieving positive outcomes is high. The **number of children who are home educated is 101** which, although small when compared to all children accessing school, is monitored and reviewed by the Partnership annually to ensure oversight of this cohort of children and young people. Based on 2022 January School Census, **19.3%** of the Hartlepool compulsory school age population were **SEND** (EHCP and SEN Support). As at 31st March 2022 the number of children with Education, Health and Care (EHC) Plans or Statements of SEN issued by Hartlepool is 584 (216 primary age, 345 secondary and 23 post 16).

In 2021, the End Child Poverty data classified Hartlepool as being **within the top 10% of the most deprived areas in the country**. The proportion of **children living in poverty being 39%,** compared to 38% across Teesside and 27% nationally. Living in an area of high deprivation, the children and young people of Hartlepool, their families and the professionals who work to support them, therefore face many challenges. There is a large body of evidence and research to show that **children who live in poverty are more likely to face additional traumatic experiences** or be exposed to a range of risks that can have a serious impact on their mental health and life chances. With Hartlepool's deprivation being higher than the national average for children already living in poverty and many families experiencing uncertain employment prospects as a result of COVID-19, the research suggests that the impact is only likely to increase; putting further pressure on families. It is therefore important for the Safeguarding Partnership to be fully aware of this cohort of children and young people and ensure that these are considered within aspects of the partnerships work programme.

HARTLEPOOL SAFEGUARDING SNAPSHOT

Throughout 2021-22 there were approximately:

20,108 children & young people under 18

Which equates to:

21% of the total population

39% of children living in poverty

39.5% of primary school children in receipt of free school meals (the national average is 20.8%)

517 average contacts to the Children's Hub* per Month

1970 referrals to children's social care

21% were re-referrals

628 Early Help assessments completed

107 Early Help cases escalated to Social Care

1387 open Child in Need cases

180 children subject to a Child Protection Plan

2141 children and young people receiving services through Special Educational Needs and Disability (SEND) support

17 children and young people identified as being at risk of Child Sexual Exploitation

29 children and young people identified as being at risk of Child Criminal Exploitation

671 missing episodes by 234 young people

212 missing episodes by 47 Hartlepool looked

308 children and young people looked after

1315 children present during a domestic abuse incident

292 domestic abuse incidents witnessed by children within 12 months of a similar incident

145 cases discussed in MARAC (Multi-Agency Risk Assessment Conference)

345 children involved in MARAC

48 referrals in relation to allegations against staff working with children and young people

3 new Private Fostering arrangements reported

** NB: The Children's Hub is the multi-agency front door for referrals into Children's Social Care.*

Hartlepool & Stockton-on-Tees SAFEGUARDING CHILDREN PARTNERSHIP

About Stockton-on-Tees

Hartlepool & Stockton-on-Tees SAFEGUARDING CHILDREN PARTNERSHIP

STOCKTON-ON-TEES DEMOGRAPHICS

Stockton has a population of **197,419** living in,,,

89,600 HOUSEHOLDS

Stockton -On-Tees covers **81** square miles

With...

44,021 children under 18

and...

35.3% children in poverty

95.8% of Stockton schools are judged to be good or outstanding by Ofsted.

Stockton Context

There are 93 schools in Stockton with 76 primary (40 academy, 28 maintained, 5 special and three independent schools), 21 secondary (12 academy, 1 maintained, 5 special and three independent school). With 95.8% of Stockton schools judged to be good or better by Ofsted, the potential for children achieving positive outcomes is high. The **number of children who are home educated is 246** (as of March 2021) which, although small when compared to all children accessing school provision, is monitored and reviewed by the Partnership annually to ensure oversight of this cohort of children and young people. Based on the January 2021 school spring census **16.3% of the school population were SEND** (Special Educational Needs and Disabilities). This figure includes those that had an Education Health Care Plan (EHCP) and those that have SEN support. The number of children with Education, Health and Care (EHC) Plans or statements of SEN in Stockton is 1821 (678 primary age children, 759 secondary, 384 post-16) .

The latest available data from End Child Poverty (May 2021) shows **35.3% of children are living in poverty in Stockton-on-Tees** (after housing costs are included), compared to an average of 37% in the North East and 31% nationally. Living in an area of high deprivation, the children and young people of Stockton-on-Tees, their families and the professionals who work to support them, therefore face many challenges. There is a large body of evidence and research to show that **children who live in poverty are more likely to face additional traumatic experiences** or be exposed to a range of risks that can have a serious impact on their mental health and life chances. With Stockton's deprivation being higher than the national average for children already living in poverty and many families experiencing uncertain employment prospects as a result of COVID-19, the research suggests that the impact is only likely to increase; putting further pressure on families. It is therefore important for the Safeguarding Partnership to be fully aware of this cohort of children and young people and ensure that these are considered within aspects of the partnerships work programme.

STOCKTON-ON-TEES SAFEGUARDING SNAPSHOT

Throughout 2020-21 there were approximately:

44,021 children & young people under 18

Which equates to:

22% of the total population

35.3% of children living in poverty (Source - End Child Poverty data May 2021)

26.2% of mainstream primary school children in receipt of free school meals (the national average is 20.8%)

995 average contacts to the Children's Hub per month

3624 referrals to children's social care

21.5% were re-referrals

616 Early Help Episodes were opened

8 Early Help cases escalated to Social Care

2373 open Child in Need cases

301 children subject to a Child Protection Plan

5259 children and young people receiving services through Special Educational Needs and Disability (SEND) support

20 children and young people identified as being at risk of Child Sexual Exploitation

1478 missing episodes by 473 young people

609 missing episodes by 98 Stockton looked after young people

574 children and young people looked after

3 new Private Fostering arrangements reported

2153 children witnessing a domestic abuse incident

258 cases discussed in MARAC (Multi-Agency Risk Assessment Conference)

503 children involved in MARAC

118 referrals in relation to allegations against staff working with children and young people

Hartlepool & Stockton-on-Tees
SAFEGUARDING
CHILDREN
PARTNERSHIP

Key Successes and Achievements

PRIORITIES

BUSINESS PRIORITY

PRIORITY 1: PARTNERSHIP EFFECTIVENESS, GOVERNANCE AND ENGAGEMENT

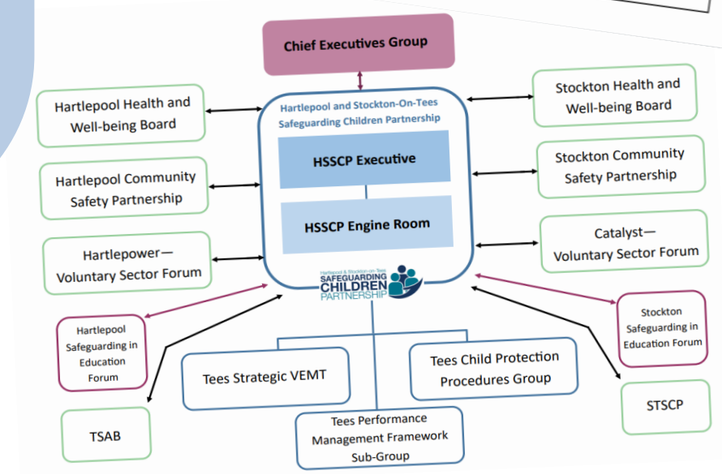
What did this priority entail?
This priority focussed upon the effectiveness of HSSCP as a partnership.

What has been done?
It reviewed and scrutinised:

- Partnership governance and structures – including whether the elements of the HSSCP are working well together, and if any changes were needed;
- The effectiveness of scrutiny arrangements - including the role of the independent chair;
- Engagement of partners and if any changes are required to structures to facilitate greater partner engagement and understanding; and
- Communications plans.

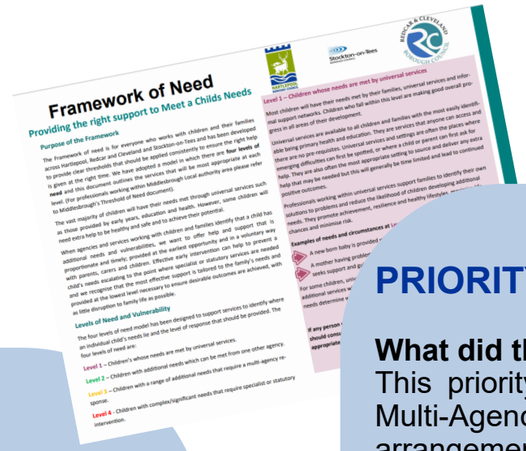
Impact
Key changes include:

- Recruitment of a lead scrutineer / chair
- Additional relevant agency representation on the partnership Executive
- Changes to the way reviews are structured
- Ongoing work to measure effectiveness
- Ongoing role for the new chair / scrutineer on effectiveness of the partnership to test implementation of recommendations.



PRIORITIES

THEMATIC PRIORITIES

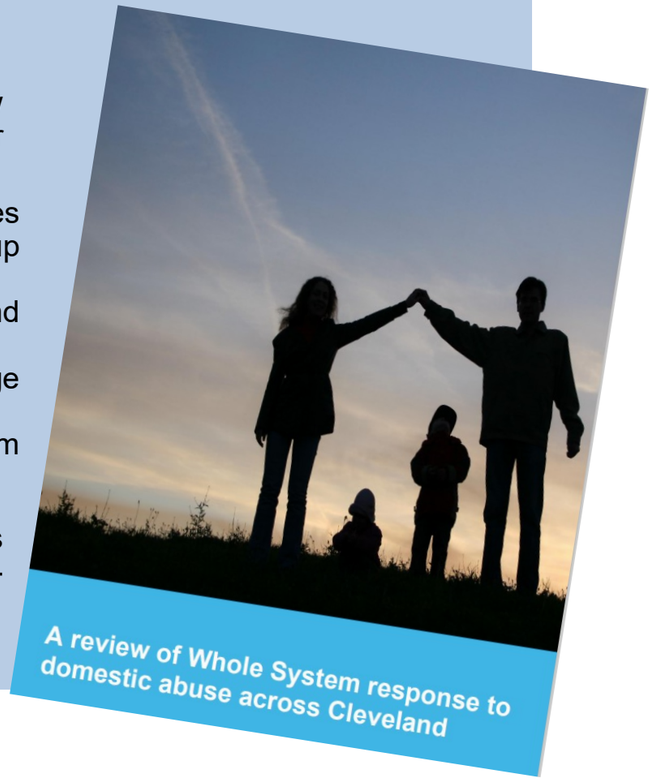

Framework of Need
Providing the right support to Meet a Childs Needs
Purpose of the Framework
Levels of Need and Vulnerability

PRIORITY 2: DOMESTIC ABUSE

What did this priority entail?
This priority focussed upon developing a better understanding of the level of Domestic Abuse (across Tees) and the multi-agency response to it.

What has been done?
- Safe Lives were commissioned to review DA and MARAC processes
- Consultation with partnership / partners as well as victim and survivor engagement
- Considered implications of the DA Bill
- A HSSCP Domestic Abuse task and finish group reviewed existing partnership training and tools

Impact:
- The Safe Lives completed review outlines recommendations for progression in 22-23 in relation to:
  - How can the 4 Local Authorities deliver a better, joined up coordinated approach to DA?
  - What should governance and partnership work look like?
  - What is the culture change needed across the system?
  - How do we develop system minimum standards?
- New Safe and Together training is to be commissioned by the partnership for rollout in 2022-23.



PRIORITY 3: CONTEXTUAL SAFEGUARDING

What did this priority entail?
This priority focussed upon the development of a North of Tees Multi-Agency Child Exploitation (MACE) Hub to improve arrangements to protect and safeguarding children and young people at risk of criminal and sexual exploitation. It aimed to replace existing local VEMT arrangements and provide real time information sharing, risk assessment and response to children at risk.

What has been done?
- Development of the MACE arrangements and Teams
- MACE went live on 1st October 2021
- Delivery followed the business case model and range of policies, procedures, practice guidance, standard operating procedures, systems and processes were produced and implemented; including an updated framework of need
- Identification and commitment of appropriate resources from partner agencies to the Hub
- Training delivered across the multi-agency workforce in relation to the new arrangements

Impact:
- Multi agency children's exploitation teams were created across Hartlepool and Stockton made up of local authority and police partners as well as a strengthened education support. The team has worked collaboratively over the last six months and identified ways in which the work of the teams needs to shape and develop responsive to local need.
- Training needs analysis completed and positive feedback is being received as to the training in place, which is now built into the workforce training schedule.
- Dedicated resources for responding to child exploitation enable the team to work with partners in adults services to identify and protect those who transition into adult services. The expertise of the team is shared with adults services and available to colleagues in TSAB.

PRIORITIES

PRACTICE THEMES PRIORITY

Information-Sharing

Professional Curiosity

Voice of the Child

Professional Challenge

Over-Optimism

Assumptions

Consent

PRIORITY 4: LEARNING FROM REVIEWS AND BEST PRACTICE

What did this priority entail?
This priority focussed upon recurring themes which have arisen through review activity. HSSCP recognised that the Partnership sees the evidence of these themes when things go wrong and sought assurance that this is not indicative of practice more widely cross the system. This priority sought to understand why recurring themes continue and what, as a Partnership, can be done differently to break this 'cycle'.

This priority aimed to pull together what we already know about what good practice looks like and what the expectations of effective practice are across our safeguarding system. It sought to reflect on and challenge thinking around what is meant by 'compliance' at a Partnership, System, Agency, Service and Practitioner level; moving beyond compliance set against performance indicators to compliance set against good / best practice expectations to achieve the partnership's vision for the children and young people we serve. It sought to:

- Understand why we have repeating SIN /near misses.
- Understanding what is happening in the different agencies from an assurance perspective: how they are assured in relation to compliance / good practice / analysis / reflection and how they measure quality
- Understanding how agencies are assured and how that contributes to the system
- Understand how agencies share/disseminate learning to practitioners
- Understand how any changes to practice are implemented and monitored for impact assessment
- Analyse and reflect – model behaviour that is expected / wanted
- Training / reflective discussions for the workforce

What has been done?
- A Joint Tees-wide 'learning from reviews' task and finish group and planning for a Tees-wide event.
- Analysis of themes arising from reviews and training implemented to the multi-agency workforce.

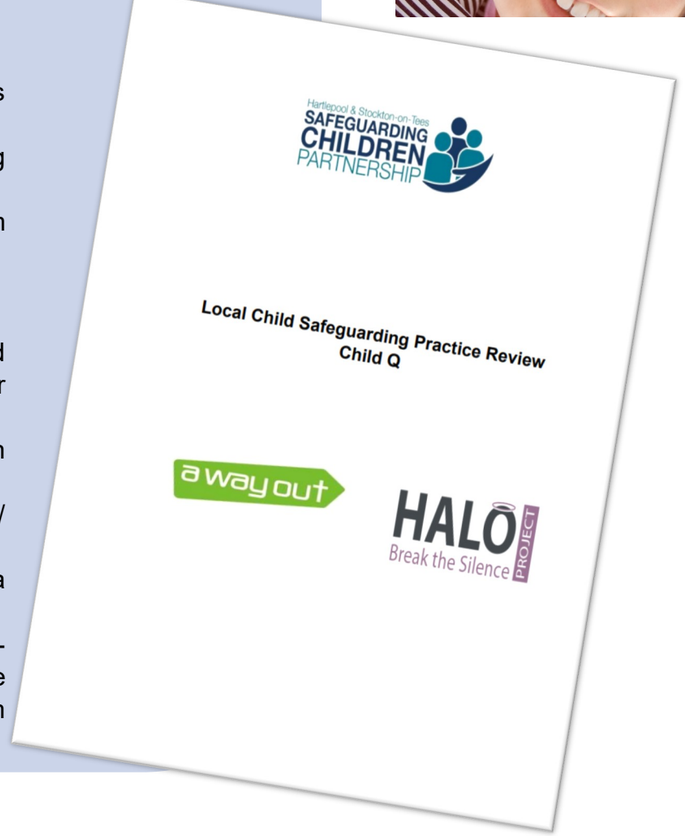
CASE REVIEWS - Local Child Safeguarding Practice Review

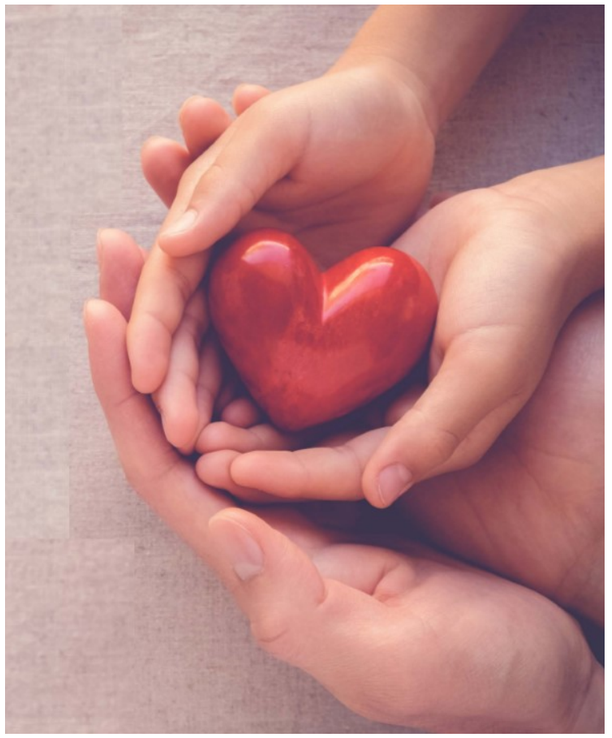
LCSPR - CHILD Q

Context
Child Q was 14 months old when admitted to the A&E department due to concerns raised by Social Care and the Police following a welfare visit that Child Q was severely underweight. Child Q was subsequently assessed by health as being severely malnourished, his mother having followed a diet of milk and honey both during her pregnancy with Child Q and beyond impacting significantly on the growth and development of Child Q. Child Q was reported to have severe Vitamin D deficiency, advanced rickets, severe metabolic bone disease with multiple fractures and iron deficiency anaemia.

Learning Themes
- Over optimism
- Lack of professional challenge – particularly in relation to the decision not to initiate care proceedings
- Lack of professional curiosity
- Poor information sharing
- Cumulative vulnerabilities were not considered
- Assessments were not holistic in nature
- Lack of understanding around the impact of religious and cultural issues
- Difficulties and need for specialist support when dealing with complex cases
- What to do when cases are 'stuck' or engagement from families is poor

What is being done?
- Staff to receive training which specifically triggers and recognises disguised compliance, domestic and honour -based abuse (HBA), trauma, culture and faith
- Multi agency supervisions to be introduced when dealing with complex cases
- Implementation of a programme of champions/ specialists around certain fields such as HBA
- Improve understanding around vulnerabilities using a whole family approach with BME and diverse groups
- Development of a toolkit to support and improve under-standing and delivery around honour-based violence enabling indicators and questions to be asked to inform safeguarding practices and decision making





CASE REVIEWS - Local Child Safeguarding Practice Review

LCSPR - CHILD O

Context
Child O, aged 9 years, was assaulted by their mother's partner and witnessed the assault of their mother who was stabbed multiple times in the attack. Child O suffered bruising and swelling and their mother suffered lacerations to her head and face. At the time of the incident, Child O was subject to their second child protection plan with the previous child protection plan being in place due to similar concerns. The review was carried out to identify key learning themes from the involvement of agencies and how to ensure wider input, over-sight and challenge when a professional team consists of only two agencies.

Learning
- Where there is insufficiently evidenced suspicion that something is happening, the Core Group needs to take an investigative approach, practice 'respectful uncertainty' and use professional curiosity to enquire deeper.
- Professionals need to use active information sharing and look not only at information on the identified child and parent(s) but also the significant adults around the child.
- Social workers need to make sure that new information of concern that they receive is quickly shared with schools .
- When a child has suffered trauma/ACEs, it should be assumed there are health needs, even where none are immediately identifiable.
- Professionals need to remember that group supervision and complex case discussions can be convened when there are worries that need to be unpicked.
- Professionals need to use clear understandable language with families, avoiding professional jargon and take the time to explain complex issues allowing families the time to reflect on and then question the information at a later date.

What is being done?
- Review of the multi-agency meeting (Core Group / Team Around) agendas to include a dedicated section for other agency information - to prompt multi-agency professionals to consider what is not known and where / how they could find out more to inform their planning and decision-making.
- Development of a 'Complex Case' guidance.
- Learning shared with the MARAC review - schools need to be informed when a child is linked to a MARAC discussion, so that they can contribute to the MARAC information sharing and discussion.

CASE REVIEWS - Multi-Agency Audit

Contextual Safeguarding Audit
Being one of HSSCP's four key priorities for 2021-22, Contextual Safeguarding was selected as the first of two themed multi-agency audits undertaken in 2021-22. As part of this priority, new Multi-Agency Child Exploitation (MACE) hubs had been established for Hartlepool and Stockton-On-Tees with a view to replacing the existing VEMT Practitioner Group process. The aim of the Contextual Safeguarding Multi-Agency audit was to act as a bench marking exercise; taking place at the commencement of the new MACE arrangements in November 2021, to be repeated the following year; with a view to demonstrating impacts of the new MACE hubs and model.

What is working well:

- Professionals are recognising the signs and indicators of exploitation and are making appropriate referrals
- Timeliness of referrals to VEMT were appropriate
- There is a recognised increase in understanding of contextual safeguarding over recent years across the multi-agency workforce
- Multi-agency screening and risk assessment is taking place

Areas for Development:

- 5 out of the 6 children had needed to be placed out of area, indicating a potential gap in appropriate local placements, effective risk / safety planning and disruption
- Risks reduced for children whilst in secure placements and escalated again when these placements ended. Disruption was often reactive to a significant incident / crisis. Multi-agency pro-active disruption planning needs to be integral to new arrangements.
- All children had self-harmed / attempted or threatened suicide and had been identified as requiring support (mental health / therapeutic service). Barriers identified were around:
  - the order in which Mental Health intervention needed to be completed
  - closure to an intervention when not engaging (responsibility for engagement placed on child rather than agency).
  - A need for a lead professional for MH support/oversight
- Professionals need to be mindful of blaming language – For example: support seeking rather than attention seeking
- Consider the need for preventative work to intervene when children are younger / prior to being entrenched

CASE REVIEWS - Multi-Agency Audit

Neglect –Themed Audit
Since going live as a partnership in April 2019, HSSCP has reviewed 11 serious safeguarding incidents. Neglect was a feature in all of these cases and in five of them was the actual cause of the serious injury or death. In light of learning from these reviews, HSSCP has relaunched their Neglect Statement of Intent and Six Question Tool and delivered 3 tiers of training. The aim of this being to share the learning, to foster a curiosity in the multi-agency workforce and to provide professionals with a tool that will assist them with assessing and analysing cumulative vulnerability and risk. This themed multi-agency audit aimed to measure the impact of the work undertaken by the partnership around neglect.

What is working well:

- Professionals are recognising the signs and indicators of neglect and are making appropriate referrals.
- The referrals to Children's social care were timely in the majority of cases and appropriately acted upon.
- There was evidence that demonstrated professionals had built up good relationships with families.
- There was evidence of professional challenge - for example between the Chub and out of area agencies and in Health agencies challenging families lack of contact with services.
- There was evidence of good relationships and communication between professionals involved with children and families.

Areas for Development:

- Assessments showed a lack of understanding about the parents historical Adverse Childhood Experience's and cumulative vulnerability and how these impact upon their ability to parent and ability to change. It would have benefited from professionals digging deeper and being more curious in their questioning and assessments.
- Plans appeared to be addressing the symptoms of neglect and not the root causes. They didn't always have clear, realistic, achievable goals agreed and understood by the family.
- The child's lived experience was not evident in the audit submissions. Gaining the 'voice' of non verbal children and of individual children where there are large sibling groups and understanding the impact neglect is having on their day to day life appeared to be difficult for professionals .
- Understanding of culture featured as a barrier in some cases, particularly in relation to understanding Domestic Abuse and in English as an Additional Language (EAL) vs child's voice.
- Evidencing parental motivation and ability to change was difficult for professionals; with many families doing 'just enough' to comply with the plan.
- There was an over-reliance on parental self report in many of the cases.
- There were mixed opinions over the value of tools with no evidence that the 6 question tool had been used in any of the cases.
- 50% of attendees had attended HSSCP neglect training. The audit did not demonstrate evidence that this had impacted upon practice.


HSSCP Multi-Agency Audit
NEGLECT
March 2022

Hartlepool & Stockton-on-Tees SAFEGUARDING CHILDREN PARTNERSHIP

6 cases were selected for audit - three from Hartlepool and three from Stockton-On-Tees. These were children that had opened to children's social care in the past 6 months and were subject to a CP plan under the category of neglect.

Since going live as a partnership in April 2019, HSSCP has reviewed 11 serious safeguarding incidents. Neglect was a feature i all of these cases and in five of them was the actual cause of the serious injury or death. In light of learning from these reviews, HSSCP has relaunched their Neglect Statement of Intent and Six Question Tool and delivered 3 tiers of training. The aim of this being to share the learning, t foster a curiosity in the multi-agency workforce and to provide professiona with a tool that will assist them with assessing and analysing cumulativ vulnerability and risk. This multi-agency audit aimed to measure the impact of the work undertaken by the partnership around neglect.

3 were boys, 3 were girls, with a variety of ages, ranging from 3 to 14 years of age.

4 families had moved from other areas.

The majority had historical multi-agency involvement and a range of cumulative vulnerabilities within the family.

83% (5 out of the 6) parents had failed to seek health advice or take the child to health appointments.

100% (all 6) had Domestic Abuse sighted as a factor in the assessment.

67% (4 out of 6) had parental substance misuse sighted as a factor in the assessment.

33% (2 out of 6) had parental mental ill health sighted as a factor in the assessment.

Learning about the audit process:

The quality of submissions varied between agencies; particularly in relation to single agency self-reflection and analysis.

The contribution to discussion on the audit day varied.

Professionals would benefit from having an aide-memoire or rough guide to completing multi-agency audits.

HSSCP to consider how best to promote contributions from GP surgeries.

What is working well:

• Professionals are recognising the signs and indicators of neglect and are making appropriate referrals

• The referrals to Children's social care were timely in the majority of cases and appropriately acted upon.

• There was evidence that demonstrated professionals had built up good relationships with families.

• There was evidence of professional challenge - for example between the Chub and out of area agencies and in Health agencies challenging families lack of contact with services.

• There was evidence of good relationships and communication between professionals involved with children and families.

Audit Findings:

Areas for Development:

• Assessments showed a lack of understanding about the parents historical ACE's and cumulative vulnerability and how these impact upon their ability to parent and ability to change. It would have benefited from professionals digging deeper and being more curious in their questioning and assessments.

• Plans appeared to be addressing the symptoms of neglect and not the root causes. They didn't always have clear, realistic, achievable goals agreed and understood by the family.

• The child's lived experience was not evident in the audit submissions. Gaining the 'voice' of non verbal children and of individual children where there are large sibling groups and understanding the impact neglect is having on their day to day life appeared to be difficult for professionals .

• Understanding of culture featured as a barrier in some cases, particularly in relation to understanding DA and in EAL vs child's voice.

•Evidencing parental motivation and ability to change was difficult for professionals; with many families doing 'just enough' to comply with the plan.

• There was an over-reliance on parental self report in many of the cases.

• Mixed opinions over the value of tools - no evidence that the 6 question tool had been used in any of the cases.

•50% of attendees had attended HSSCP neglect training. No evidence that this had impacted upon practice.

• Transfer process across boundary * Health - physical need vs emotional

Neglect has been identified as a key priority for the partnership in 2022-23.

Hartlepool & Stockton-on-Tees SAFEGUARDING CHILDREN PARTNERSHIP

HSSCP Business Plan 2022-23

Key Priority: NEGLECT

The vision for Hartlepool and Stockton-On-Tees Safeguarding Children Partnership (HSSCP) is to ensure: **"Every child in Hartlepool and Stockton feels safe, secure and is protected from harm; enabling them to reach their full potential."**

Since going live as a partnership in April 2019, HSSCP has reviewed 11 serious safeguarding incidents. Neglect featured in all of these cases and in five of them was the cause of the serious injury or death. The pressures on services across Hartlepool and Stockton-On-Tees in relation to neglect are significant; with the numbers of children becoming Looked After by the Local Authorities due to neglectful parenting at a high (approximately 69%). It has been agreed that HSSCP's agreed key priority for 2022-23 is **neglect**. This business plans sets out three key areas of focus in relation to the neglect priority.

Neglect Priority 1: Identifying Neglect – Evidencing the Child's Lived Experience	Aim: For the multi-agency workforce to focus on what life is like for the child and for neglect to be identified at the earliest opportunity

Rationale:

Neglect can be devastating for children yet it can be difficult to identify as its effects are cumulative. Workers often get snapshots of information about a situation for the child but this does not give a full picture of the neglect a child may be subject to. It is important for all members of the workforce to understand what life looks like for a child in order to effectively identify neglect at the earliest possible opportunity.

Learning from HSSCP Child Safeguarding Practice Reviews undertaken over recent years has indicated that children's lived experiences need to be better sought, captured and understood by professionals. Professionals need to be more curious in their questioning and exploration; to go beyond what is on the surface and build a bigger picture and understanding of the persistence and cumulative impact of the neglect children are experiencing.

Findings from a recent neglect-themed audit supported this learning. Professionals told us that gaining the 'voice' of non-verbal children and of individual children where there are large sibling groups and understanding the impact neglect is having on their day to day life, was difficult. The child's lived experience was not evident in the audit submissions provided by agencies and HSSCP recognised the need to support the multi-agency workforce in evidencing what life is like for the child and in identifying neglect at the earliest opportunity.

TRAINING AND DEVELOPMENT

70 multi-agency training sessions delivered

6,745 e-learning sessions completed

1,475 people attended multi-agency training

A very well delivered course that gave the opportunity to learn and expand my knowledge base

I really enjoyed the training, took a lot from it and the time flew by .

This has given me lots to reflect on - This training was excellent!

The small break out groups worked well and it was great that there was a mixture of professional so we could share experiences.

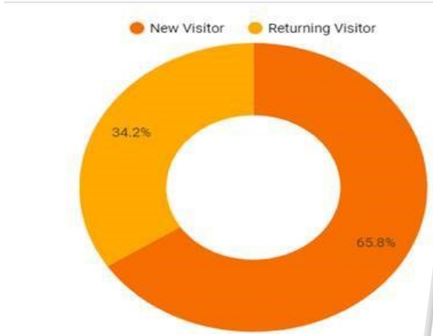
All training is worthwhile and even if it is one piece of information or one technique that my team members return with then it has been beneficial.

COMMUNICATION AND ENGAGEMENT

HSSCP continued to engage with partners and professionals and share key messages across the multi-agency workforce. The partnership produced and circulated their monthly e-bulletins which provide a range of useful articles, resources and tools on key up-to-date safeguarding issues and themes. Quarterly newsletters, updating professionals on the work undertaken each quarter, were also shared. The HSSCP website continues to be regularly updated with partnership news and publications and key messages are also shared via HSSCP's Twitter account.

6396 visitors to the HSSCP website

24,253 page views on the new HSSCP website

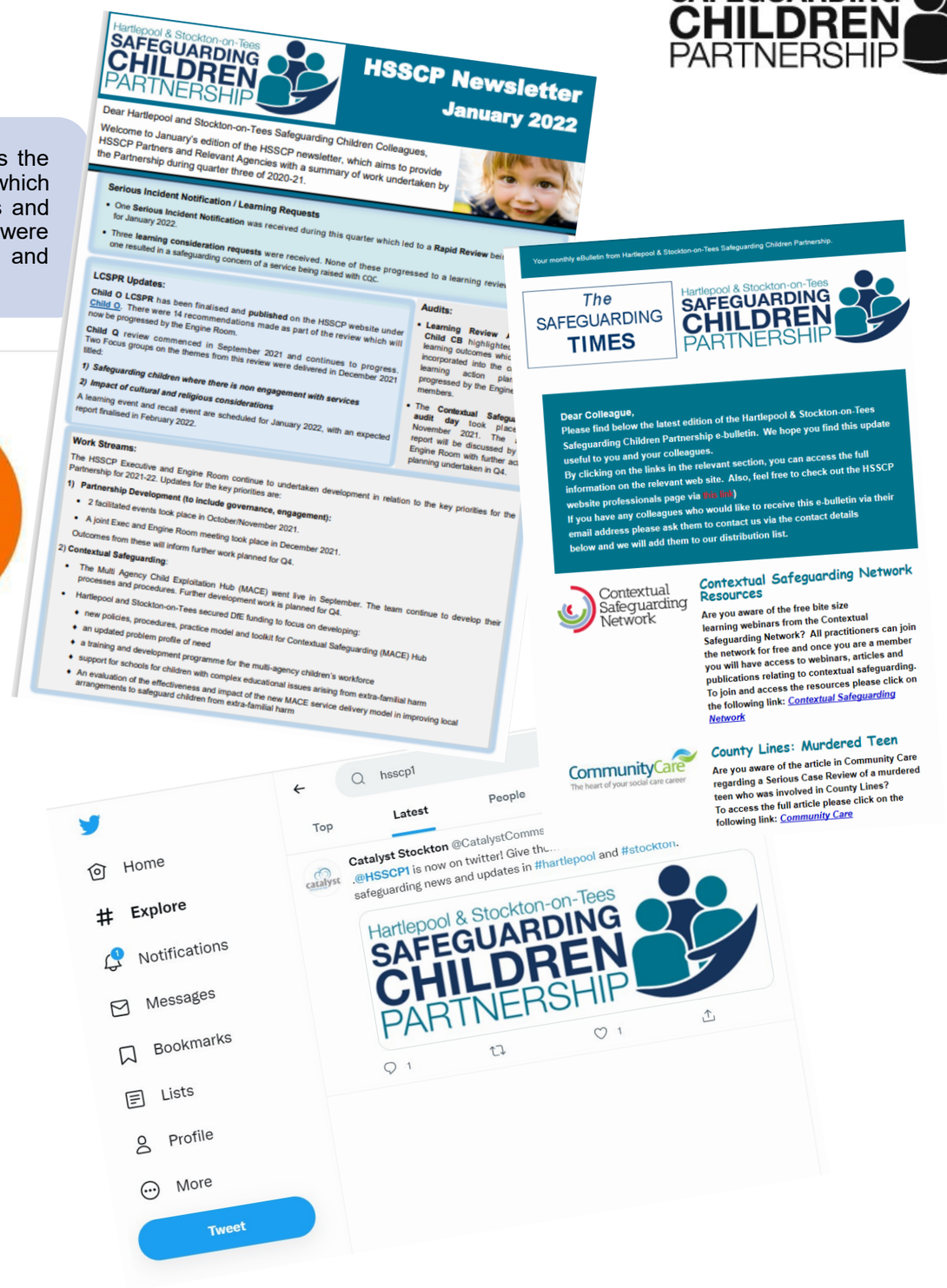


Monthly e-bulletins were circulated to **890** partner representatives for wider distribution. These outlined key messages around pertinent safeguarding themes.

6 Termly Safeguarding Forums were delivered to Designated Leads and Head Teachers across Hartlepool and Stockton Schools.

4 Quarterly newsletters were circulated to partner agencies to communicate HSSCP activity.

HSSCP **Twitter** account - @HSSCP1



Hartlepool & Stockton-on-Tees
SAFEGUARDING
CHILDREN
PARTNERSHIP

Next Steps

NEXT STEPS

HSSCP Priorities for 2022-23

Key Priority: NEGLECT

Since going live as a partnership in April 2019, HSSCP has reviewed 11 serious safeguarding incidents. Neglect featured in all of these cases and in five of them was the cause of the serious injury or death. The pressures on services across Hartlepool and Stockton-On-Tees in relation to neglect are significant; with the numbers of children becoming Looked After by the Local Authorities due to neglectful parenting at a high (approximately 69%). It has been agreed that HSSCP's agreed key priority for 2022-23 is neglect . This key priority has been broken down into three key areas.

Neglect Priority 1: Evidencing the Child's Lived Experience

Neglect can be devastating for children yet it can be difficult to identify as its effects are cumulative. Workers often get snapshots of information about a situation for the child but this does not give a full picture of the neglect a child may be subject to. It is important for all members of the workforce to understand what life looks like for a child in order to effectively identify neglect at the earliest possible opportunity.

Learning from HSSCP Child Safeguarding Practice Reviews undertaken over recent years has indicated that children's lived experiences need to be better sought, captured and understood by professionals. Professionals need to be more curious in their questioning and exploration; to go beyond what is on the surface and build a bigger picture and understanding of the persistence and cumulative impact of the neglect children are experiencing.

Findings from a recent neglect-themed audit supported this learning. Professionals told us that gaining the 'voice' of non-verbal children and of individual children where there are large sibling groups and understanding the impact neglect is having on their day to day life, was difficult. HSSCP recognise the need to support the multi-agency workforce in evidencing what life is like for the child and in identifying neglect at the earliest opportunity. This key area aims for the multi-agency workforce to focus on what life is like for the child; describing their lived experience and how neglect is impacting upon their health and development. It will seek to achieve:

- An improvement across the multi-agency workforce on understanding the child's lived experience
- A strengthened understanding across the multi-agency workforce of:
  - how to evidence what life is like for a child living with neglect
  - how to fill the gaps in what is known to build a bigger (cumulative) picture
  - how to evidence the impact of neglect on children
  - the impact of ACEs on parenting
  - how to evidence cumulative vulnerability and risk

NEXT STEPS

Neglect Priority 2: Assessing and Intervening with Neglect – Understanding and responding to the Impact of Neglect

Neglect is notoriously difficult to define as there is no common view across cultures as to what are desirable or minimally adequate child rearing practices. There is no single cause for neglect. Most neglectful families experience a variety and combination of adversities and it is important for workers to undertake a thorough assessment leading to an analysis of needs in order to implement evidence based interventions. Addressing the causes and not the symptoms through assessment of the specific circumstances is always necessary to establish the difficulties that underpin the neglect.

Learning from HSSCP Child Safeguarding Practice Reviews undertaken over recent years has indicated that assessments need to be more holistic; with deeper analysis of long term chronology and family history as an indicator of future risk. The impact of parental cumulative vulnerabilities on parenting and on parental ability to change needs to be explored within assessments and plans need to be based on a change journey for children with an understanding and use of evidence-based interventions. A large proportion of plans focus on compensatory care without fully addressing the parental actions needed to improve the lives of their children. This does not promote positive change.

Findings from a recent neglect-themed audit supported this learning. Assessments showed a lack of understanding about the parents' historical ACEs and cumulative vulnerability and how these impact upon their ability to parent and ability to change. Professionals recognised the need to dig deeper and be more curious in their questioning and assessments. Plans appeared to be addressing the symptoms of neglect and not the root causes. There weren't always clear, realistic, achievable goals agreed and understood by the family. HSSCP seeks to achieve:

- An improvement in the understanding of and response to cumulative vulnerability and risk (including the impact of Adverse Childhood Experiences upon ability to parent) in assessments across partner agencies and the multi-agency workforce
- A stronger approach to addressing the root causes of neglect and evidence-based interventions within plans and multi-agency meetings
- A strengthened understanding across the multi-agency workforce of:
  - ◊ how to analyse cumulative vulnerability and risk
  - ◊ how to evidence parental motivation and ability to change
  - ◊ the impact of neglect on children and the impact of ACEs on parenting
  - ◊ how to work in a trauma-informed way

Neglect Priority 3: Priority Communication and Engagement

In the recent governance review undertaken by the partnership, HSSCP identified the need to develop a clear set of priorities each year, and to communicate how these are going to be addressed. It set out the need for HSSCP to reinforce and strengthen communications with a stronger focus on the activities and progress of the partnership. It was felt that this would assist in the engagement of partners especially on key thematic priorities. It would improve the visibility of HSSCP, galvanise partners, become the key points of focus of effort and enable a sense of purpose.

The review also identified the need to develop clear objectives for engagement, focusing on groups, organisations and communities; to identify who HSSCP should be talking to, why, how and with what messages based on an assessment of which geographies, communities, organisations ought to be the focus in order to extend the partnerships reach and engagement. In particular, HSSCP wish to develop a specific ongoing mechanism for engaging children and young people, hearing their views, engagement and input into priorities. It is felt that this would have a significant input into the outcomes / impact work above. HSSCP seeks to:

- Strengthen lines of communication from HSSCP to the multi-agency workforce and partner agencies
- Develop mechanisms of communication with children and young people
- Strengthen communication with the public to make HSSCP a recognised body within the community
- Strengthen engagement of partners in the work of the partnership

For more information about HSSCP, visit the HSSCP website by clicking the image below:

HSSCP

Annual Report 2021-22

Hartlepool & Stockton-on-Tees
SAFEGUARDING CHILDREN PARTNERSHIP

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