

# Rotherham Safeguarding Children Partnership First Annual Report 2019 - 2020

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#### Introduction

Welcome to the first Rotherham Safeguarding Children Partnership Annual Report (RSCP) which has been prepared by the Interim Business Manager on behalf of Rotherham Safeguarding Children Partnership.

The Rotherham Safeguarding Children Board (RLSCB) transitioned into the Rotherham Safeguarding Children Partnership (RSCP) on 19 September 2019. The RSCP now provides the safeguarding arrangements under which the safeguarding partners and relevant agencies work together to coordinate their safeguarding services, identify and respond to the needs of children in Rotherham, commission and publish local child safeguarding practice reviews and provide scrutiny to ensure the effectiveness of the arrangements.

Statutory guidance, *Working Together to Safeguard Children (2018)*, sets out that the partnership annual report should provide transparency for children, families and practitioners about the activity undertaken by safeguarding partners in the previous twelve months. It must also set out what the partnership have done as a result of the arrangements, including learning and improvement from Serious Case Reviews and their replacement local Child Safeguarding Practice Reviews, and how effective these arrangements have been in practice.

The report therefore highlights how the safeguarding partners have committed to work together effectively in a multi-agency approach to identifying where action can be taken to improve the services provided to children and their families. A structured programme of highlight reports and multi-agency audits has identified areas for further improvement and this together with performance analysis, consideration of inspection outcomes, and learning from recent Serious Case Reviews have informed the RSCP Business Plan for 2019-2022.

The priorities for the new partnership are grouped under three key headings:

- Safe at Home
- Safe in the Community
- Safe Safeguarding Systems

Through these priority areas the new partnership sought to focus on specific areas for improvement, to keep a strong focus on exploitation and drive further child focussed, self-reflective practice with strong challenge within and across agencies. The partnership safeguarding plan was designed to build on previous improvements and any challenges or barriers to making progress. The above priorities were also informed by key principles which underpinned all activity undertaken by the partnership to safeguard promote the welfare of children in Rotherham as follows:

- **Principle 1.** Championing the interests and rights of children and young people
- **Principle 2.** Involving all partners in Rotherham in a duty to cooperate on safeguarding matters

- **Principle 3.** Receiving independent challenge and scrutiny, to ensure feedback, accountability and learning
- **Principle 4.** Change is led by measurable improvements in the safeguarding systems and outcomes for children and their families.

This report provides evidence of the impact of this work and analysis of our progress against these priorities during our first year of operation from our inception on 19 September 2019 and ends on 30 September 2020. The layout of this annual report and analysis of its effectiveness is framed around the partnership priorities and underpinning principles. The report begins with the Independent Chair's analysis of the effectiveness of the safeguarding arrangements and implementation of the safeguarding plan in Rotherham against its priorities which also acts as an Executive Summary of the report.

As this report is published, all services for children and families in Rotherham, and the Country as a whole, face unparalleled circumstances and challenges brought about by the spread of COVID-19 and the resulting pandemic. However, these challenges have also presented an opportunity for the new partnership to demonstrate how well and quickly they have embedded the arrangements to work collaboratively and respond to these challenges. The report, therefore, recognises the progress the RSCP has made throughout the year, despite the challenges presented, whilst also highlighting those that remain and which we will continue to address in 2020/21.

Chris Edwards, Chief Officer, NHS Rotherham Clinical Commissioning Group

Sharon Kemp, Chief Executive, Rotherham Metropolitan Borough Council

Lauren Poultney, Assistant Chief Constable, South Yorkshire Police

# Independent Scrutiny of the Multi-Agency Safeguarding Arrangements and Safeguarding Plan

Rotherham introduced their new Multi-Agency Safeguarding Arrangements in September 2019 at which time the LSCB ceased to exist. I was recruited to take on the role of Independent Chair and scrutineer of the safeguarding arrangements for Rotherham Safeguarding Children Partnership (RSCP) from the 1st October 2019.

Nationally there is a wide variation in how scrutiny is taking place, In Rotherham, it was agreed by Chief Officers and Executives that the new arrangements would retain an Independent Chair who will provide the necessary scrutiny and judge the effectiveness of the Multi-Agency Safeguarding Arrangements.

The purpose of Independent scrutiny is to provide **assurance**, **monitoring & challenge** to the quality of agencies' work and to:

- Provide assurance in judging the effectiveness of multi-agency arrangements to safeguard & promote the welfare of all children, including arrangements to identify & review serious child safeguarding cases
- Act as constructive critical friend & be a key driver to promoting reflection for continuous improvement
- Judge how effectively the arrangements are working for children & families as well as for practitioners, as well as how well the safeguarding partners are providing leadership.

The approach taken by me over the last 18 months has involved:

- Chairing the Executive Group of the RSCP
- Charing the Wider Safeguarding Partnership Group
- Scrutinising the work of RSCP the serious child safeguarding case review delivery group to ensure the effectiveness of arrangements to identify & review serious child safeguarding cases
- Chairing the Chief Officer's group
- Scrutinising the work of the RSCP delivery groups, including their terms of reference, work plans and outputs
- Reviewing reports into multi agency audits, training and performance data
- Resolving partnership escalation and conflict resolution process including around budgets
- Ensuring that the partnership response to COVID-19 effectively safeguarded the most vulnerable children.

Following a meeting with Chief Officers and the Executive Group at the end of 2019, it was agreed that my scrutiny of the arrangements would be based around a self-assessment of the Rotherham Multi-Agency Safeguarding Arrangements using the <u>Independent Scrutiny:</u> Safeguarding Children Partnership Arrangements Report 2019 developed by Jenny Pearce.

The six steps below are not intended as a checklist for inspection but as a tool for partners to use separately and together to develop and reflect on the effectiveness of the safeguarding children plan. The template will be presented to the Chief Officers and Executive Group as part of the review of the Multi-Agency Safeguarding Arrangements in November 2020. The overall assessment against each of the six steps can be seen in more detail on the website.

STEP 1	The three core partner leads are actively involved in strategic planning and implementation
STEP 2	The wider safeguarding partners (including relevant agencies) are actively involved in safeguarding children
STEP 3	Children, young people and families are aware of and involved with plans for safeguarding children
STEP 4	Appropriate quality assurance procedures are in place for data collection, audit and information sharing
STEP 5	There is a process for identifying and investigating learning from local and national case reviews
STEP 6	There is an active program of multi-agency safeguarding children training and workforce development

#### **Summary points**

The strategic partnership in Rotherham has worked hard to maintain effective oversight of the safeguarding arrangements in Rotherham. There is strong leadership and constructive, critical challenge of practice. Whilst there have been a number of significant challenges over the last year that put the partnership and some individual agencies under pressure, it has demonstrated a willingness by all to seek resolution and gave me confidence that concerns will be acted on in a timely way and children's welfare put first.

#### What has gone well?

#### Partnership engagement

This was the first year of the new arrangements and the three core partners have been actively involved in the strategic planning and implementation of the new Multi-Agency Safeguarding Arrangements demonstrated through the regular Executive Group meetings. They agreed some core principles and three key areas of priority as reflected in this report: Safe at Home, Safe in the Community and Safe Safeguarding Systems.

The wider partnership meetings have good representation from both statutory and voluntary organisations, including schools. Relevant agencies have demonstrated their commitment to safeguarding by contributing across a range of meetings and delivery groups. I have also met regularly with Chief Officers, lead members and chaired the Chief Officer safeguarding assurance group.

I have developed solid working relationship with the Safeguarding Adults Board, Independent Chair to ensure that where possible we address activities together. The Section 11 partnership safeguarding assurance reporting was a shared activity, as is the forthcoming and previous Safeguarding Awareness Week (SAW). Under the partnership protocol, I also meet with other wider strategic partnership chairs and councillors through a variety of meetings so that there is more focus and join up on the whole system response to some of the issues that affect each group such as domestic abuse, exploitation and substance misuse, and mental health. A wider protocol for joint working is in the process of development.

#### Learning from Serious Case Reviews and Child Safeguarding Practice Reviews

It is the responsibility of the Safeguarding Partners to identify serious safeguarding incidents at a local level and then to review them as appropriate so that improvements can be made. Serious incidents, notifications and rapid reviews have been carried out as per government guidance and where necessary single/multi agency reviews or audits commissioned. Review of the case review group and membership resulting in more senior chairing and representation from key agencies.

There has been scrutiny by the RSCP of how partners embed lessons from reviews and audits into practice and their own training and a review of outstanding action plans. I would suggest that more work is needed over the next 12 months to evaluate the impact of various approaches to reviews and to ensure that the focus of learning includes both local and national reviews. Key agencies took part in case review training I facilitated and consequently templates and processes have been updated accordingly.

The RSCP also participated in working with the Child Safeguarding Practice Review Panel on the national thematic review into non-accidental injury into children aged under one, with a focus on the role of fathers. When published the partnership will reflect on its findings and consider any improvements that can be made locally in response to the learning identified.

#### COVID-19 assurance that children are effectively safeguarded

The partnership response to COVID-19 and safeguarding children was reassuring both at a strategic and operational level. I held regular assurance meeting with named partners and the Executive Group to ensure there was a joined-up approach to the identification of the most vulnerable children and families. The response and joint working between the local authority, schools and agencies has been excellent and all have worked hard to ensure that the most vulnerable children continued to have access to school and support. The number of Elective Home Educated (EHE) children is, however, rising which is a cause for concern and will need to be carefully monitored by the partnership.

#### Performance Monitoring/assurance/audit

As highlighted in the partnership safeguarding snapshot and through the report there has been scrutiny of both single and multi-agency performance and assurance information. There have been several audits presented to the RSCP that provide a window into the multi-agency safeguarding system. The RSCP also received the section 11 self-assessment and

provided challenge to partners and relevant agencies regarding their evidence against the descriptors within each safeguarding standard.

The performance information has led to the partnership focussing on reducing the number of children subject to a Child Protection Plan and the number of Looked After Children, which are higher than statistical neighbours and other areas in the region. The partnership has also worked together to increase the number of Early Help Assessments undertaken by partners and relevant agencies and this maintains a focus going into 2020-2021.

The partnership has also tested the application of thresholds through audit of contacts from the health economy and education settings as well as taking forward learning from the audit of strategy meetings to strengthen the response from the multi-agency safeguarding system.

#### Holding agencies to account

All key partners have presented assurance reports post any inspection. The Rotherham Foundation Trust (TRFT) have provided details of their action and improvement plan to the Executive as a result of CQC inspections resulting in challenge and assurance meetings. I have also held two meetings with the Chief Executive and deputy executives of TRFT and the Chief Nurse. Ofsted have recently undertaken a focused visit to Children's Social Care and the outcome of the report will be published on the 4<sup>th</sup> December 2020.

# Partnership Challenges - What do we need to do differently or better? Budget

When I took up the role of Independent Chair it was clear that there was a significant overspend on the partnership budget, resulting in a deficit that needed to be met. Partners agreed after consultation to split the deficit to achieve a balanced budget for 2019/20. There was, however, no agreement across the three named partners as to the contribution to 2020/21 budget. The long delay in confirming the police contribution by the PCC resulted in significant drift and delay in a review of the back-office support arrangements and a restructure resulted in a reduction of staff and redundancy. Going forward the potential of a reduction in contributions and pressure on partners continues and without timely agreement will have a direct impact on the ability of the business office to carry out its statutory functions.

#### Ensure that babies and very young children are kept safe

Nationally there has been a rise in serious injury in children aged under one. I have requested a multi-agency audit of children who have recently been stepped down from child protection plans or have caused concern in the past and had a new baby to ensure that locally agencies are doing the best they can to identify and support families with new babies. Finalising and promoting the new neglect strategy alongside the Graded Care Profile 2 will be a key part of this work.

More scrutiny of the Early Help Strategy and Front Door

The second year of the Multi-Agency Safeguarding Arrangements should have more of a focus on Early Help to really assure itself that thresholds are being applied consistently and that families receiving the right help at the right time by the right people.

#### **New developments**

There is the beginning of an exploration of how the wider safeguarding system could understand more about contextual safeguarding in the identification, assessment and response to criminal exploitation and adolescent neglect. This is in the early stages but should form part of the partnership work over the next year.

#### **Review of the Multi-Agency Safeguarding Arrangements**

It is timely now to begin to plan for a review of the Multi-Agency Safeguarding Arrangements with Chief Officers and the Executive Group. The delivery groups need to demonstrate over the next year more of an impact on the work of the partnership with clear and joined up delivery plans against the partnership priorities. I would suggest that at the end of next year that key assurance is sought and evidenced around how and why were priorities selected and more narrative around how they have made a difference to outcomes for children and young people. The voices and lived experiences of children and young people, families and workforce also need to be shown to have more direct influence on partnership work.

#### **Final comments**

The legacy of Rotherham and the continued media spotlight continues to have an impact on Rotherham and the partnership which, my view, creates a level of anxiety that other areas don't experience to the same extent. The demographics of the area which has a high proportion of young families means that number of children who are in local authority care or on child protection plans continues to be high. The additional pressure on Children Services as a result of Operation Stovewood continues to put a strain on already scarce resources. The impact of COVID-19 continues to test the partnership capacity and resources. However, despite all of the above, there is innovation and pride in the work and a real ambition to continue to do the best they can to keep children safe.

In my view the move from the LSCB ways of working to the new Multi-Agency Safeguarding Arrangements has taken some time. So, although the structures were in place on implementation, the functions and operation of the delivery groups, back office review and wider responsibilities did not happen at pace which resulted in some drift and delay. I believe that scrutiny by the Executive and in my role as Independent Chair, alongside the commitment and hard work of staff has improved this, and that next year will see more focused work.

Going forward I would suggest that the named partners could focus an aspect of the scrutiny on some more specific areas of practice to get more direct feedback from children and families and the front-line staff. Ensuring the voice of the child and their lived experience is at the heart of the safeguarding partnership.

Jenny Myers MA CQSW Independent Chair

# **Rotherham Multi-Agency Safeguarding Arrangements**

#### Implementation of the Rotherham Safeguarding Children Partnership

The Children and Social Work Act 2017, which received Royal Assent in April 2017, made significant changes to statutory arrangements to promote the welfare of and safeguarding children in their local area.

- Section 30 of the Act removed the requirement for local areas to have a *Local Safeguarding Children Board (LSCB)*.
- Sections 16 23 of the Act amended the Children Act 2004 and introduced a duty on the safeguarding partners (the Local Authority, Police and Clinical Commissioning Group) to make arrangements with other locally determined relevant partners to work together in a local area to protect and safeguard children.

Working Together to Safeguard Children (2018), changed the governance arrangements which existed under the earlier legislation and statutory guidance and outlines what the responsibilities of safeguarding partners are, delivered through the new Multi-Agency Safeguarding Arrangements. This includes a shared accountability between the three statutory safeguarding partners, the requirement to have independent scrutiny and the transition to undertaking national and local Child Safeguarding Practice Reviews.

The three safeguarding partners were required to publish their safeguarding arrangements by 29 June 2019 and implement those arrangements by 29 September 2019. Transitional guidance was also published to set out the process of change from the Local Safeguarding Children Board (LSCB) to the new safeguarding children arrangements, which included new accountability arrangements for Child Death Reviews, the completion and publication of Serious Case Review and transition to local Child Safeguarding Practice Reviews.

Rotherham Safeguarding Children Partnership (RSCP) published its arrangements on 17th June 2019. Further details regarding the arrangements and structure of the partnership can be found in the RSCP published safeguarding arrangements, on their new and updated RSCP website. The safeguarding arrangements explain the RSCP governance arrangements, how the Executive Group operates, what the wider partnership entails, what is expected of its members, the functions of its Delivery Groups and where risk, liability, accountability and ownership lie.

The RSCP is led by an Executive Group, comprised of senior leadership representatives from the three statutory safeguarding partners:

- Rotherham Metropolitan District Council,
- NHS Rotherham Clinical Commissioning Group
- South Yorkshire Police

It also includes senior leadership colleagues from two health provider organisations, the Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH) and The

Rotherham NHS Foundation Trust (TRFT). In addition, Rotherham's Wider Safeguarding Partnership encompasses all *Relevant Agencies* whose work contributes to children and young people's wellbeing, education, physical and mental health, safeguarding, citizenship and contributions to society.

The Multi-Agency Safeguarding Arrangements has been strengthened by revised terms of reference for its Executive Group and each of the Delivery Groups that feed into and are held to account by the Executive regarding progress with their work plan and the RSCP safeguarding plan objectives. The three Safeguarding Partners have introduced regular scheduled Executive Group meetings, chaired by their Independent Chair to discuss issues such as the local priorities, the structure and functioning of the Partnership, the agenda of forthcoming Partnership meetings, the financial arrangements and any cases subject of Local Child Safeguarding Practice Reviews.

This includes agreeing on ways to co-ordinate safeguarding services, acting as a strategic leadership group to engage and support others, and implementing learning from both local and national serious child safeguarding incidents. *Working Together 2018* is also clear that the Multi-Agency Safeguarding Arrangements does not work in isolation but is part of the locality's broader means of ensuring citizens' wellbeing. As such the RSCP operates a partnership protocol with other statutory partnerships in the locality. This has strengthened the oversight of the Partnership.

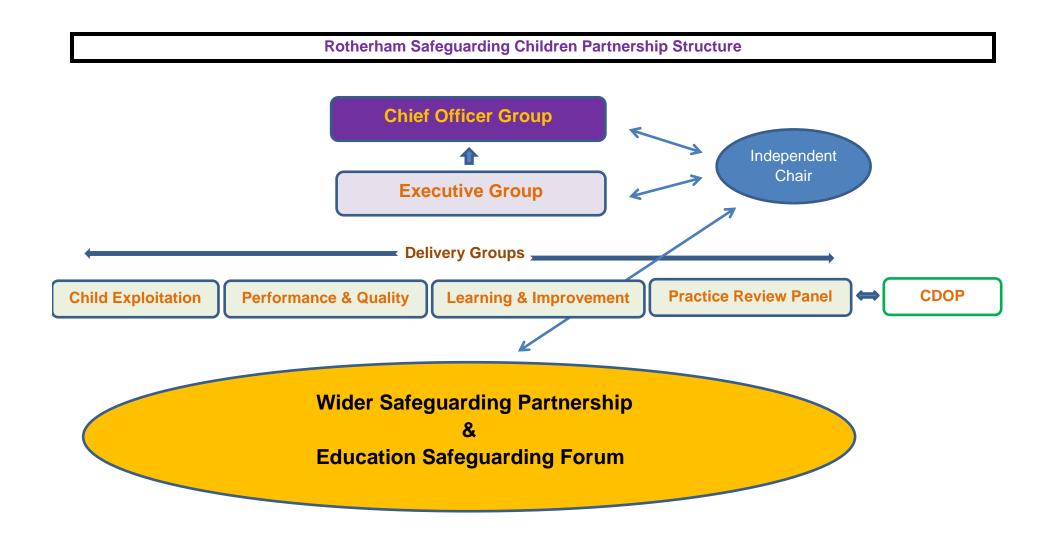
Independent scrutiny is a statutory requirement and is designed to provide assurance internally to partners and relevant agencies as well as their governing and scrutiny bodies and externally to inspectorates. Independent scrutiny is provided to the RSCP by an independent chairperson, who provides a further layer of scrutiny and assurance in judging the effectiveness of multi-agency arrangements to safeguard and promote the welfare of all children in Rotherham, including arrangements to identify and review serious child safeguarding cases and the child death review arrangements.

This independent scrutiny is part of a wider system which includes the independent inspectorates' single assessment of the individual safeguarding partners, Joint Targeted Area Inspections (JTAIs) and Peer Review activity across the region. Safeguarding partners also ensure that the scrutineer is objective, acts as a constructive critical friend and promotes reflection to drive continuous improvement. The Independent Chair therefore considers how effectively the arrangements are working for children and families as well as for practitioners, and how well the safeguarding partners are providing strong leadership.

The revised partnership structure, which build on, streamlined and strengthened the existing partnership arrangements which were already working well can be seen below. The priorities and underlying principles for the partnership are outlined in the <a href="RSCP 2019-2022">RSCP 2019-2022</a> Business Plan on a Page and are:

- Safe at Home
- Safe in the Community

• Safe Safeguarding Systems



#### **Contextual Information**

Rotherham is one of four metropolitan boroughs in South Yorkshire and lies at the centre of the Sheffield City Region. The Borough is divided into 21 wards covering a wide diversity of urban, suburban and rural areas. Rotherham covers an area of 110 square miles with a resident population of 263,400<sup>1</sup>.

There are **50,900** children aged 0-15 in Rotherham and 26,100 young people aged 16-24. Whilst the majority get a good start in life, child poverty is highly polarised across the Borough and life chances can vary greatly. In the most deprived areas, **25%** of the population are aged 0-15, but in the least deprived, the proportion is only **16%**. Rotherham has a lower proportion of young people aged 18-24 than the national average due to young people moving elsewhere to study or work.

Rotherham is the 52nd most deprived district in England (In 2015, 31.5% of Rotherham's population lived in the most deprived fifth of England whilst only 8% lived in the least deprived fifth of England). Further information on the composition and context of Rotherham can be found in the Joint Strategic Needs Assessment (JSNA) at <a href="http://www.rotherham.gov.uk/data/">http://www.rotherham.gov.uk/data/</a>.

Safeguarding Snapshot 2019/2020



There has been a decline in the number of contacts since last year

Timeliness of Early Help Assessments improved, with 82.4% on time

The number of Section 47 Investigations completed remains stable.

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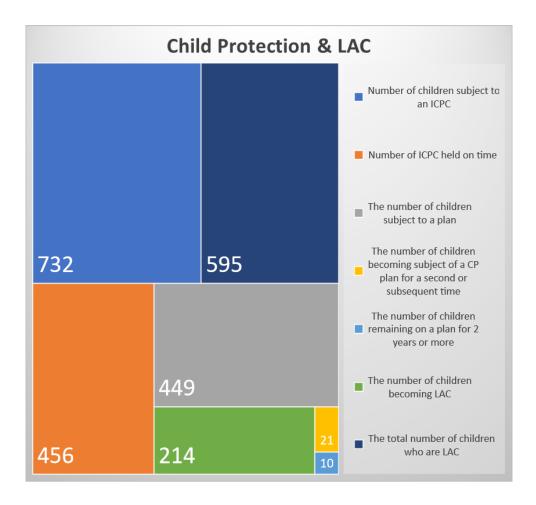
<sup>&</sup>lt;sup>1</sup> Office for National Statistics (ONS) mid-year estimate for 2017

Initial child protection conferences (ICPC) - The number of children subject to an ICPC at year end was lower than that of previous year (786). There was a 62.5% increase in the number of children subject to an ICPC. The overall timeliness for ICPC for 2019/20 (62.3%) reduced significantly by 24.3% from previous year end (86.6%).

Child protection plans (CPP) - The numbers of children becoming subject to a plan and ceasing to be subject to a plan have remained relatively stable. The number of CPP cases has been gradually reducing over the last few months to 449 and now stands at 58 less than previous year end.

Child protection plans - time period - The number of children becoming subject of a plan for a second or subsequent time (in 24 months) is 2.1% higher than the previous year. Plans lasting 2 years or more increased and the yearend figure was 1% higher than the previous year. Plans lasting 2 years or more that were 'ceased' in period outturn is significantly higher (4.7%) when compared to the previous year (1.2%).

Looked After Children - The number of LAC children has continued a downward trend throughout the year and at 595 has ended at 47 less than in 2018/19 (642). The number of admissions into care has reduced by to 214 versus 271 when compared to the previous year end. The number of children ceasing to be LAC has remained consistent at 259 compared to 254 at previous year end.



LAC permanence has increased to **32.4%** at yearend and similarly the number of children who ceased to be LAC due to a Special Guardianship Order has also increased to **16.2%**.

# **Priority 1 - Safe at Home**

The majority of children who need help and support are suffering from some form of neglect. This may be because parents do not understand how to meet their child's needs or because their ability to do so is impaired because of substance or alcohol abuse, mental health needs or domestic abuse. Our aim through the Rotherham neglect strategy to help professionals to spot the early signs of neglect and to intervene as early as possible with the right level of support to improve outcomes for children.

We will continue our focus on the safety and well-being of children who are looked after by the local authority, seeking assurance that there are sufficient quality places for children in or near Rotherham and that their needs, including their health needs are assessed and met in a timely fashion.

#### What went well?

The Rotherham Multi-Agency Safeguarding Hub is working well. There is close working with RMBC Children and Young People Service (C&YPS) Safeguarding, Early Help, South Yorkshire Police (SYP), NHSR CCG senior representatives and other multi agency partners. They all attend the joint meetings to ensure abuse or neglect is recognised early and are involved in making decisions around appropriate levels of responses. This ensures that the thresholds are consistently applied for children in circumstances of abuse or neglect.

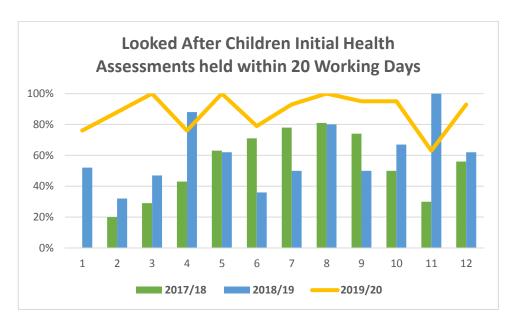
The Partnership has progressed the development of key guidance, to promote the provision of more timely, appropriate support for children and families within Rotherham. Partners have engaged to ensure this is embedded within their agencies. The Partnership provides multiagency training and support to ensure workers are able recognise and respond appropriately to concerns about a child. The voice of the child is central to all work undertaken with children. There has also be progress regarding children in particular circumstances as detailed below:

#### Neglect

- Following a multi-agency working party, the Neglect Strategy is being revised and refreshed and as a co-production piece of work with young people. There was also a review of the use of the Graded Care Profile 2 (GCP2) toolkit will be used. Further virtual learning delivery was agreed regarding the use of the toolkit and other tools that sit alongside it such as the hoarding scale, alongside further guidance for practitioners to consider strategically as to where the GCP2 will be used and clear practice guidance.
- This work could not have been done, had it not been for the strong partnership arrangements, which exist in Rotherham. This ensured the work on refreshing the strategy was co-produced, with work now ongoing to support its conclusion and delivery, with learning being captured, and areas for improvement being acted upon quickly. In support of the Neglect Strategy, training has been led by Rotherham Social Care in training attendees at Strategy meetings on what is required and why.

#### **Looked After Children**

- Rotherham partners worked together to ensure that the needs of all children in care
  were rated according to level of need and that the most appropriate professional sees
  the child or young person based on their identified unmet need. This could be a Social
  Worker, School Teacher, health worker or police officer. Agencies are sharing
  intelligence well and always in the interest of the child.
- Rotherham multi-agency teams are working together innovatively to deliver adult
  medicals for Foster Carers and prospective Adopters. These are unprecedent times and
  require staff to all pull together in the interest of our children and families. The Deputy
  Designated Nurse has set up robust systems to support this way of working and has
  received national interest as it appears extremely effective. GPs in Rotherham are
  supportive of this work and it has released them to care for patients.
- Proactive and tenacious senior leadership within NHS Rotherham Clinical Commissioning Group (NHSR CCG) and Rotherham Metropolitan Borough Council (RMBC) has provided both grip and traction on challenges within the Borough regarding our high number of children in care when compared to other Local Authorities (LA) in South Yorkshire.
- The CCG were able to implement the changes that the Looked After Children Council raised with us in 2018. Initial Health Assessments (IHAs) are now undertaken in a more 'user friendly' manner; with appointments for school age children being outside of school hours and several clinics being held in alternative venues.
- The CCG have worked across commissioners and providers to ensure that our children in care receive timely statutory health assessments. The outturn data for Initial Health Assessments within the 20-working day timeframe was 88%. Below is a chart displaying a monthly breakdown and it also includes previous year's data to show the overall progress.



• TRFT have expanded their Looked After Children service, which provides a consistent point of contact, a direct response to work involving looked after children who expressed the need to develop therapeutic relationships with health care staff. The LAC team work closely with RMBC colleagues to ensure a seamless approach to care for this group.

#### What could we do differently or better?

As well as the progress referenced above the RSCP has experienced some challenges and barriers in achieving its objectives and activities under Priority 1.

- The numbers of children in care remain high and this has resulted in a proportion of our children being placed in host authorities. Unfortunately for children placed outside of the local area there are national challenges in ensuring that health needs are met. These challenges are raised regularly with NHS England & Ireland.
- Child abuse investigations have dedicated officers and staff working in roles across the
  Partnership, and due to the nature of their work, turnover of staff can be frequent.
  Challenges often revolve around maintaining requisite skills and sharing information in
  a timely way. This can lead to service level agreements and accurate recording/sharing
  of information being delayed. The ongoing audit work has highlighted areas for
  improvement e.g. to improve detail on police investigation systems and more efficient
  sharing of information from partnership meetings.

#### What more do we need to do or change?

- The safeguarding partners have been shown to act quickly on recommendations, embed good practice and ensure staff continue to have appropriate training to discharge their duties to the highest standard. This needs to continue in the coming year.
- 2020/2021 will see the full implementation of a personalized LAC nursing team which
  has been commissioned by RMBC and NHSR CCG to focus on improving health
  outcomes. This team will be fully established by Autumn 2020 and will make a huge
  difference to our children in care health and welfare issues.
- 2020/2021 will see us strive to be in a strong position in readiness for the anticipated developments and opportunities that an Integrated Care System can give. NHSR CCG leaders for safeguarding and children in care continue to be proactive and add value for Rotherham residents. Examples include leading on aspects of care delivery such as health contribution to MASH; LPS and reducing unwarranted variation in care delivery.
- The next steps from a Rotherham perspective is to consider a wider health and social care footprint and drive up the standard of healthcare for our children placed out of authority. In 2020/2021 TRFT LAC health team are increasing paediatric time by appointing a Named Doctor for LAC. This appointment is imminent and adds to the CCGs desire to improve LACs wellbeing. In addition, our dental offer will increase awareness for the nursing and social work teams.
- Liberty Protection Safeguards (LPS) are due to come into force in Oct 2020 which will impact on 16 to 18 year olds. LPS will replace the Deprivation of Liberty Safeguards (DoLS) as the system to lawfully deprive somebody of their liberty. Regular updates provided regarding possible implications/ risks, are being sought and the CCG awaits further guidance for 2020/21.
- COVID-19 has forced agencies to adapt to different means of communication. Some of these have shown positive results, and more should be done to explore how to maintain these different ways of working can be integrated into routine practice.

• The further development of the new RSCP website will be helpful in ensuring access to information throughout the area as well as updated practice guidance for children in particular circumstances

# **Priority 2 - Safe in the Community**

We continue to give priority to child sexual exploitation to maintain the significant progress made across the partnership and to further improve practice. We are now integrating our work on CSE with other forms of exploitation through the Child Exploitation Strategy and will take account of the recent research on contextual safeguarding. The partnership will also consider the implications of the research on the impact of adverse childhood experiences on children's development and well-being and agree actions to ensure that services for children are informed by this.

This priority is led by the **Child Exploitation Delivery Group (CEDG)** whose work plan cuts across five key themes, each of which has a lead within the CE delivery plan:

- Safeguarding Vulnerable Children
- Support to Victims and Survivors
- Learning and Development
- Child Protection and Detection of Crime
- Operation Stovewood

While this work is firmly aligned with the partnership priority **Safe in the Community**, the activity also supports many aspects across all the other two priorities in terms of its preventative work and in ensuring that governance and structures for Child Exploitation are effective.

#### What has worked well?

- The Partnership has developed an overarching strategy, which encompasses all forms of Child Exploitation. Some of the ongoing work includes refreshing awareness campaigns linked to spotting the signs of exploitation and reducing the risk of exploitation. Both in a working environment and as a member of the public. These campaigns include initiatives such as See Something-Say Something, Ask for Angela and Operation Makesafe.
- The Ask for Angela campaign has been adapted to address other issues which people may be experiencing during lockdown. It's aimed at all ages and the posters include generic questions such as 'is someone making threats to you?' and 'are you being harassed by someone?'. The posters are currently being displayed in around 40 small, local shops across the borough.
- The partnership has received performance and assurance data on child exploitation including children missing and their return home interviews. Information and intelligence is reviewed daily, and reported on at a weekly partnership meeting, chaired by South Yorkshire Police (SYP). All information and intelligence relating to potential victims, offenders and locations for exploitation, are discussed, and acted upon at this meeting.
- Subsequent investigations are then progressed through the Evolve Team, who are made up of police, social care, health and Barnardo's. This investigation structure ensures agencies

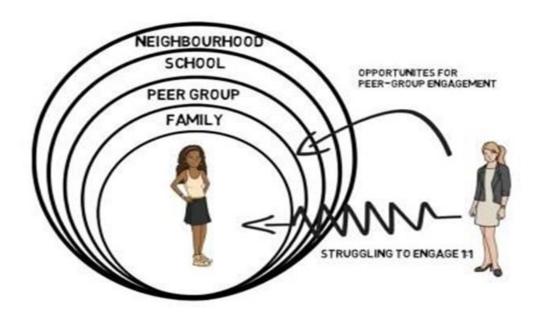
work together in a timely, efficient way to minimise the trauma on victims, maximise the evidential capture and ensure all options for identifying and bringing a suspect to justice are exhausted.

- The Partnership provided challenge and scrutiny on charging and prosecution decisions and as a result agreed a new audit to inform future actions.
- The multi-agency partnership continued to respond to referrals received regarding risks associated with child criminal exploitation. Under new safeguarding partnership arrangements, the delivery group for child exploitation continued to meet regularly, ensuring further learning opportunities for all professionals.
- Contextual safeguarding is promoted throughout agencies, Early Help assessments are key in supporting early identification and intervention to those at risk.
- The partnership Child Exploitation assessment tool is now in use to support the identification of children who may be subject to exploitation and supports multi-agency management.
- A range of 7-minute briefings including on Contextual Safeguarding and Adverse Childhood Experiences (ACEs) were produced by NHSR CCG and were widely distributed and well received.
- Work with multiagency sectors who have influence over extra-familial contexts (e.g. schools, youth groups), has taken place to assist young people to:
  - Recognise and recover from trauma,
  - o Re-build family relationships,
  - o Re-engage in education and other activities.
- Within Rotherham we are currently seeing challenges around gangs and groups involved in exploitation in its many guises. Partners in Rotherham take concerns very seriously.
- MASH meetings are held on all cases of CCE and frontline professionals informed of outcomes. CCG colleagues within the MASH maintain a database on children who go missing and the outcome of each episode to provide detailed multi-agency evidence of unmet need.
- Rotherham Trauma & Resilience Service (TRS) supports/delivers a wraparound health and well-being offer to victims/survivors of historic sexual exploitation. TRS continue work with local statutory and voluntary partners to create a 'Trauma Informed Rotherham'.
- In addition, TRS work closely with the National Crime Agency (NCA) to ensure that
  responses are integrated and take account of research on how best to support individuals
  and staff from the impact of this abuse. TRS are leading the research into partnership
  working on wraparound services for victims/survivors and their families. Their annual
  academic evaluations being shared widely and well received.
- The partnership has continued to ensure that the vulnerability of missing children is recognised, and they are effectively safeguarded. Key to delivery was the commitment and attendance at the Child Exploitation Delivery Group by all statutory partners, relevant agencies and voluntary sector.

#### What could we do differently or better?

• There remain challenges in ensuring people and the wider community recognise the signs of exploitation and report it when they see it. Information and intelligence reports have

- reduced over the last twelve months, along with referrals from agencies. Training and awareness sessions across Rotherham are key to ensuring risks are identified and met.
- Traditional approaches to protecting children/young people from harm have focused on the risk of violence and abuse from inside the home, and don't consider the time that children/young people spend outside the home. Parents and carers have little influence over these contexts. Contextual Safeguarding expands the objectives of the traditional child protection systems with a Contextual Safeguarding approach aiming to disrupt harmful extra-familial contexts rather than move young people away from them.
- This approach seeks to identify ways in which professionals, adults and young people can change social conditions of environments in which the abuse has or is occurring. As a Rotherham partnership we therefore need to focus more on Contextual Safeguarding and continue to develop our work with schools who have a vast array of knowledge of our children and young people and their peer networks.
- The partnership could better or increase our understanding of services available to victims
  of Child Sexual Exploitation (CSE), Child Criminal Exploitation (CCE) and Contextual
  Safeguarding to identify and resolve any delays in engagement. As part of this we also need
  to understand whether there been any impact on access to services for CSE and CCE due to
  the COVID-19 restrictions.
- The partnership also seeks to better understand the increase in online offending and the use of technology by perpetrators in order to enhance its awareness and response to grooming and offending through digital environments.

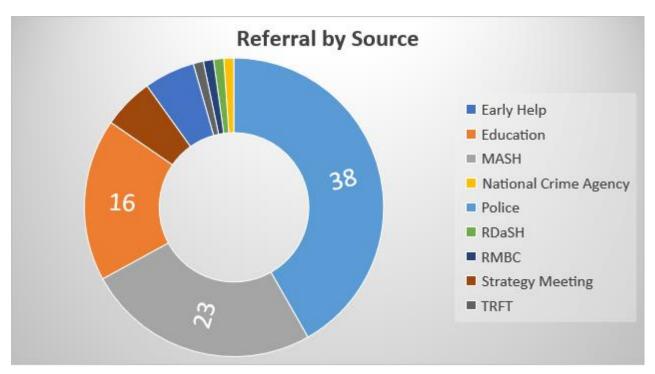


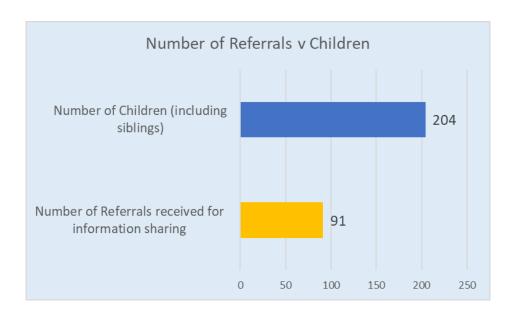
#### What more do we need to do or change?

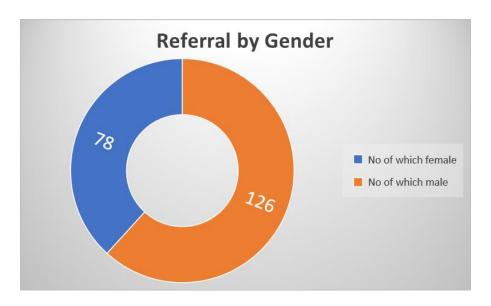
- In order to understand the wider picture of CSE, CCE and contextual safeguarding and to support all aspects of the delivery plan, the partnership will seek to align all performance data into a single format.
- Understanding the impact of contextual safeguarding on children and young people within the Black, Asian & Minority Ethnic (BAME) communities. Collation of information

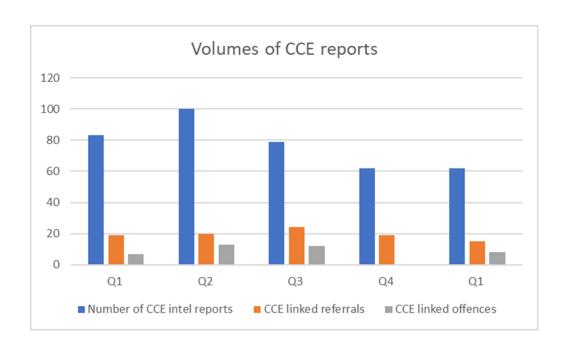
- that identifies the ethnicity of children and their families routinely and their friendship groups and where positive influences are derived from.
- With the closures of school due to COVID-19, the opportunities to see children have been greatly reduced. This is likely to impact on recognition of those who may be subject to child exploitation. As schools resumed, there will be a challenge to identify and meet the needs of such children, particularly as there will be many additional needs identified across the safeguarding spectrum.
- As a borough we will need to look at how we can best understand the risks of contextual safeguarding and engage more with children and young people in order that together we help to keep them safe. Contextual safeguarding is a community response rather than merely a statutory services response.
- The partnership also needs an improved understanding of support agencies available for children and young people at risk or exposed to contextual safeguarding, CSE and CCE.
- The Wider Safeguarding Partnership meeting on 18<sup>th</sup> November 2020 will focus on moving forward from Child Exploitation approaches to embedding Contextual Safeguarding in practice across partners and relevant agencies.
- The partnership will develop wider opportunities for online learning, focusing on key messages for our staff and the wider public as to what constitutes exploitation and how best to report it.
- As communities become more reliant on mobile or digital data, the opportunities to commit offences widen. There is a need with the support of SYP to identify Technology Champions in agencies who can identify signals/concerns, give advice and capture evidence linked to online offending. Funding for this year will train and enhance the skills of Champions who will go on to Safeguard children and give advice across Rotherham on how best to manage investigations focussed on offending online.

#### **Children Exploitation Data Snapshot**









# **Priority 3 - Safe Safeguarding Systems**

The partnership will deliver a programme of audit and workforce development tied to the priorities we have established. A new safeguarding self- assessment across adults and children's services will be introduced and the evidence in these self-audits will be tested through multi-agency challenge. We will also examine the findings from audits undertaken within agencies and undertake a programme of multi-agency audit to measure the effectiveness of practice.

The Wider Safeguarding Partnership has met three times since the inception of the Multi-Agency Safeguarding Arrangements in September 2019. It has used each of these meetings as an opportunity to seek input from relevant agencies and the voluntary sector to consider and contribute to the RSCP safeguarding plan and to also brief them on safeguarding developments both locally and nationally, including Safeguarding Awareness Week and the new refreshed RSCP website. The members of the Wider Safeguarding Partnership also used the opportunity to report on their COVID-19 response and to collective discussion solutions to emerging issues.

#### What has worked well?

- The Multi-Agency Safeguarding Arrangements for Children were published in June 2019 and commenced on 19<sup>th</sup> September 2019 in line with statutory guidance. The three statutory partners (NHSR CCG, RMBC and SYP) together with wider local agencies and third sector organisations are committed to building on progress already made and securing further improvements to ensure children and families are given help as early as possible and are protected.
- The partnership has used this first year of new arrangements to establish how it will work, develop the priorities and come together as a strategic group willing and able to promote positive change and improvement. It has faced financial challenges which it has managed to resolve and worked within reduced means. The partnership has been able to have challenging conversations about issues and the difficulties facing the children and young people of Rotherham, with its unique history which remain a very high priority.
- The Partnership delivery groups have clear work-plans to ensure that their work is focussed and drives forward the priorities and is accountable to the Partnership Board.
- The Partnership has acted quickly to develop audit and assurance reviews in line with wider aspects of safeguarding children across Rotherham. Some of these audits have already been completed, with recommendations implemented and immediate improvement seen. As a result, for example, there has been improved data quality within police investigations, more timely sharing of information and increased use of technology/mobile data when attending strategy meetings.
- Agencies completed their Safeguarding Self-Assessment in July 2020 which enabled their practice to be measured and audited against the standards.
- The Partnership has developed and worked to deliver a comprehensive programme of training, using alternative methods. This has been supported by the Delivery Groups.

- The RSCP Safeguarding Children Procedures have been amended as a result of audit findings and other learning to ensure that practices are effective to safeguarding children between agencies.
- TRFT have worked with partners to review and update the RSCP Safeguarding Procedures, such as bruising in non-mobile babies.
- The NHSR CCG has produced a range of safeguarding 7-minute briefings for use across the partnership on a range of subjects in line with the partnership priorities.
- The Local Authority and NHSR CCG have implemented Child Death arrangements.

#### What could we do differently or better?

- The Partnership has a wealth of performance information from several agencies including police, social care and health. While important, there is a need to review this information, to identify the most appropriate partnership data to inform progress against current priorities.
- While there are several strategies in place, operationally arrangements to safeguard children can rely on workers having an awareness of policy and procedure. The Partnership is challenged by the current situation of COVID-19, potential staff shortages across the agencies and fiscal limitations.
- The resolution of the safeguarding partner financial contributions delayed actions in respect of arrangements about the partnership support team, however, these are now resolved and the revised structure and approach within the Partnership Business Support Unit is in place.

#### What more do we need to do or change?

- The partnership should continue to focus on the development of a stable skilled and competent workforce, who are able to work proactively together to ensure robust arrangements are in place to safeguard children. Communication is key in this, and the development of systems which can communicate with each other will be pivotal to improving this.
- The COVID-19 pandemic has resulted in a raft of new ways of working some of which as a partnership we would wish to take the opportunity to further explore and consider more innovative ways of working in future.
- The partnership should review the front door and early help arrangements.

As part of the RSCP's role in ensuring effective governance, accountability and communication to the wider safeguarding partnership it has undertaken activities that are cross cutting and that provided traction across all three of its priorities. These activities sought to enhance effective partnership working and to provide partners and relevant agencies with a clear understanding of the wider safeguarding context and their roles and responsibilities within it. Much of the work was undertaken under the refreshed partnership protocol which provides clarity about the relationship between these partnerships and their individual priorities. This has strengthened the work of partnership to make safeguarding

children a priority and in ensuring that the needs of children in Rotherham are foremost in service design and delivery.	

#### **COVID-19 Safeguarding Assurance**

In early April 2020, the RSCP quickly came together as a partnership to consider how the COVID-19 pandemic and national lockdown would impact on safeguarding and promoting the welfare of children in Rotherham. The partnership began to hold regular COVID Assurance meetings to provide oversight of any key issues, emerging themes, effectiveness of partnership working and any safeguarding risks across the partnership.

Within this the partnership received updates from individual partners and the key data around contacts, referrals and outcomes as well as any impact on the workforce. These strategic meetings were chaired by the Independent Chair, Jenny Myers who has remained in regular contact with Chief Officers and Senior Leaders in the partnership, to gain assurance that vulnerable children will continue to be safeguarded. The assurance meetings and conversations confirmed that:

#### What is working well:

- The Multi-Agency Safeguarding Hub (MASH) is operating well with the support of virtual and on-site staff.
- Mechanisms are in place to review, assess and plan for domestic abuse cases, including how Multi-Agency Risak Assessment Conference (MARAC) will operate.
- Daily Multi-Agency Domestic Abuse (MADA) meetings are being held for victims of highrisk domestic abuse
- Health Professionals in the MASH are assisting with information sharing for other areas as required such as Early Help, Strategy meetings etc.
- Health professionals within the MASH have worked regionally in considering missing children and sharing systems and process that track children from missing to found.
- Active participation at a senior level in Multi–Agency Zoom Meetings to consider how best for health, Local Authority, Education, Police and voluntary sector to support children who are vulnerable.
- Vulnerable children and their families are still being 'seen' and their voices are still being heard. But in different and innovative ways.
- Frontline Staff are utilising a variety of methods to explain the current challenge of COVID-19 to different age groups. All resources are shared across Rotherham.
- The safeguarding partners and relevant agencies are working closely together to consider all aspects of children's vulnerability including children who are 'shielded' for their own issues and those of their immediate family members.
- Safeguarding assurance is sought via virtual media from healthcare providers this includes safeguarding standards and Key Performance Indicators (KPIs).
- Continuity plans are in place for reviewing child deaths and any serious incidents reported into the partnership and the Government have issued guidance in relation to serious incident notifications and responses.
- Work has taken place regionally with newly qualified dental staff and locally with community dentists and TRFT to consider LAC dental needs as a priority.

 Potential foster carers, adoptees and family carers continue to have a medical completed. This has been achieved through partnership working with RMBC, NHSR CCG, TRFT and the GP's of Rotherham. This has resulted in approximately 180 medicals being completed from April 2020 to September 2020.

#### What could we do differently or better?

- Identifying Black, Asian, Minority Ethnic (BAME) needs and data sharing, although partners have attended the Children Commissioners Launch of the CHILDRN APP, which will dramatically improve data sharing opportunities.
- The possibility of missing an unmet need or risk due to reduced face to face contacts which has brought challenges regarding our ability to effectively safeguarding children and young people. These include young people not always having the confidential space to effectively explore their concerns and make subsequent disclosures and a lack of opportunities to physically observe the child or young person's appearance, presentation, and home environment.
- The ability to effectively assess how safe the service was, as there were so many unknowns due to lack of face to face contacts in community and acute settings.
- The challenges of distributing laptops and other resources to schools.
- Some areas have stopped undertaking Out of Area health assessments due to redeployment; however, this work was picked up by the local TRFT resources.

#### What more do we need to do or change?

- Partners in Rotherham together developed a tool to consider how every contact was made to count. This tool includes discussing with the child how they were coping during lockdown and what did a day in their life look like. Staff working in new ways would have like to utilise it earlier to benefit more children. The tool will be promoted further, and its impact considered as part of the COVID-19 assurance work.
- To continue offering a broad menu of digital engagement options, including platform such as WhatsApp, Zoom, Microsoft Teams and Webchat. These are not used as a replacement for therapeutic delivery, but to maximise engagement in between scheduled appointments.
- Consultation with young people to get a sense of which platforms are most popular or better suited for the purposes of digital engagement.
- Maintain strong multi agency links that have developed by linking services virtually across Rotherham; to continue the 'can do' attitude to be proactive and responsive to challenges that lie ahead.
- RSCP would like to see a more cohesive approach from central government departments in their working relationships as this has sometimes proved challenging at the point of provision.

#### **Learning from Experience**

The **RSCP Executive Group** receives assurance from several different sources in order to ensure the RSCP is making sufficient progress against its business plan priorities, as well as to

consider how well agencies are contributing to safeguarding and promoting the welfare of children.

These activities are managed through the RSCP Delivery Groups and other focussed Task and Finish group as need arises. The activities are linked to the RSCP priorities and objectives and there is alignment of cross cutting activity across delivery plans. This is to not only ensure there is good governance, as set out within the Safe Safeguarding Systems priority, but also that to ensure it contributes to the other two priorities of Safe at Home and Safe in the Community. The work of the Delivery Groups and their contribution to the RSCP Priorities is set out below.

#### **Child Death Review**

- The Child Death Overview Panel (CDOP) is a multi-agency panel which reviews the death of any child aged from 0 to 18 years who is normally resident in the local authority area. The purpose of the panel s to consider the circumstances of the death, and whether there are any areas of learning that can prevent future similar deaths.
- During the year 2019-2020 sadly there have been 14 child deaths in Rotherham. 7 were classed as 'expected' child deaths. 7 were classed as 'unexpected' child deaths. Most of the expected deaths related to children with long term health conditions. Two of the unexpected deaths related to young babies and were categorised as sudden infant deaths. Messages related to safe sleep continue to be promoted within RDASH training and across Rotherham.
- The partnership also received an Interim Report on Sudden Unexpected Deaths if Infancy and Childhood (SUDIC). The purpose of the review was to look at the effectiveness of the CDR arrangements against statutory requirements.
- A review was conducted of the cases which would have been termed as unexpected deaths between October – December 2019. During this period 4 deaths occurred within Rotherham which would have met the criteria for SUDIC. Following a review into the processes of these deaths, 5 learning points were identified which were to be followed up by the CDOP.
- It was noted the new process had brought additional complexities, but this was now being embedded. However, the Executive Group agreed the report provided reassurances and it was evident that responses to child deaths were good.

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#### **Learning and Improvement**

The purpose the Learning and Improvement Delivery Group (LIDG) is to:

 Receive the key areas of learning arising from Lessons Learned Reviews, Child Safeguarding Practice Reviews, multi-agency audits and other quality assurance work. The delivery group will then establish how to implement the learning in terms of changes to practice, procedures, standards, learning, commissioning, and service delivery.

- Review new national practice guidance and research on behalf of the RSCP, taking into account how it impacts upon multi-agency safeguarding children policies and procedures
- Maintain and promote relevant and up-to-date safeguarding children policies and procedures for multi-agency working and oversee their maintenance and publication
- Review a multi-agency learning and development offer based on the priorities of the Partnership, outcomes from audit and the needs of the workforce.
- Assure the Partnership that learning and development by agencies is evaluated by agencies and the impact on outcomes for children and young people is understood.

The Learning and Improvement Delivery Group is responsible for delivering on **safeguarding children training and awareness raising**. The RSCP is committed to supporting a range of multi-agency learning opportunities to practitioners working within Rotherham. Details of the blended learning offered by the RSCP can be found in the <u>Multi-Agency Learning Prospectus</u>. The partnership has developed a Learning and Improvement Strategy which acknowledges a wide range of learning is offered by agencies across the Partnership and will where possible seek to support and enhance this.

The Partnership recognise the significance of a co-ordinated approach in which the overriding principle is that 'safeguarding is everyone's responsibility'. The importance of safeguarding across the wider partnership is recognised and therefore many voluntary and statutory organisations (relevant partners) will be consulted and active partners of this strategy.

In line with the RSCP its core values all safeguarding learning should:

- Place the child at its centre and promote the importance of understanding the child's
  daily life experiences, ascertaining their wishes and feelings, listening to the child and
  never losing sight of his or her needs.
- Create and support an ethos that values working collaboratively with others (valuing different roles, knowledge and skills),
- Respect diversity (including culture, race, religion and disability)
- Promote equality and encourage the participation of children and families in the safeguarding processes.

#### What is working well?

#### Safe at Home:

- Neglect has been a main area of focus during 2019/20 and much work has been undertaken to refresh the Neglect Strategy and to consider approaches to benchmark neglect. This work is detailed further under Priority 1.
- Neglect is a main agenda item at the next Learning and Improvement Delivery Group in order to seek assurance regarding the partners understanding of the long-term impact of cumulative harm through neglect and has been linked to the learning from recent practice reviews.

 The partners and relevant agencies continue to ensure they receive appropriate training on a range of safeguarding topics both on a multi-agency basis and in-house, this includes learning and development on neglect.

#### Safe in the Community:

- There are strong links to Child Exploitation and Performance & Quality Assurance Delivery Groups regarding disseminating learning and testing the impact on practice
- Safeguarding Awareness Week in November 2019 covered a wide variety of sessions and topics and is due to be rolled out again to include a session with the wider partnership on Contextual Safeguarding.
- The partnership provided a response to *Operation Makesafe* where early identification and response was key to progressing work with Early Help Services.

#### **Safe Safeguarding Systems:**

- The Learning and Improvement Delivery Group has refreshed its membership and Terms of Reference as well as streamlining and revising its delivery plan to ensure it is focussed on the RSCP priorities and plans.
- There are regular updates to the online multi-agency procedures and associated pathways, protocols and practice guidance in line with local and national agendas.
- The Learning and Improvement Delivery Group produces and disseminate 'learning on a page' from audit findings.
- Further learning has been extracted through case specific practitioner learning events which highlighted further work around neglect, trauma and impact on parenting.
- The RSCP has received assurance from serious cases and lessons learnt reviews and undertaken a validation exercise to ensure the action plans have been concluded and are demonstrating impact.
- The RSCP has participated in a partnership practitioner event for the National Review and has disseminated the key messages and learning across the partnership.
- The RSCP has developed and implemented a Learning and Improvement Strategy in order to ensure that all training and development provides a focus on practitioner development and improving standards of practice.
- Due to the COVID-19 pandemic, all multi-agency face to face safeguarding sessions run by the RSCP were halted in March 2020 in line with Government guidance. Learning and development resources and sessions have therefore moved to elearning, virtual classroom courses or webinars. Webinars and virtual classroom courses are led by a real tutor and are run in real time. Via this medium, delegates can still ask questions and interact with the facilitator and the other attendees, thus learning and best practice remains shared. This conversion was swift and effective.
- The platform allows for workshops, exercises, polls, videos, audio, documents, tutor
  webcam and games to be shared with the delegates making the experience
  immersive and interactive and experiential. These current arrangements will be
  reviewed by the Learning and Improvement Delivery Group in compliance with
  further Government guidelines as further information arises.

- This provided a comprehensive online training catalogue designed to support practitioners across the workforce with safeguarding children learning and development that includes access to over 30 e-learning courses, virtual classroom courses or webinars including safeguarding awareness and a variety of subjects for children experiencing or living in particular circumstances.
- The RSCP training offer is continually reviewed to ensure that it responds to local need and priorities and the training strategy takes into account national, regional and local factors, including acting on the recommendations of serious incidents, practice reviews, child death reviews, and other lessons learned.
- In 2019-2020, **58** courses across a range of safeguarding subjects were offered to practitioners across the partnership in Rotherham as per the course prospectus.
- Safeguarding Awareness Week (SAW) held by the partnership in November 2019 saw all partners and relevant agencies across the Wider Safeguarding Partnership take part in a range of training, workshops and briefings that covered a range of subjects.

# What could we do differently or better?

- A full Learning Needs Analysis needs to be undertaken to provide a fuller analysis of the multi-learning offer so as to better understand the take up and effectiveness of the learning delivered both for and by agencies. This needs to include a review of the RSCP virtual offer and to consider the delivery strategy for 2020/21.
- Following this there needs to be an update of the RSCP Learning Offer and course prospectus for Jan–April 2021, building on feedback thus far.

#### What do we need to change or do more of?

- There needs to be further work on embedding learning from serious incident actions, this is to include Neglect and Trauma Informed Approaches.
- Following the refresh of the Neglect Strategy there is a need to increasing awareness and use of Graded Care Profile2 (GCP2) as a tool to benchmark neglect and which supports the signs of safety approach.
- There is a need to ensure that the RSCP can work within budget to provide multiagency learning as required which is over and above partners' own offer and to consider whether to implement some form of charging policy.

#### **Performance & Quality Assurance**

The purpose the Performance and Quality Assurance Delivery Group (PQADG) is to:

- Use the Performance Assurance Framework (PAF) to monitor the effectiveness of work undertaken by Rotherham Safeguarding Children Partnership and partners to keep children safe.
- 2. Analyse and explore the story behind the received data to advise on ways to improve on its presentation and dissemination; and on improving services by identifying gaps and challenging single and multi-agency services/organisations.
- 3. Plan and develop a schedule for multi-agency and themed audits in relation to relevant areas of interest. Ensure actions arising from the audit activity is completed in a timely

- manner and learning themes or trends passed to the L&I Delivery Group for consideration.
- 4. Develop quality assurance mechanisms for monitoring the effectiveness of the functioning of the RSCP in order to ensure continuous improvement.
- 5. Assist agencies in developing and monitoring local performance indicators.

As well as receiving and scrutinising the Performance data from the PAF, as detailed in the safeguarding snapshot data within this report, the RSCP considered several audits undertaken by the Performance and Quality Assurance Delivery Group over the year.

These included the Education MASH Contacts Audit, Re-audit of Strategy Meetings and Joint S11 Joint Self-Assessment Adult and Children 2019/21. The key findings from these are summarised on the pages following the analysis of the Performance and Quality Assurance Delivery Group activity against the RSCP Priorities.

# What is working well?

#### Safe at Home

- The audits undertaken through the year are demonstrating partners understand the thresholds and are making appropriate contacts and referrals to MASH.
- Partner representation, contribution to meetings and multiagency working is good, an audit of 'achieving timely and best outcomes for children' is already well in progress.

#### Safe in the Community

• The PAF is more focussed on the RSCP priorities and provides evidence of how well the partners are safeguarding and promoting the welfare of children and has been jointly developed with the Child Exploitation Delivery Group.

#### **Safe Safeguarding Systems**

- The PQA has refreshed its membership and streamlined its Terms of Reference and delivery plan, there has been improved attendance and participation by partners.
- Partnership stakeholders are fully engaged in the auditing process, from scope development to discussion of findings and action planning.
- The partnership Multi-agency audit schedule is in place to end of 2020/2021.
- Audit reports are comprehensive and reference effectiveness of safeguarding procedures, application of thresholds and evidence-based research.
- The Section 175 schools' and education settings safeguarding self-assessment and findings from practice audits are shared with the Education Forum.
- Completed self-assessments using the shared joint self-assessment with the Safeguarding Adults Board was reported to RSCP Executive Group in July 2020.

#### What could we do differently or better?

 The capacity within organisations to participate in audit work within timescales is being impacted by factors intrinsic to their organisations e.g. internal audit work, COVID-19 response, Regulatory Inspections. • Going forward into 2021, how best to utilise the partnership resources most effectively to deliver on the Performance and Assurance Framework.

#### What do we need to change or do more of?

- An audit is planned for safeguarding infants where families have stepped down from Child Protection Planning, there is a scope drafted, and cohort identified.
- The audit schedule for 2020/21 needs to provide clarity regarding the audit work planned or each Quarter in 2021, whilst retaining flexibility to respond to emerging issues. A clear steer from the Executive and communication is required within organisations to ensure that there is resource commitment to achieve this.
- Organisations to share their audit schedule/findings with the RSCP P&QA Delivery Group when it is appropriate to do so to enable added value from partnership working.

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# **Education MASH Contacts Audit - Summary**

The audit was commissioned by RSCP to consider why there had been an overall increase in contacts to MASH, as well as a low conversion rate from contact to Social Care referral. There was a concern that the MASH was receiving a number of 'inappropriate' contacts. In total **69** contacts to MASH from across education settings were audited from early years through to college provision. **Eight** site visits were completed to undertake audit work with designated safeguarding leads in schools and collate qualitative data

# What's working well?

- Education professionals make appropriate and timely contacts to MASH.
- Education settings are completing lots of diverse and creative prevention work with children and families; this does not always fall under the formal remit of Early Help but plays a part in prevention of escalation of cases within a universal arena.
- Professionals working in the safeguarding remit of schools are passionate and committed to the children and young people they are working with.
- Education professionals involved in the audit report a positive, supportive working relationship with MASH and the duty and assessment and locality teams.
- Education professionals involved in the audit reported feeling very supported by the MASH Education Representative and Education Safeguarding Coordinator, via the education safeguarding forum.

## What do we need to do differently or better?

- Professionals making contact to MASH should complete the 'worried about a child' form wherever possible following telephone contact with MASH.
- The RSCP online procedures need to be updated to accurately reflect the name of the online referral form previously e-MARF, now 'worried about a child' form.

- Professionals making contact with MASH should always seek consent in line with Multi-Agency Safeguarding Children Procedures. This should be recorded clearly by MASH in the contact record.
- All contacts to MASH should be recorded onto a child's CYPS records; if information is not being recorded, this needs to be clearly articulated to the professional making contact and a reason offered as to why.
- Clarity is needed with MASH around the expectations with regards to feedback, and the online multi-agency procedures updated to reflect this accordingly.
- When a case is open to Early Help this needs to be communicated back to education provisions and they need to be involved in any assessment and plan.
- Referrers to reference in the 'worried about a child' form any preventative or early intervention work that has been completed with children and families

# Next Steps/Future Plans 2020/21

- Partners to develop action plan with clear timescales for completion.
- The action plan to be monitored via the Learning and Improvement Delivery Group.
- The timescale for a re-audit to be agreed.

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#### **Re-audit of strategy meetings**

# What's working well

- Partner representation, contribution to meetings and multiagency working is good; representatives from across the partnership provide good quality, relevant and appropriate information to meetings, even if they are not the allocated worker.
- A wide range of professionals (outside of the 3 key agencies) attend strategy meetings and contribute to decision making for children.
- Social Workers and Team Managers have good knowledge of the children and families they are working with.
- Thresholds for convening strategy meetings and undertaking s47 enquiries are understood and effectively applied.
- There were no cases within the audit sample that identified any concerns around the safeguarding unit declining a request for an ICPC.

#### What are we worried about?

- Some Strategy Meetings were not held in a timely manner.
- Action planning from strategy meetings was not always SMART.
- There were a few cases where the outcome was for a single agency s47 investigation and it was reflected that a joint investigation should have been considered.
- Minutes from strategy meetings are not always shared with partner agencies or are sometimes not shared in a timely manner.

#### Next Steps & Future Plans 2020-21

- Partnership to develop an action plan with clear timescales for completion.
- The action plan to be monitored via the Learning and Improvement Delivery Group
- A clear escalation route is to be utilised where there is any drift and delay in implementation or improvements are not achieved.
- The timescale for a re-audit is to be agreed with the Performance and Quality Assurance Delivery Group.

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#### Joint S11 Joint Self-Assessment Adult and Children 2019/21

#### What worked well?

- All partners engaged with Section 11 safeguarding self-assessment process. There
  were detailed and well evidenced returns with some clear identified actions which
  highlighted the comprehensive use of Section 11 self-assessment
- Both RSCP and RSAB acknowledged that the overall process was beneficial in understanding the Section 11 standards better and identifying actions required for further improvement.
- There was evidence that agencies referenced their evidence sources against the standards.
- Comprehensive version control is evidenced within most self-assessments which provided a level of rigour and assessment.
- RSCP and RSAB have made a commitment that the joint Section 11 process is ongoing rather than a standalone event.

#### What could we do differently or better?

- Joint challenge meetings were postponed due to COVID-19 restrictions. These discussions are an opportunity for organisations to reflect on the comments made within the challenge meeting and update their submission, which would really enrich the current information and would also provide a useful baseline for next year. This needs to be considered in undertaking the next round of self-assessment
- Further assurance was required from some agencies on standards 4 & 7.

#### What more do we need to do or change?

- Organisational action plans for Standards 4 & 7 will be reviewed in 2021.
- The self-assessment tool has been re-opened so users can continue to populate and evidence organisational safeguarding arrangements.

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#### **Safeguarding Practice Review Group**

The purpose the Safeguarding Practice Review Group (SPRG) is:

- To consider referrals for Local Child Safeguarding Practice Reviews (LCSPRs) and to receive notifications and referrals from the safeguarding partners and relevant agencies.
- To ensure Rapid Reviews are undertaken

- To discuss the local implications of recent national practice reviews and learning from other reviews nationally to identify any actions to be taken locally.
- To prepare reports to be agreed by the safeguarding partners which are to be sent to the National Child Safeguarding Practice Review Panel.
- To commission, and quality assure SGPR's as required and consider and disseminate learning from reviews in accordance with the Local Case Review guidance.
- To track the timeliness of SGPRs ensuring they are completed within timescales and that any barriers to this are reported to the safeguarding partners.
- To commission, and quality assure SGPRs as required and consider and disseminate learning from reviews.

In recognition of the transition to the Multi-Agency Safeguarding Arrangements and requirements for Child Safeguarding Practice Reviews a session took place in December 2019 with the SPRG members to reiterate the changes in notifiable incidents and agencies duty to notify and the duty of the Local Authority to notify the national review panel of a serious child safeguarding incident.

#### What is working well?

#### Safe at Home:

- The Safeguarding Practice Review Group has received referrals for considered as to whether the case meets the criteria for Child Safeguarding Practice Review and undertaken a rapid review. As a result of this consideration it has identified cases where there is local learning to be gained. As a result, they have undertaken practice appraisal in cases where neglect, cumulative harm and trauma are factors in order to learn from what has happened in the and to improve practice in similar cases in the future.
- The Safeguarding Practice Review Group has received learning from a single agency serious incident report around physical harm to an infant and the importance of effective information sharing. As a result, they commissioned a thematic review regarding injuries to non-mobile babies. The learning from this review was presented to the RSCP and challenge has been established regarding practice improvements. As an outcome of this, multi-agency training regarding the identification and prevention of abuse and neglect in non-mobile babies is to be coproduced and delivered cross agencies.

# Safe in the Community:

• The RSCP has received assurance through the Safeguarding Practice Review Group that recommendations from legacy Serious Case Reviews have been completed and shown impact in improving practice. The Safeguarding Practice Review Group has also provided 7-minute briefings on learning from legacy SCRs commenced by the RLSCP, these have included adolescent neglect, contextual safeguarding and trauma informed approaches. The RSCP has also utilised national resources regarding injuries to non-mobile babies called the ICON approach.

#### **Safe Safeguarding Systems**

- There has been a commitment to regular attendance at meetings from partners and other relevant agencies at a senior level including strategic safeguarding leads.
- There has been a review of the Terms of Reference for the meeting and streamlining of the agenda and an increase in frequency of meetings to ensure that objectives within the delivery plan are progressed and any rapid reviews can be conducted efficiently and within timescales.
- There has been a better overview of whole of the safeguarding agenda by regularly reviewing the Serious Case Review / Child Safeguarding Practice Review tracker, to ensure following up on recommendations and seeking assurance of impact.
- Actions from legacy Serious Case Reviews and recent learning reviews are complete.
- There has been a swift shift of learning points to the Learning and Improvement Delivery Group to take forward and ensure a complete learning loop.

#### What could we do differently or better?

- Moving forward from previous practice within Serious Case Reviews so as to improve the quality, impact and number of recommendations from local Child Safeguarding Practice Reviews.
- There is a need to ensure full partner attendance from the wider safeguarding partnership so that all service areas for children and families can contribute to learning from practice both in individual cases and thematically.
- There is a need to ensure ongoing and effective links to the other delivery groups so as to ensure actions have meaningful impact.

#### What do we need to change or do more of?

- To continue with the current agenda and delivery plan format in line with the revised Safeguarding Practice Review Group Terms of Reference and requirements within Working Together 2018.
- To seek to raise partner attendance from the wider safeguarding partnership.
- To continue to quality assurance recommendations so they are achievable and effective learning is gain and the improvements sought demonstrate impact.

#### **Summary Conclusion**

The RSCP Executive has been proactive and robust in its approach to progressing the priorities and objectives of its safeguarding plan. In ensuring the effectiveness of the arrangements to safeguard and promote the welfare of children in Rotherham it has established stronger and more streamlined systems for scrutiny, performance management and quality assurance. Partner agencies have shown that the leadership, drive and direction provided by the RSCP has resulted in a more confident and outcome-oriented wider safeguarding partnership. Good use is being made of the RSCP Multi-Agency Safeguarding

Arrangements to improve the effectiveness of partnership functions and to respond to key safeguarding risks.

There appears to be good confidence in the ability of the RSCP, through its processes, to have an accurate understanding of the strengths and areas for development in safeguarding in Rotherham and to be able to take early action with partners to tackle any emerging gaps in practice or performance in any of the partner agencies.

There is clear evidence in this Annual Report that the progress made during the last year to ensure the effectiveness of multi-agency arrangements to safeguard children has been far reaching despite the challenges experiences over the year, particularly in the later six months of operation during the COVID-19 pandemic. The RSCP has, from the strong foundations laid by the RLSCB, met its full range of its statutory responsibilities including those for assurance of safeguarding effectiveness across its three priorities.

However, there is still further work to be done in delivering on its strategic priorities and objectives. This includes strengthening the alignment between the partnership's strategic activity and the priorities and concerns of young people and frontline practitioners. In addition, in assuring themselves regarding Early Help delivery and the Front Door and the embedding of contextual safeguarding across the partnership.