



Annual Report

1 April 2018 – 31 March 2019

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Foreword from the Independent Chair

I am pleased to present the Telford & Wrekin Safeguarding Children Board (TWSCB) annual report for 2018/2019. This report covers the period from 01 April 2018 to 31 March 2019.

The purpose of this report is to provide an update on progress made by the TWSCB over the last 12 months and an assessment of its effectiveness, as well as outlining the development plans for the next 12 months.

We are fortunate in Telford & Wrekin to have a strong partnership committed to safeguarding children. As a result of lessons learned from national and local audits and reviews, the Telford & Wrekin Safeguarding Children Board continues to improve safeguarding arrangements for the protection of children in Telford and Wrekin now and in the future. This report provides evidence of the robust work undertaken by all agencies during the year 2018/19.

I would like to record my appreciation for the TWSCB's hard work during this time of organisational transition and budgetary pressures. As always, the TWSCB can rely on the dedication and skills of all the staff engaged in working with children, families and communities. I would like to thank them for what they have achieved in safeguarding and promoting the welfare of children in Telford & Wrekin. I am confident that the TWSCB and partners will continue to work together to improve the quality of services and learn from their own experience and the practice of other organisations and the final section of the report outlines our plan to do this in 2019-20.



Andrew Mason
Independent Chair
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Executive Summary

The Telford & Wrekin Safeguarding Children Board (TWSCB) is a key statutory mechanism for coordinating work in Telford and Wrekin to safeguard and promote the welfare of children and ensure the effectiveness of that work. The purpose of the report is to provide an assessment of the performance and effectiveness of local safeguarding services, identify areas requiring improvement and set out the actions and plans to be taken in the following year to improve the performance and effectiveness of the TWSCB.

This report covers the period April 2018 to March 2019 and is written for both professionals and members of the public.

The TWSCB has continued to work with Partners to ensure that the Board priorities are supported and risks identified with mitigating actions. Strategies, policies and procedures, both regionally and locally have continued to be developed and reviewed to ensure they are fit for purpose.

Local context

a) Our Population

Telford and Wrekin is a place of contrasts, a distinctive blend of urban and rural areas, with green open spaces alongside new housing developments and traditional market towns. On the face of it, the Borough is a prosperous place but there are clear differences across it. Some neighbourhoods and communities in the Borough are among the most deprived areas nationally, whereas equally some communities are amongst the more affluent in England.

The population of the Borough continues to grow at above national rates – driven by the expansion of the local economy and record levels of housing growth. As the population grows, it has continued to change in line with national trends, with the population becoming more diverse and ageing. Although the population is ageing, it is younger than the national structure – with concentrations of younger population in south Telford. However, over half of the population increase between now and 2031 will be in the 65+ age group.

One of the biggest challenges for the Borough remains health inequalities. It is important though to emphasise that the health of the Borough is improving overall, however, for a number of key measures the health of the population is not as good as the national average. This gap to the national position is most evident in the most deprived communities of the Borough with key challenges including a lower life expectancy, higher rates of long term illness and disabilities, high obesity rates and high rates of admissions to hospital for a variety of conditions.

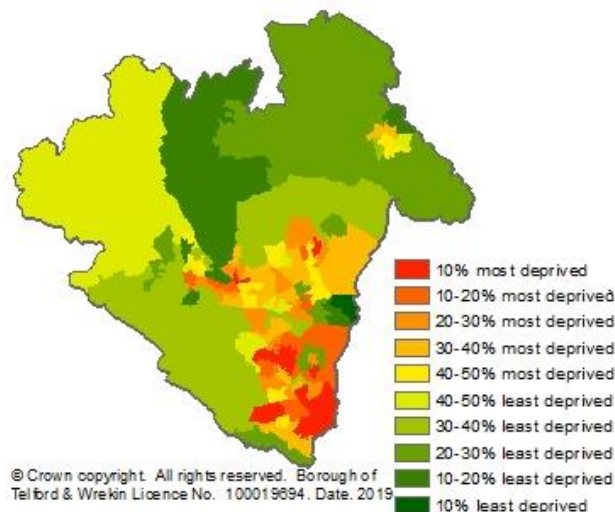
- Telford & Wrekin has an estimated population of 175,800. The population is younger than the national picture, with a greater proportion of the population aged under 20 (T&W 25.2%, England 23.7%).
- The population of the Borough is projected to grow at a faster rate than the England population (T&W 11.2%, England 6.8%) and is projected to grow to 196,900 by 2031, an increase of some 19,900 people.
- There were around 44,300 people aged 0-19 in Telford and Wrekin based on the 2017 mid-year estimates, and around 55,600 in the 0-24 age bracket. As the population of the Borough grows, the number of young people aged 0-24 is set to increase to around 62,200 by 2031 – an extra 3,800 0-15 year olds and an extra 2,100 16 – 24 year olds. The 0-15 age group in particular will increase at a notably higher rate than England (T&W 10.2%, England 0.9%).

- There are just over 2,000 births per year in the Borough. The birth rate in the Borough increased in 2016 for the first time since 2012. Infant mortality rate in the Borough has remained similar to the national rate since 2014-16.
- Around 13.1% of young people were from a BAME background during the 2011 census, the highest rate of any age group. After White British, the next three highest ethnicities in the Borough are Other White, Pakistani and White and Black Caribbean. The proportion of school age children from a BAME background shows a year-on-year increase- 15.1% in 2014 to 20.5% in 2018.
- Around a third of households in Telford and Wrekin (33%) contained dependent children during the 2011 census- higher than the England rate (29.1%).
- 1,530 (2.8%) children and young people (aged 0-24) provided unpaid care during the 2011 census, and around 200 of these young people provided care for 50+ hours per week.

Poverty and deprivation have a known impact on people's wellbeing and their ability to fulfil their potential. Eighteen of the Borough's neighbourhoods are in the 10% most deprived nationally with a further 10 in the 10% to 20% most deprived.

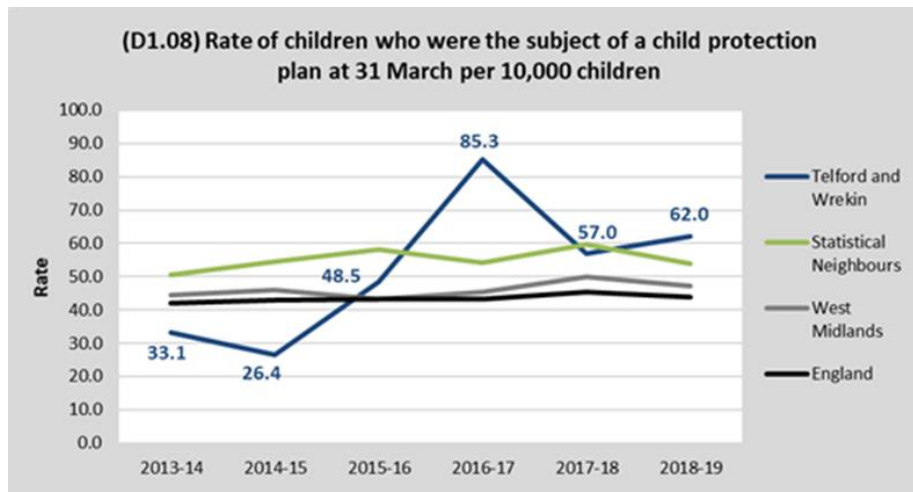
- It is estimated that a quarter of the Borough's population (26%), some 53,800 people are living in areas in the 20% most deprived nationally with 27,300 (16%) in areas in the 10% most deprived.
- The most deprived LSOA in the Borough (Brookside) is ranked 346 nationally (where 1 is most deprived) placing it in the top 2% most deprived of areas nationally, this LSOA was also the most deprived area in the Borough in 2015, but was ranked at 575 nationally, showing an increase in relative deprivation.
- Some 19% of Telford and Wrekin's children live in areas ranked in the 10% most deprived nationally, with a further 9% living in areas ranked 10-20% most deprived.
- There are four areas in Telford and Wrekin (Malinslee & Dawley Bank, Brookside x2, Madeley & Sutton Hill) where more than half of children are estimated to live in income deprivation.
- The most deprived area in Telford and Wrekin is in Malinslee & Dawley Bank and is ranked 171 of 32,844 areas nationally.

Map: Income Deprivation Affecting Children 2019:



b) Child Protection and Children in Care Headline Performance

At the end of March 2019 there were 252 children subject to a child protection plan, an increase from 229 at the same point in 2018. The rate of child protection plan registrations per 10,000 children was 62.0, an increase from 57.0 at the same point in 2018. The England rate was 43.7.



Of the 315 child protection plans started during the year, just under half of those children who were subject to a child protection plan during 2018/19 were categorised as being subject to emotional abuse (149 children, 47%), with a further 119 (38%) subject to neglect.

In 2019 22.5% of children became the subject of a Child Protection Plan for a second or subsequent time, a higher rate than regional, national and statistical neighbours (Stat Neighbours 19.9%, West Mids 20.6%, England 20.8%).

The Borough's rate of LAC per 10,000 population rose from 92 in 2017/18 to 96 in 2018/19, a 4% increase. The Borough's rate of new LAC episodes per 10,000 children increased in 2018/19, rising to 27 from the previous year's figure of 23. Over the same period, its rate of LAC cessations fell, from 29 in 2017/18 to 26 in 2018/19. In 2017/18, the Borough had a higher rate of cessations than new episodes.

In 2018/19 this position was reversed, with more new episodes than there were cessations. This change contributed to the overall increase in the Borough's year end LAC rate.

The Board

Safeguarding and promoting the welfare of children requires effective co-ordination.

Until the Children and Social Work Act 2017 came into force, the Children Act 2004 required each Local Authority to establish a Local Safeguarding Children Board (LSCB). Section 10 of this Act placed a duty to cooperate to improve the wellbeing of children and young people on the Local Authority and its Board Partners. The organisations which are partners are laid out in S 13(3) of the Act.

In 2018-19, the TWSCB was the statutory mechanism for agreeing how the relevant organisations in Telford & Wrekin cooperate to safeguard and promote the welfare of children and young people in the area and for ensuring the effectiveness of what they do.

The definition of safeguarding and promoting welfare of children and young people adopted by the TWSCB and based on Government Guidance is:

“Making sure that children grow up in safety and in a way that they are cared for; protecting them from harm or ill-treatment; making sure that their health or development is not damaged in any way and doing this in a way that means that children have the best possible chances in life.”

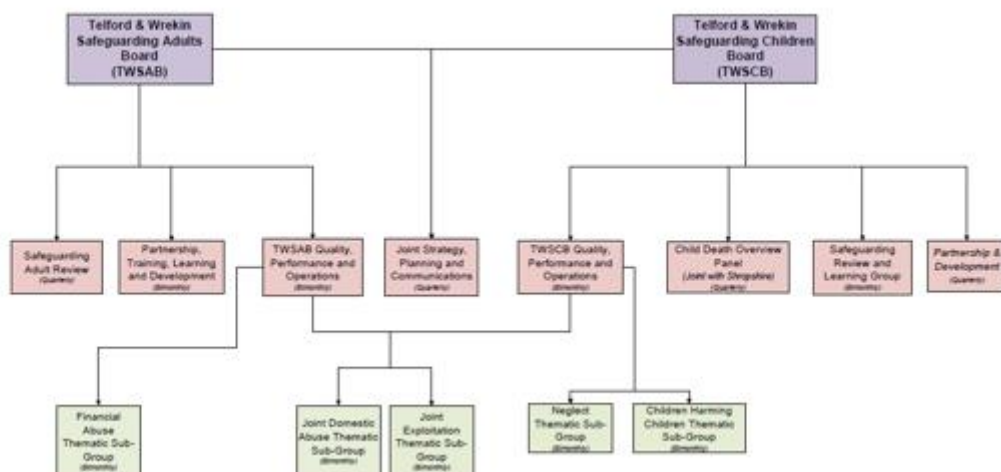
The role of the TWSCB is:

- To put the person who has been harmed or at risk at the centre of everything that we do and listen to their views about what we can do to improve the safety of people;
- To hold Board members to account;
- To collect and share information about how well we are keeping people safe and what more we could do;
- Make sure our workers and volunteers get the training they need to provide safe services and share concerns if they think a person is being hurt or abused;
- To review our policies and guidance to make sure we are constantly improving;
- To raise awareness of safeguarding issues and what to do; and
- To commission Serious Case Reviews and other reviews where appropriate in order to learn and improve practice.

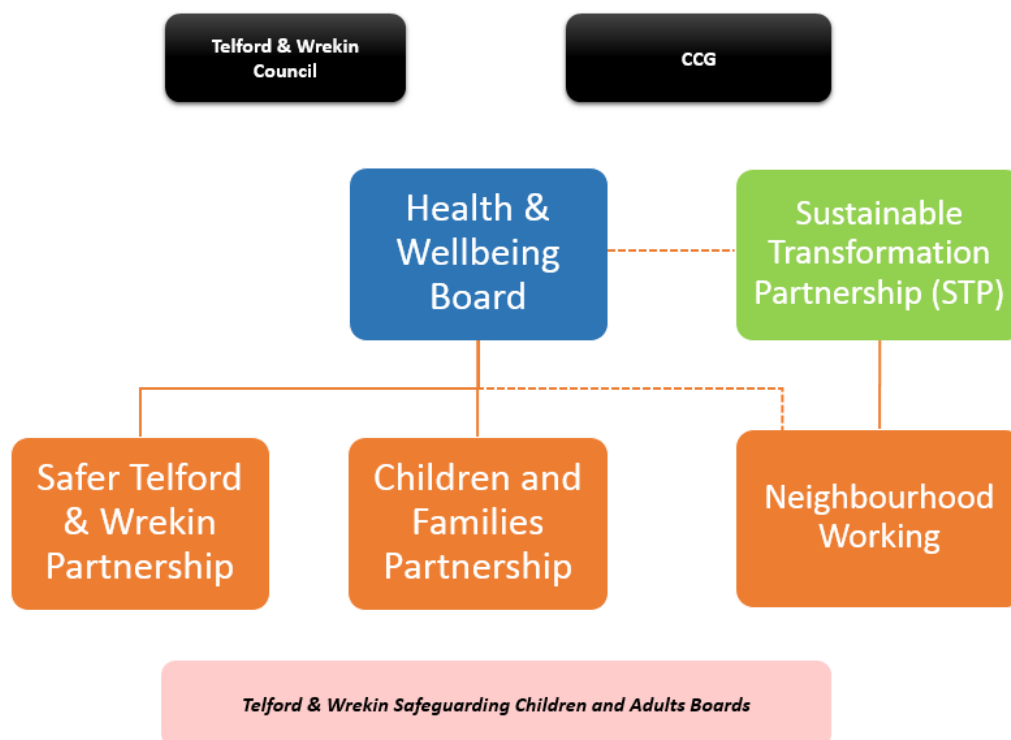
For more detail on the role of the TWSCB, please see the current Terms of Reference.

a) TWSCB structure

The TWSCB structure as at 31 March 2019:



The Telford & Wrekin Safeguarding Children and Adults Boards and Safer Telford & Wrekin Partnership are part of a wider strategic network of partnerships, as detailed below:



b) Board membership

In line with Working Together 2015, the Board is comprised of the Independent Chair, the Partnership Manager and the following partners:

	Organisation/Representing/Job Role	Attendance
Independents	Independent Chair	100%
	Lay members ¹	0%
Telford & Wrekin Council	Director of Children and Adults Services	100%
	Assistant Director: Children's Safeguarding and Specialist Services (Chair of SRL Sub-group)	50%
	Assistant Director: Education and Corporate Parenting	0%
	Assistant Director: Health, Wellbeing and Public Protection (Public Health representative)	75%
	Local Authority Legal Representative	100%
	Lead Member for Children, Young People and Communities (<i>Observer</i>)	50%
Health	NHS Local Area Team Representative	0%
	Shropshire Community Health NHS Trust (SCHT) Representative	50%

¹ Lay Member representatives stepped down at the beginning of the year. Attempts have been made to recruit others, however we are now waiting for the new Working Together to Safeguard Children 2018 guidance to be published before pursuing this further.

	Organisation/Representing/Job Role	Attendance
	Shrewsbury and Telford NHS Hospital Trust (SaTH) Representative	75%
	Staffordshire and Shropshire NHS Trust (SSSFT) Representative (Chair of QPO Sub-group)	75%
	T&W Clinical Commissioning Group (CCG) Representative (Chair of SPC)	75%
	Designated Doctor	100%
	Designated Nurse (Chair of Child Death Overview Panel)	50%
	Designated GP	100%
Police	Local Policing Commander Representative	100%
Education	Private Early Years Representative	75%
	Primary School and Team Safeguarding Voice [©] Representative	75%
	Secondary School Representative	100%
	Special School Representative	50%
	Academy School Representative	50%
	Further Education Representative	50%
	Lead Governor Representative	100%
Probation	National Probation Service (NPS) Representative	75%
	Community Rehabilitation Company (CRC) Representative	50%
YJT	West Mercia Youth Justice Team (YJT)	100%
CAFCASS	Children & Family Court Advisory and Support Service (CAFCASS)	25%
Housing	Wrekin Housing Trust	100%
Voluntary	Chief Officer Group Representative	100%

c) Financial position

The TWSCB's work is funded by the following statutory partner agencies:

- Telford & Wrekin Council;
- Telford & Wrekin Clinical Commissioning Group (CCG);
- West Mercia Police;
- Community Rehabilitation Company;
- National Probation Service;
- Child and Family Court Advisory and Support Service (CAFCASS); and
- Youth Offending Service (YOS).

The TWSCB relies not only on financial contributions from the above agencies but also resources from all agencies involved, for example, the use of meeting rooms. Their contribution and participation on the Board and its Sub-groups is vital to the effective implementation of TWSCB priorities.

The following summary details a breakdown of the budget and spend in 2018/19 and the proposed budget for 2018/19.

	2018- 19	2019-20
	Actual Outturn	Projection
Expenditure		
Independent Chair	£17,911	£17,755
Salaries	£130,024	£115,000
Non-Salaries	£37,180	£71,808
Total	£185,115	£204,563
Income		
Partner Contributions	£185,115	£204,557
Total	£185,115	£204,557

Reserves	2018-19
Opening reserves	£66,000
Closing Reserves	£56,561

The TWSCB budget is monitored by the Partnership Manager and the Joint Strategic, Planning and Communications Sub-group. An annual update is provided to the Board, or when further resources are needed, for the Board to review and revise its budget for the following year.

To build upon the joint work between the TWSCB and the Telford & Wrekin Safeguarding Adults Board (TWSAB), and the introduction of new Working Together to Safeguard Children 2018 legislation, from 2019-20, there will be one budget allocated to cover the work of both partnerships.

Sub-groups

a) Joint Strategy, Planning and Communications *written by Nikki Barden, Assistant Partnership Development Officer*

Since July 2017, the Strategy Planning and Communications (SPC) sub-group has remained as a joint sub-group with the Telford & Wrekin Safeguarding Adults Board (TWSAB), to ensure strategic links and efficiencies across both Boards. The SPC Sub-group remained responsible for strategy development, business planning, governance, timetabling and coordination, for both the Safeguarding Children and Adults Boards priorities. The group met on a quarterly basis and was well supported by partners.

During 2018/19 the group focused on the following:

- Development of the Communication, Inclusion and Engagement Strategy 2018-19; which outlines how the Board will effectively communicate and seek feedback from the relevant audiences such as children, young people, adults with care and support needs, families,

practitioners and the wider community in Telford and Wrekin. The published Strategy is available to download on the TWSCB website

- Reviewing the multi-agency Performance Dashboard ensure it is fit for purpose; using information and intelligence to inform targeted raising awareness in the community and amongst professionals.
- Overseeing the monitoring of TWSAB and TWSCB budgets.
- Reviewing and monitoring the TWSCB Risk Register.
- Horizon scanning and maintaining links with other strategic boards within the Borough.
- Engagement with Housing Associations and Providers to promote safeguarding.
- Reviewing the membership and attendance of all Sub-groups and challenging partners to ensure they are represented, where appropriate.

Going forward, the group will concentrate on the implementation and impact of the Communication, Inclusion and Engagement Strategy, including communication campaigns in relation to safeguarding.

With the introduction of new Working Together to Safeguard Children 2018 legislation, the group will support the development, publication and introduction of the new multi-agency safeguarding arrangements from June 2019.

b) Partnership Development *written by Nikki Barden, Assistant Partnership Development Officer*

The Partnership Development Sub-group has remained responsible for the West Midlands multi-agency policies and procedures and TWSCB training courses.

The Sub-group has delegated authority for delivering the following statutory objectives and functions of Working Together to Safeguard Children 2015:

- *“Coordinating what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children and young people in the area.*
- *Developing policies and procedures for safeguarding and promoting the welfare of children and young people in the area of the authority, including policies and procedures in relation to:*
 - *the action to be taken where there are concerns about a child or young person’s safety or welfare, including thresholds for intervention;*
 - *training persons who work with children and young people or in services affecting the safety and welfare of children and young people;*
 - *recruitment and supervision of persons who work with children and young people;*
 - *investigation of allegations concerning persons who work with children and young people;*
 - *safety and welfare of children and young people who are privately fostered;*
 - *cooperation with neighbouring children’s services authorities and their Board partners; and*
 - *monitor and evaluate the effectiveness of training including multiagency training to safeguard and promote the welfare of children and young people.”*

The group met on a quarterly basis and was well supported by statutory partners. During 2017/18 the group focused on:

- The successful development and implementation of the [West Midlands Regional Safeguarding Policy & Procedures](#) website, which was launched in April 2017. TWSCB joined eight safeguarding boards across the region to develop the regional procedures and to procure a website to host the procedures. The initiative has provided policy consistency across Boards in the region, economies of scale (significantly reducing the cost of providing multi-agency procedures), and provided regional expertise on policy development.

The regional website allows professionals to access procedure on three levels:

- Level 1 procedures are those that are overarching child protection procedures;
- Level 2 procedures are those agreed at a regional level; and
- Level 3 procedures are area specific, including referral guidance, local levels of need, and named contacts.

The Regional Safeguarding Procedures Group (RSPG) continues to meet regularly with the TWSCB representation. RSPG has a rolling programme in place to refresh and update the West Midlands procedures. As part of the commitment to signing up to a regional site, each Safeguarding Board was given responsibility for monitoring and reviewing the content of specific sections. The TWSCB was given the responsibility for reviewing the policy on Exploitation

c) Quality, Performance and Operations *written by Nikki Barden, Assistant Partnership Development Officer*

The Quality, Performance and Operations Sub-groups role is to ensure that the Board's strategic plan is delivered. The group does this through performance and quality assurance processes which include quantitative information (including targets where appropriate) and qualitative information from both multi-agency and single agency sources.

The Sub-group has delegated authority for delivering the following statutory objectives and functions of Working Together to Safeguard Children 2015:

Working Together 2015 specifically outlines that the performance management function for LSCBs is to *“use data as a minimum and should:*

- *Assess the effectiveness of the help being provided to children and families, including early help;*
- *Assess whether LSCB partners are fulfilling their statutory obligations; and*
- *Quality assure practice, including through joint audit of case files involving practitioners, identifying lessons learned and the difference it has made; challenge and test it out.”*

The Sub-group provides:

- Evidence based assurance to the Board that there are robust processes for monitoring systems in place to safeguard children and young people within Telford and Wrekin.
- Assurance that the Board's Learning and Improvement Framework is monitored and reviewed effectively by the Safeguarding Review and Learning Sub-group.
- Monitoring of the progress made within each of the TWSCB thematic Sub-groups, by receiving a progress update from the Chairs of the thematic Sub-groups, at each meeting.

The sub-group met on a quarterly basis throughout 2018-19, and remained well supported by partners.

During the year, the group:

- Received regular updates from the Shrewsbury and Telford Hospitals Trust (SaTH)

d) Safeguarding Review and Learning *written by Nikki Barden, Assistant Partnership Development Officer*

The purpose of the Sub-group is to promote a culture of continuous learning and improvement across the partner agencies through using learning from case reviews to drive improvements in practice.

The Sub-group meets the statutory requirements under Section 14 Children Act 2004, Regulation 5 (1)(e) and 5(2) of The Local Safeguarding Children Board Regulations 2006 [as amended] and the requirements of Working Together to Safeguard Children 2015 [Chapter 4 – Learning and Improvement Framework].

The Sub-group has progressed the following specific activities during the year:

- Ongoing evaluation and review of the available models/methodologies, to ensure that the most appropriate methods were being used for each case for consideration received by the TWSCB.
- Received 4 cases for consideration, whereby 1 of these processed to a Serious Case Review and 1 to a learning review.
- Ongoing learning/case reviews were kept under review pending decisions being made that were outside of the group's control. Learning continued to be developed and shared where appropriate and the action plans reviewed, monitored and impact recorded and challenged. Examples of this included seeking reassurance that supervision arrangements are in place for all professionals, from all agencies and recognition of disguised compliance by professionals.
- Understanding and learning at both a regional and national level has also taken a high priority in 2018/19, with the Sub-group considering and identifying the learning from reports, including the SCR carried out by Wolverhampton Safeguarding Children Board in relation to Child G.

For further information on the reviews which were conducted throughout 2018-19, please refer to the Case Review section of this report.

e) Multi-agency Case Reviews *written by Nikki Barden, Assistant Partnership Development Officer*

In February 2019, a Multi-Agency Case File Audit (MACFA) was carried out by the Neglect sub-group to audit the work of all available agencies with four children and their families identified by TWSCB as children where there were concerns about neglect. The audit had a particular focus on

the effective use of the Graded Care Profile 2 (GCP2) assessment in the recognition, identification and management of neglect.

Actions identified during the MACFA were grouped into the following categories:

- Case Management, including reflection;
- Escalation;
- Parental support;
- Record keeping; and
- Training.

Actions were all assigned a lead to update the Neglect sub-group on progress, and they were included as part of the over-arching sub-group Action Plan, to ensure effective monitoring and implementation.

Following the implementation of Working Together 2018, further thematic MACFAs will be scheduled to tie in with the new thematic priorities of the partnership.

f) Child Death Overview Panel (joint with Shropshire SCB) *written by Audrey Scott-Ryan, Designated Nurse for Safeguarding Children and Chair of CDOP*

The Child Death Overview Panel contributes to the LSCB priorities by working partnership in preventing and reduction of child deaths in Telford and Wrekin. Since the 1st April 2008 Local Safeguarding Children Boards (LSCBs) have had a statutory responsibility to review all deaths of children from birth (excluding stillborn babies and planned terminations) up to 18th birthday, who are normally resident in their area. The duties of the LSCB regarding these procedures are set out in Chapter 5 of Working Together to Safeguard Children (WT 2018).

Part of the CDOP process involves a coordinated, multi-agency 'Joint Agency response, (previously referred to as rapid response) providing a framework for a comprehensive and sensitive enquiry aimed at establishing the cause of sudden unexpected deaths in infants and children. An unexpected death is defined as the death of an infant or child which was not anticipated as a significant possibility for example, 24 hours before the death; or where there was an unexpected collapse or incident leading to or precipitating the events which lead to the death (*WT 2018*). This immediate response is led by the Police/HM Coroner and also includes information sharing and decision making with Social Care, Health and Agencies providing care immediately before and at the time of the death.

The CDOP Process is the Joint Multi-Agency Shropshire and Telford & Wrekin Child Death Overview Panel. This meets 6 times a year to review all child deaths, identifying trends, and working together across agencies to make recommendations to help reduce the number of potentially preventable deaths in the future. The statutory basis of the CDOP's is documented in Working Together.

Dedicated Neonatal CDOP Panels are now well established with a local Consultant Neonatologist from the Shrewsbury and Telford Hospital NHS Trust, joining the Panel to help review neonatal deaths. This has proved invaluable and allows greater integration with neonatal reviews undertaken within local maternity and neonatal units and well as linking in with national reviews such as MBRRACE (National Perinatal Mortality Surveillance).

The functions of the Panel include:

Ensuring, in consultation with the local Coroner, that local procedures and protocols are developed, implemented and monitored in line with the guidance in Chapter 5 of the *Working Together to Safeguard Children – March 2018* - on enquiring into unexpected deaths by:

- reviewing all child deaths up to the age of 18, excluding those babies who are stillborn and planned terminations of pregnancy carried out within the law;
- discussing each child's case, and providing relevant information or any specific actions related to individual families to those professionals who are involved directly with the family so that they, in turn, can convey this information in a sensitive manner to the family;
- determining whether the death was deemed preventable, that is, those deaths in which modifiable factors may have contributed to the death and decide what, if any, actions could be taken to prevent future such deaths;
- making recommendations to the LSCB or other relevant bodies promptly so that action can be taken to prevent future such deaths where possible;
- identifying patterns or trends in local data and reporting these to the LSCB;
- where a suspicion arises that neglect or abuse may have been a factor in the child's death, referring a case back to the LSCB Chair for consideration of whether an Serious Case Review (SCR) is required;
- identifying any public health issues and consider, with the Director(s) of Public Health and other provider services how best to address these and their implications for both the provision of services and for training; and
- increase public awareness and advocacy for the issues which affect the health and safety of children.

The number of Telford & Wrekin child death notifications for 2018-2019 was 11; this is a significant decrease as the previous year was 14. Of the 11 child deaths, 4 deaths were babies born prior to 24 weeks gestation i.e. 'pre viable', extremely unlikely to survive.

Pregnancy loss and the death of a baby

On the 28th January 2019, CDOP organised the Pregnancy loss and the death of a baby SANDS one day workshop for multi-disciplinary groups for 20 participants. The aim of the course was to enable professionals to develop the insight and skills to provide high quality, sensitive care to parents who experience the death of a baby, before, during or shortly after birth. The quality of care that the bereaved families receive when their baby dies can have long lasting effects. Good care cannot remove parent's pain and grief, but it can help parents through this devastating time. Poor care can and does make things much worse. Supporting and engaging the family who have lost a child is of prime importance throughout the whole death review process and our CDOP strives towards delivering high quality bereavement care.

Sudden Unexpected Deaths in Infancy

CDOP focuses on 'preventable' deaths and continues to review a number of babies dying from Sudden Infant Death Syndrome (SIDS). Although it is not understood why these babies, who appear to be well, suddenly die, there are known risk factors such as sleeping position, overheating, smoky environment, co-sleeping.

In many cases babies are found whilst co-sleeping with their parent/s. Co-sleeping is associated with SIDS especially where there are other risk factors. In April 2016 the 'safer sleep assessment tool' was introduced into the Personal Child Health Record (red book) which is issued to all new born babies as the main record of the child's health and development. The tool assists midwives and Health Visitors in informing parents of the known risk factors relating to SIDS. The tool has now

been incorporated into Shropshire Community Health NHS Trust's new electronic patient record, RiO.

The Joint Shropshire and Telford & Wrekin CDOP Panel organised the local 'Reducing the Risks of SIDS' talk which were held in July 2018 and March 2019 with the key speaker from The Lullaby Trust, a charity that supports bereaved families and raises awareness of the risks. The event was held at The Lantern, Shrewsbury and attended by approx. 50 practitioners from health, police, and social care. This year it was pleasing to see staff from local nurseries attending. The opportunity was also taken to highlight other factors that may contribute to babies dying including deliberate harm/shaken baby, safety around dogs and the risk of suffocation from nappy sacks. As with previous presentations the talk had very positive feedback and is planned to be repeated in autumn 2019.

Care of the Next Infant Programme (CONI)

The CONI programme supports bereaved parents who go on to have another baby. These parents often have increased anxiety and feel a loss of control about being able to protect their new baby from dying of SIDS. The CONI programme has been transferred to 0 to 19 years' service from January 2018. Shropshire Community Health Trust is committed to continuing to provide CONI through the Health Visitor CONI Co-ordinators across Shropshire and Telford & Wrekin. The joint Shropshire Community Health NHS Trust and Shrewsbury and Telford Hospital NHS Trust's CONI guideline, leaflets and CONI Resource folders have all been updated.

Neonatal deaths

Nationally and locally the age range with the greater number of deaths are babies under 1 month of age. The dedicated neonatal focused CDOP Panels are now well established with attendance of a Consultant Neonatologist from the Shrewsbury and Telford Hospital NHS Trust. Regular updates are provided on the neonatal reviews being undertaken such as MBBRACE, NHS England etc.

Regional CDOP Group

The Regional CDOP Group was relaunched in 2016 and all meetings have had attendance by one of the Shropshire/T&W CDOP Professionals. The Group's terms of reference include the Group's aims:

- To share information on local, regional and national developments;
- To identify particular work streams to promote regional good practice;
- To support the development of consistent regional policies and procedures;
- To improve the way sudden unexpected deaths are investigated and co-ordinate responses to challenges in the system such as cross county issues;
- To enable regional trends and issues to be identified;
- To identify areas that require research or innovation;
- To identify regional training and development needs and training opportunities; and
- To facilitate safeguarding supervision specific to CDOP/SUDIC practice.

The Group was committed to developing Pan West Midlands Sudden and Unexpected in Childhood Protocol however this has been challenging due to the number of Police areas and Coroners within the West Midlands. Therefore until the new CDOP guidance is launched the West Mercia Multi Agency Management of Sudden and Unexpected Death in Childhood Protocol is currently being updated and mirrors the Kennedy Guidance 2016 as best practice.

The Group's regional conference in February 2018 where lessons and learning was shared across the West Midlands was well received and excellent evaluations were gathered. The next event is planned for May 2019.

Key achievements

- The joint Shropshire and Telford & Wrekin CDOP Panel continues to review all child deaths from live births to 18th birthday;
- The joint Shropshire and Telford & Wrekin CDOP Panel continues to facilitate multi-agency working across both LSCB areas within the Rapid Response and at CDOP Panel;
- Delivering awareness of the CDOP Process on behalf of the LSCB across agencies and other groups such as the West Midlands junior paediatric doctors;
- Risk factors in pregnancy continue to be identified in cases including smoking, with a commitment to reduction in smoking rates in pregnancy;
- Development of improved guidelines for use of defibrillator for parents;
- Working the local authority community safety partnership in road safety and bike safety awareness for families, ie mobile phone use, use of seatbelts, and the continued bike ability programme in schools;
- Work ongoing with public health teams and vitamin D use in pregnancy and new-born babies, free healthy start vitamins distributed, air pollution and air quality levels;
- Public health accident prevention strategy for health economy updated;
- Ongoing maternity developments in relation to raising parental awareness in identifying foetal movements;
- Development of Local Maternity service plan to improve maternity outcomes and ongoing independence scrutiny;
- Updating suicide prevention strategy and tool kit supported by training for front line practitioners;
- West Mercia protocol - Management of Sudden and Unexpected deaths in infants and children (SUDIC) updated;
- 50 practitioners, including staff from nurseries, attended the Annual Reducing the Risk of SIDS talk held in July 2018 and March 2019 with key note speaker from the charity The Lullaby Trust;
- CDOP Chair participated in national Alan Wood review of CDOP;
- Two commissioned Midwife posts for vulnerable women and smoking cessation;
- Care of the Next Infant Programme: Guideline for practitioners, leaflets and resource folders updated and transferred to 0 to 19 service;
- 100% attendance at the Regional CDOP Group; and
- CDOP have commenced a newsletter and the first edition was distributed in March 2019. This was following modifiable factors identified in a baby's death in relation to the sleeping environment. The newsletter concentrated on safe sleeping, raised awareness of the Lullaby Trusts safe sleep week and advertised the SIDS training that was hosted in March 2019. The aim is to raise awareness of CDOP, bring news on our ongoing campaigns and highlight any issues identified at CDOP.

Plans for 2019-2020

CDOP Professionals continue to be active members of the West Midlands Regional CDOP group influencing the transfer from the Department for Education to NHS England.

The new Working Together (July 2018) and new statutory guidance for Child Death Reviews (2018) have now been published with transitional guidance for statutory partners.

From 29 June 2018, local authority areas must begin their transition from LSCBs to safeguarding partner and child death review partner arrangements. The transition must be completed by 29 September 2019. Where any child death reviews have not been completed at the point the new child death review arrangements begin to operate, the LSCB has **up to four additional months** to complete those reviews. Where it has not completed a review, it must pass the information to the child death review partners. The latest date for completion is 29 January 2020. Any CDOP set up under LSCB arrangements may not undertake any new child death reviews during this four-month period. If any child death reviews remain incomplete by the end of the four-month period, the LSCB must ensure that all relevant information is provided to the child death review partners.

Child death review partners should publish their arrangements, and should notify NHS England when they have done so, at England.cypalignment@nhs.net. At the end of the **12-month period**, or at any time before, child death review partners have **up to three months** to implement the arrangements. If the child death review partner arrangements are in place and ready to operate before the safeguarding partner arrangements for a local area, the child death review partners may begin child death reviews and their analysis of information from them, without waiting for the safeguarding partner arrangements to begin.

Child death review partners should consider any incomplete child death reviews passed to them by former CDOPs, and take appropriate action. As a result, the child death review partners may identify matters relating to the deaths that are relevant to the welfare of children in the area, or to public health and safety. If so, and they identify that it would be appropriate for anyone to take action (for example, the safeguarding partners), they must inform that person or organisation.

CDOP 10 Year Annual Report completed with analysis charts, national changes/ guidance, child death review information and key achievements within the health economy. The report has been presented to the LSCBs by the CDOP Chair in 2018.

In January 2016 the Secretary of State commissioned a rapid review of the role and functions of Local Safeguarding Children Boards including reviewing the Child Death Overview Processes. The Wood Report was published in March 2016 and recommended that:

- National oversight of Child Death Reviews should transfer from the Department for Education to the Department of Health.
- The development of a national child death database in the Department of Health.
- Panels should review a minimum number of child deaths (60 -180) which may result in some CDOP Panels merging with neighbouring Panels.

In July 2018, the revised Working Together to Safeguard Children was published alongside transitional guidance. It is anticipated that the Joint Shropshire and Telford & Wrekin CDOP Panel will need to work in partnership with neighbouring CDOP Panel/s to ensure that the minimum number of child deaths are reviewed and learning is maximized and shared locally as well as nationally through the national child death database anticipated to be running from April 2019.

Shropshire and Telford & Wrekin CDOP will require amalgamation with other local CDOPs to meet statutory requirements of reviewing 60 to over 100 deaths. Shropshire and Telford & Wrekin currently average 30 deaths a year, over last few years. The LSCB chairs have discussed this issue at board level and after partner discussions proposed that we work in regional partnership with Worcestershire and Herefordshire CDOPs to maintain one police force robust focus in rapid response/ sudden infant death processes (West Mercia Police Force). This year, the CDOP chair has completed a CDOP resource position statement for the LSCBs future transformational planning

with neighbouring CDOPs. The local resource budget/ costing template has been circulated to Child Death Partners across the four areas to support discussions about the CDOP footprint going forward. A CDOP West Mercia Regional Group Meeting (Shropshire, Telford, Worcestershire & Herefordshire) with Local Authority Directors of Children Services/ Public Health, CCG Executives and Designated Professionals co-ordinating a discussion about our local and future regional CDOP arrangements.

Hence, on the 24th March 2019, Shropshire and Telford and Wrekin CCG Executives and CCG Designated Nurse for Safeguarding Children/ CDOP Chair met with Shropshire and Telford Wrekin Public Health colleagues to tailor our local CDOP footprint including resources to prepare for a future working together model with Worcester and Herefordshire to formulate a regional panel and meet Chapter 5 of Working Together to Safeguard Children (WT 2018) and CDOP statutory guidance.

The meeting concluded the following:

- It was decided that Shropshire and Telford and Wrekin CDOP meetings would continue to meet to review local child deaths on a quarterly basis with future regional meetings with Worcester and Herefordshire twice a year to share lessons learnt and identify child death themes to proactively strategically plan public health campaigns and link with West Midlands contemporaries;
- The Designated Nurse for Safeguarding Children would continue to chair Shropshire and Telford and Wrekin CDOP;
- The Named CDOP Associate Specialist would attend the future regional CDOP meetings twice a year with support from CDOP Nurse Specialist;
- eCDOP software development funding is required locally to implement locally; and
- The CDOP team is managed by Shropshire Community Health NHS Trust (SCHT) with Named CDOP Associate Specialist and Nurse Specialist providing rapid response processes locally. Further development of additional professionals in CDOP rapid response is a future requirement in SCHT to cover CDOP team if off.

The regional CDOP meeting with Shropshire, Telford and Wrekin, Worcester and Herefordshire health and local authority professionals on the 5th May 2019, It has been agreed that across the West Mercia area there will be two CDOPs (Herefordshire/ Worcestershire and Shropshire/Telford and Wrekin) with a wider West Mercia approach to thematic discussions to consider learning from the independent reviews undertaken. This would meet new statutory guidance requirements of a wider footprint to view a higher number of child deaths to identify future themed reviews and share lessons learnt to prevent child deaths. Initial meeting to discuss West Mercia regional Terms of Reference to be arranged for September 2019 and first regional West Mercia CDOP meeting planned for before the end of March 2020.

Due to the transfer of national oversight of CDOP from the Department for Education (DfE) to the Department of Health (DoH) there has been a delay in the National DfE child death data collection for year ending March 2018. Data collection is now being completed to be submitted by March 2019. Nationally, future eCDOP software development is being advocated for each CDOP area to implement with cost implications per local authority area. A recent West Midlands Regional eCDOP presentation stipulated set yearly costs at £9813 per 60 - 90 deaths with higher costs in Local Authority areas with higher CDOP numbers over 90 – 120 deaths a year. In February the eCDOP presentation was circulated with previous CDOP report to LSCBs for support with future funding. Worcester, Herefordshire, Shropshire and Telford and Wrekin are in negotiations to be more cost effective in the submission of a West Mercia CDOP bid with each individual area paying 25% contributions from their LSCB areas. The West Mercia CDOP area will cover less than 90 deaths and plan for the proposed set yearly costs of £9813 for West Mercia eCDOP data system

implementation this year. If Shropshire and Telford and Wrekin set up eCDOP data system alone the set yearly costs are £5750 for local implementation. The West Mercia eCDOP monetary option is the more cost effective and both Shropshire and Telford and Wrekin have agreed to fund to implement locally.

The proposal plan to meet new statutory requirements is to work more closely with other areas in reviewing child deaths will provide a greater opportunity to identify trends in child deaths and promote the sharing of lessons learnt. In conclusion child deaths are reduced in Shropshire and Telford & Wrekin with on –going themed neonatal panels with Consultant Neonatologist present with paediatricians to challenge/review neonatal deaths. The panel continues to work proactively with key partners in supporting bereaved parents, coroner and other professionals in the prevention of child deaths by actively identifying key areas of modifiable factors of concern that may help improve children’s health and wellbeing as well and reduce child death rates.

Thematic Sub-groups

a) Neglect *written by Nikki Barden, Assistant Partnership Development Officer*

The Neglect Sub-group ensures that there is improvement in the identification investigation and support for those who are subject to neglect within Telford and Wrekin and reduce the numbers of those at risk.

During 2018-19, the sub-group:

- Continued to enhance the level of engagement with GPs and Dentists, to enable the identification of neglect, through invitations to briefing sessions and sharing of briefing notes;
- Worked alongside the Safeguarding Review and Learning (SRL) sub-group to embed learning from local Serious Case Reviews (SCR), by working through the learning action plans which are produced as an outcome of the review;
- Carried out a Multi Agency Case File Audit (MACFA) and used these findings to develop an Action Plan for learning implementation;
- Reviewed agency paperwork in line with the NICE guidelines on Child Abuse and Neglect; and
- Drove forward the organisation and delivery of Child Centred Practice when working with Resistant Families and Graded Care Profile 2 briefing and training sessions. Further details on the attendance of these sessions are detailed in page 25;

In 2019-20, the sub-group will:

- Promote a culture of continuous multi-agency learning and improvement through the development and communication of guidance, and resources (pathways, assessment tools) and ensure there are robust processes for monitoring learning outcomes;
- Disseminate national and local learning in relation to neglect, including learning from Serious Case Reviews (SCR) which is to be called Child Safeguarding Practice Reviews (CSPR) and Multi Agency Case File Audits (MACFAs);
- Take responsibility for the development of multi-agency policy and procedures on neglect;

- Review the interventions available for neglect cases and identify preventative and therapeutic support tools, in addition to the Early Help Assessment (EHA) and Graded Care Profile 2 (GCP2)
- Review the suite of training courses and evaluate the impact and effectiveness of training; and
- Review the dataset for neglect, and identify trends, areas of concern and areas to improve.

b) Exploitation *written by Nikki Barden, Assistant Partnership Development Officer*

From November 2017 until January 2019, the Child Exploitation Thematic Sub-group became the Joint Exploitation Thematic Sub-group with the Telford & Wrekin Safeguarding Adults Board. The purpose of the Sub-group is to address the issues of exploitation within Telford and Wrekin through improvement in identification, investigation, prosecution, prevention and support. The main focus of this thematic Sub-group is on Sexual Exploitation (adult and children) and Modern Slavery including Human Trafficking.

The joint sub-group was disbanded to allow dedicated focus on Child Exploitation and Adult Exploitation, respectively.

During 2018-19, the sub-group:

- Reviewed and assessed the relevance of the Police and Crown Prosecution intelligence about the number of cases of Child Sexual Exploitation (CSE) where an investigation has not progressed to court due to insufficient information or the witness withdrew from the process.
- Reviewed the evaluations of the new Developing Practice Module: Child Sexual Abuse and Exploitation, to ensure it is addressing the needs of the professionals effectively.
- Worked to ensure that all foster carers have received appropriate training in relation to CSE.
- Identified the key areas for improvement, based on evidence from the community, professionals and research (local, regional and national).

During 2019-20, the sub-group will:

- Ensure that the child exploitation pathway is developed, implemented and embedded across the Borough of Telford and Wrekin and that all partner agencies are confident in recognising child exploitation and applying the pathway;
- Develop a programme of training and suite of resources to cater for different levels of understanding and practice - universal, operational and professional;
- Continue the culture of listening to children; to ensure the voice of the child is heard and used and is used to inform our practice in relation to Child Exploitation;
- Ensure that new Level C West Midlands Regional Policies and Procedures are embedded;
- Revisit the recommendations of both internal and external reviews to ensure they are completed and reflected in both single agency and multi-agency practice; and
- Develop a performance framework and explore how multi-agency data can be used to measure impact of the pathway, training programme and identify factors of exploitation within Telford and Wrekin.

c) Domestic Abuse *written by Nikki Barden, Assistant Partnership Development Officer*

The group was newly reformed in December 2017, and the terms of reference revised to address the issues within Telford and Wrekin through improvement in identification, investigation, prosecution, prevention and support of:

- Domestic abuse;
- Female Genital Mutilation,
- Honour Based Violence; and
- Forced Marriage.

The Sub-group is accountable to the Quality Performance and Operations Sub-group of the Telford & Wrekin Safeguarding Children Board and Telford & Wrekin Safeguarding Adults Board. The Sub-group is also delivering against the Safer Telford & Wrekin Partnership Strategy and the Health and Wellbeing Board's workstream.

During 2018-19, the sub-group:

- Mapped local service provision against the AVA Coordinated Community Response Model Online Toolkit.
- Evaluated Operation Encompass to establish what difference it made to children and schools.
- Carried out an initial training analysis of single agency training on domestic abuse.
- Supported the White Ribbon Steering Group to maintain Telford's White Ribbon status for five consecutive years;
- Worked alongside the Family Connect service to create and embed a service pathway diagram for each type of abuse into guidance, pathways and procedures.
- Supported the Safer Telford & Wrekin Partnership with the commissioning of and embedding learning from Domestic Homicide Reviews.

During 2019-20, the sub-group will:

- Host a Joint Adult Safeguarding Awareness Conference alongside the Keeping Adults Safe in Shropshire Network, to raise awareness of Domestic Abuse amongst practitioners;
- Review and develop specialist services and support and implement comprehensive multi-agency pathways, for both victims and perpetrators and children and young people affected by domestic abuse;
- Use intelligence to inform service provision and raising awareness campaigns;
- Develop practitioner's knowledge on the dynamics of domestic abuse on the whole family and provide them with the appropriate training and resources to support the family;
- Increase awareness in the community of domestic abuse, and how to seek support;
- Review current policies and procedures associated with Female Genital Mutilation (FGM), Honour Based Violence (HBV) and Forced Marriage within the community and across the professional workforce; and
- Continue to embed learning from Domestic Homicide Reviews (DHRs).

Children Safeguarding Children

Children's Safeguarding Boards *written by Siân Deane, Project Manager and School Improvement Advisor, Severn School Teaching Alliance*

Over the last year, the work of the safeguarding boards has continued to grow. Any trauma suffered by a child can lead to a short or longer lasting impact on a child's mental health. As a result, we worked with the safeguarding board leads to develop a booklet for children, young people and their families, which explains emotional health and wellbeing, and where to seek help for their mental health. This will be finalised throughout 2019-20.

A survey was sent out to all schools and Emotional Health and Wellbeing Leads, to find out the stage they are at. We are hoping that there will be far more inter-school working during this next year.

A course to support schools in establishing their safeguarding boards will run again throughout 2019-20. The network sessions will continue to run, so that schools feel supported, and significant pieces of work can be collaboratively; worked on across schools and all phases.

Ofsted reports continue to praise the safeguarding boards within schools, and the culture of safeguarding that has been developed over time, through children and young people having a voice in keeping themselves and others safe.

The main focus for the next year is to develop a resource to support Child Exploitation, as this is recognised as a key area for our children and young people.

Training

The TWSCB has continued to provide a comprehensive programme of targeted training for partners, both statutory and non-statutory, during the year. The programme is supported and delivered by members of the TWSCB training pool and is reviewed annually to ensure the programme is fit for purpose and reflects and local or national learning.

The TWSCB's training budget has continued to be aligned towards the Board's priorities to enable more effective implementation of the training required. This has included providing specialist trainers who can support practice development, for example, Child Centred Practice when working with Resistant Families training. The following section summarises the courses that have run during the year and the total number of attendees.

Throughout 2018-19, TWSCB has continued to develop training courses to raise awareness of new and emerging issues. New courses that TWSCB has developed are:

- Raising Awareness of Exploitation & Vulnerability: increasing knowledge of the vulnerability factors and areas of exploitation, focusing on county lines, human trafficking, sexual exploitation and modern slavery.
- Enhanced Raising Awareness of Exploitation & Vulnerability: includes the course content from the basic raising awareness session, but also including multi-agency working in protecting children, young people and vulnerable adults, with specific emphasis on appropriate language, reporting processes and trauma bonding.
- Managing Allegations: providing an understanding of what constitutes an allegation, and how these are managed and investigated.

From August 2018, and in conjunction with the Safer Telford and Wrekin Partnership, two trainers were employed to deliver Exploitation and Vulnerability training, to raise awareness within schools and hard-to-reach areas.

a) Courses run from 1 April 2018 – 31 March 2019 *written by Nikki Barden, Assistant Partnership Development Officer*

From April 2018 – March 2019, TWSCB have provided a number of training courses for partner organisations, schools and volunteers to attend.

Table 1: TWSCB training courses run from April 2018 – March 2019

Course	Number of courses held	Total number of attendees
Child Centred Practice when working with Resistant Families	6	93
Early Help Assessments	11	342
Graded Care Profile 2 (GCP2)	2	33
Developing Practice: Child Sexual Abuse & Exploitation	6	104
Managing Allegations	<i>To be rolled out from September 2019</i>	
Raising Awareness of Exploitation and Vulnerability	3	27
Raising Awareness of Multi Agency Public Protection Arrangements (MAPPA)	2	34
Raising Awareness of Threshold Guidance, Early Help Assessments and Support Plans	4	18
Reducing the Risk of Sudden Infant Death Syndrome	1	13

Model of Evaluation

In order to ensure that the training we provide is effective, an evaluation form is completed by each training delegate whenever they attend training organised by TWSCB.

The evaluation looks at:

- Why the delegate chose to attend the course, asking them to provide a rating on a scale from strongly agree to strongly disagree for the following options:
 - To improve skills and knowledge;
 - As part of my personal development plan;
 - Because my job or responsibilities have changed;
 - It may be some use in the future;
 - I was asked to take part by my manager; and
 - Because new technology or work processes have been introduced.
- To what extent the course met its training objectives, asking them to provide a rating on a scale from strongly agree to strongly disagree for the following options:
 - The training objectives of the course were clear; and
 - The course training objectives were fully met.
- Asking delegates to provide a rating on a scale from very satisfied to very dissatisfied for the following options:
 - Course enrolment process;
 - Course venue; and
 - Pre-course information.
- To what extent delegates will be able to apply what they have learnt on the course to their work:
 - All;
 - Some;
 - A little; and
 - None
- To what extent do you agree or disagree with the following statements?
 - Completing this course will help me improve the effectiveness of my work;
 - Completing this course has increased my confidence in my own role; and
 - I am likely to revisit the learning/course materials.
- Thinking of all of the above, how satisfied or dissatisfied were you with the training course?
 - Very satisfied;
 - Satisfied;
 - Neither satisfied nor dissatisfied;
 - Dissatisfied; and
 - Very dissatisfied.

There are also a few open-ended questions, where delegates are asked:

- To help us assess the impact of this course, as a result of this course, what will you stop doing?
- To help us assess the impact of this course, as a result of this course, what will you start doing?
- Please set out any other comments you may have on this course.

All training courses are evaluated and an evaluation report is compiled and submitted to either the Sub-group that requested the training, or to the Partnership Development Sub-group for review and challenge.

Examples of positive feedback received from the training courses TWSCB provide, include:

- “This course will assist with prevention, and providing help when needed”
- “It gives me background knowledge – the ‘why’”
- “I will be able to identify signs of abuse and feel better prepared when working with adults who have experienced exploitation as children”
- “Be more mindful of the language used when speaking to young people”
- “Proactively protect children, young people and families with advice and support”

Partnership working

The year has seen continuing improvements in partnership working including working closely with the Health and Wellbeing Board (HWBB), Children and Families Partnership Board, the Children & Young People Scrutiny Committee and the Safer Telford & Wrekin Partnership to coordinate activity and further reduce any duplication.

Each agency was asked to summarise what they have done to contribute to delivering the TWSAB’s priorities for 2018-19 and a copy of these submissions can be found in Appendix 1.

Summary of partner contributions to delivering the TWSCB’s priorities for 2018-19:

- All TWSCB partners acknowledge that “safeguarding is everyone’s business” and there must be a “Think Family” approach.
- Partners have been integral in ensuring the TWSCB is aware of the current issues within the Borough. For example: South Staffordshire and Shropshire Foundation Trust has remained committed to raising awareness of CSE within their workforce.
- Partners have disseminated the key learning from audits and reviews conducted by the TWSCB, including updating single agency training and sharing information in their own newsletters.
- Partners have continued to engage in the safeguarding process and have been a key part of developing procedures and guidance during the year. For example, the Core Group Briefings.
- Engagement is a key part of all agency’s roles and responsibility and in partnership with the TWSCB supported the CSE Awareness Day 2018 and promoted the awareness of what abuse is within the community.
- Partners have continued to promote TWSCB training within their organisations and courses are being jointly delivered by a number of agencies. For example, Developing Practice: Child Sexual Abuse & Exploitation is delivered by trainer from the CATE Team, T&W CCG and SaTH.

Summary of partner's plans for 2019-20 in relation to safeguarding children?

- Partners have agreed to continue to support the TWSCB and its priorities, and continue to work in partnership to improve outcomes for children in the Borough.
- All partners have identified priorities for 2018/19 which includes some thematic areas, including, but not limited to: Domestic Abuse, Neglect, Modern Slavery, and Exploitation.
- Awareness raising in the community about what abuse is, is a key aspect of prevention and this is a key theme in partner's plans for 2018/19.
- Ensuring professionals have the relevant knowledge and up to date information about abuse is key to prevention and support; all partners have agreed to continually review their training to ensure that it is up to date.
- All partners will be working with the TWSCB to update policy and procedures in line with the new Working Together 2018 and Keeping Children Safe in Education 2018 guidance.

Priorities and Challenges for 2019 – 2020

2019-20 will see the introduction and implementation of the new Working Together to Safeguard Children 2018 legislation, whereby TWSCB will become a partnership, rather than a Board, and with the Local Authority, Police and Clinical Commissioning Group all having equal oversight, financial responsibility and accountability for the work of the partnership.

Throughout the period of change, and for the remainder of 2019-2020, TWSCB will continue to nurture and develop all of the joined up areas of work that has been successful throughout 2018-19, alongside our other partnerships within Telford and Wrekin.

Whilst the Exploitation sub-group has continued to focus on Child Exploitation, with TWSAB overseeing the work of the Adult Exploitation sub-group, both groups continue to work closely to join up gaps and move the work forward.

All sub-groups will continue to build on positive pre-existing relationships with other partnerships within Telford and Wrekin, and contribute to regional and national safeguarding partnerships.

Appendices

Appendix 1: Agency Contributions to TWSCB work in 2018/19

Early Years (Private) *written by Christine Harding, Early Years representative*

How has your organisation contributed to delivering the TWSCB's priorities for 2018-19?

Training has been provided on Child Sexual Exploitation (CSE) and influences of drugs and alcohol on neglect.

During 2018-19, what are the key areas of development in your organisation that have impacted on safeguarding children and young people? What impact have they had?

Practitioners have a greater understanding of exploitation, how to recognise vulnerability in families and individuals as well as observing the signs of risk-taking behaviours.

What are your organisation's plans for 2019-20 in relation to your responsibilities to safeguard children and young people?

How has your organisation contributed to delivering the TWSCB's priorities for 2018-19?

- Healthwatch Telford and Wrekin (HWT&W) have engaged with the public to gather their views and experiences of using a range of health and care services, through engagements also sign posting/enquires.
- HWT&W have attended relevant meetings which included: local CQC/HW liaison meetings, Quality Surveillance Group to share information and concerns.
- HWT&W have reported concerns directly to Children's Safeguarding Services.
- Safeguarding Adult and Children Training (and updates) for all staff. Completing training is a requirement of volunteer Enter and View (E&V) Authorised Representatives (AR's) and other volunteers.
- HWT&W have been represented at board meetings and relevant work streams.
- HWT&W have attended TWSCB's Safeguarding Children Training event
- Attended the Crucial Crew Event

During 2018-19, what are the key areas of development in your organisation that have impacted on safeguarding children and young people? What impact have they had?

- HWT&W have raised issues/concerns to Children's Safeguarding team but have also had telephone calls from people not wanting to leave any details but have advised them to report to the Children's and Young people's Safeguarding.
- HWT&W produce and publish feedback reports which are then distributed to authorities, commissioners and various other organisations.
- HWT&W ensure Children and Young people's health and care services understand their role/responsibilities to consult with them and other people to ensure they are appropriately implemented and people receiving services and their staff are safeguarded.
- To protect Children and Young people in health settings from harm, abuse or risk and report any feedback/information/concerns.

Where events/concerns have been raised, they are then promptly reported to the safeguarding teams. Where health services are prompted by us to raise Safeguarding concerns or events, HWT&W follow up to confirm it has been reported.

What are your organisation's plans for 2019-20 in relation to your responsibilities to safeguard children and young people?

- HWT&W have raised issues/concerns to Children's Safeguarding team but have also had telephone calls from people not wanting to leave any details but have advised them to report to the Children's and Young people's Safeguarding.
- HWT&W produce and publish feedback reports which are then distributed to authorities, commissioners and various other organisations.
- HWT&W ensure Children and Young people's health and care services understand their role/responsibilities to consult with them and other people to ensure they are appropriately implemented and people receiving services and their staff are safeguarded.
- To protect Children and Young people in health settings from harm, abuse or risk and report any feedback/information/concerns.

- Where events/ concerns have been raised, they are then promptly reported to the SG teams. Where health services are prompted by us to raise Safeguarding concerns or events, HWT&W follow up to confirm it's been reported.
- HWT&W will uphold the key principles that include:
- Ensure all members of staff, directors and volunteers are fully aware of the law and statutory requirements in order that vulnerable children receive the protection of the law and access to the judicial process.
- Provide appropriate assistance and sign- posting to relevant agencies, including advice.
- Safeguarding is considered in all policies and procedures.
- HWT&W will undertake safe recruitment practices for staff/volunteers.
- Give guidance about appropriate behaviours during HWT&W inductions.
- To ensure any member of staff, director or volunteer whose work involves direct contact with children at risk/or children or health settings receive face-to-face Safeguarding Training including Child Protection and awareness of procedures including how to deal with concerns.
- Ensure E&V representatives and those involved in Safeguarding and resolving enquiries/signposting are aware of the procedure for raising and reporting Safeguarding events and concerns.

Midlands Partnership NHS Foundation Trust *written by Sharon Conlon, Head of Strategic Safeguarding*

How has your organisation contributed to delivering the TWSCB's priorities for 2018-19?

MPFT are members of all CSE panels across Staffordshire, Stoke on Trent, Shropshire and Telford. By working in partnership with other agencies via panel we are able to identify physical and mental health interventions that can improve outcomes for young people who are victims of CSE. MPFT provide bespoke CSE awareness training that has been provided to all frontline staff who work with children including sexual health services.

During 2018-19, what are the key areas of development in your organisation that have impacted on safeguarding children and young people?

Midlands Partnership was formed on the 1 June 2018 by the bringing together of South Staffordshire and Shropshire NHS Foundation Trust and Staffordshire and Stoke on Trent Partnership Trust. By bringing together physical health services and mental health services MPFT are able to work towards integrated care systems that will enable improvements in joint working which will improve joint working across adult and children services. MPFT foster a think family approach which in turn will provide improvements in the recognition and response to children and young people living in households with parents who access adult health services.

By bringing together the safeguarding services from the two previous organisations, MPFT are able to redesign their safeguarding offer to promote a think family approach and work closer with all MPFT services to ensure that roles and responsibilities for safeguarding are recognised and responded to. We aim to see improvements in safeguarding governance and our ability to demonstrate good safeguarding practice from across all of our services.

Shrewsbury and Telford Hospitals NHS Trust *written by Teresa Tanner, Named Nurse for Safeguarding Children and Young People*

How has your organisation contributed to delivering the TWSCB's priorities for 2018-19?

The Trust is committed to improving safeguarding of children processes across the organisation and aims to safeguard all children who may be at risk of harm.

Processes are developed to empower staff, to be child centred, preventative and holistic. The safeguarding team continues to deliver the safeguarding agenda encompassing a multi-agency and partnership approach across Shropshire.

The governance arrangements for children's safeguarding remain in place to allow for effective monitoring and assessment of compliance against locally agreed policies and guidelines.

The Trust has contributed to the TWSCB (now Partnership) priorities by continuing to deliver a high standard of training to all staff, including training on multiagency sessions e.g. Child Sexual Exploitation.

SaTH has continued to be an active partner agencies in sub groups addressing these priorities.

SaTH has continued to be an active partner in information sharing to safeguard children and families.

During 2018-19, what are the key areas of development in your organisation that have impacted on safeguarding children and young people? What impact have they had?

The Trust has continued to increase the number of Domestic Abuse referrals through the MARAC process and works closely with the MARAC co-ordinators across Telford and Wrekin and Shropshire.

Domestic Abuse training continues to be part of the Statutory training for all clinical staff across the Trust.

SaTH now has a Hospital Independent Domestic Violence Advisor (HIDVA) on both sites.

Implementation of CP-IS across Shropshire and Telford has improved information sharing and the forthcoming FGM-IS will also be implemented.

There have been stronger working relationships within the Looked After Children Nursing Teams Increase in WRAP training sessions.

Safeguarding within Maternity continues to generate increased workload of vulnerable pregnant ladies via the SWAN meetings.

Level 2 Training currently stands at 90% for adult and child safeguarding, and Level 3 training is 85%.

What are your organisation's plans for 2019-20 in relation to your responsibilities to safeguard children and young people?

To continue to provide attendance at LSP/LSAB sub-groups to develop practices and contribute to the development of multi-agency training strategy and procedures.

To continue to provide in-house local guidance to complement LSP/ LSAB procedures, protocols and practice guidelines.

To ensure that SaTH adheres to the recommendations for staff training in child protection/adult safeguarding procedures.

Continue to work in partnership with local health and social care colleagues to keep children, young people and adults with a care and support need safe.

To participate in Child Death Overview Panels, Safeguarding Adult Reviews, Child Learning Reviews and Domestic Homicide Reviews if required.

To continue to work with Human Resource department in ensuring DBS checks and “Managing Allegations against Staff” policy and process are adhered to.

To continue to ensure that staff adheres to the training programmes and training figures continue to increase.

Continue to engage with people at risk of abuse, their family, carers, relatives and external agencies.

To continue to work with local partners with the National Child Protection Information System and new FGM information system.

To continue to be an active member of the West Midlands Regional Named Nurse for Safeguarding (Children) network.

Shropshire Community Health NHS Trust *written by Julie Harris, Head of Safeguarding*

How has your organisation contributed to delivering the TWSCB’s priorities for 2018-19?

A representative from Shropshire Community Health NHS Trust (SCHT) has attended and participated at TWSCB and at the sub-groups, which work to address the Board priorities.

Exploitation

A member of the Safeguarding Children Team (now the Safeguarding Team) regularly attends and contributes towards the Child Sexual Exploitation (CSE) panel held every two weeks. Teams within the organisation have accessed the TWSCB exploitation training.

Neglect

The Nurse Specialist Safeguarding Children is a Graded Care Profile (GCP2) Trainer, and has continued to support the delivery of GCP2 multi-agency training. The training has been actively encouraged and our staff have been supported to attend, in particular Health Visitors and School Nurses. The majority of these have attended GCP2 Multi agency training.

Domestic Abuse

SCHT staff attend and contribute to the Multi Agency Risk Assessment Conferences (MARAC). This ensures information is shared between agencies.

The Safeguarding Team have contributed to the Serious Case Review process and shared the learning across the Trust.

During 2018-19, what are the key areas of development in your organisation that have impacted on safeguarding children and young people? What impact have they had?

SCHT was inspected by the Care Quality Commission (CQC) between 9 January and 8 March 2019. This included a well lead inspection; the Trust has been rated GOOD across all domains.

The Safeguarding Team reviewed and strengthened the safeguarding children supervision model and has widened the cohort of staff now accessing supervision.

The use of the escalation process has been promoted through our internal communication systems, training and supervision. There is now an internal mechanism to record when the escalation is initiated.

Mandatory Corporate Induction training has been improved. All new starters attend a face to face interactive safeguarding children session.

The Trust now has an embedded Electronic patient record which has improved internal communication regarding children. This is of benefit to staff and service users regardless of whether or not there are safeguarding concerns.

The Looked after Children Team has been strengthened and there are robust processes in place to monitor the timeliness and quality of the statutory health assessments.

What are your organisation's plans for 2019-20 in relation to your responsibilities to safeguard children and young people?

To raise and maintain the profile of safeguarding children and adults within SCHT and with our partner agencies.

To develop more innovative ways of working which will enable us to provide safeguarding support in a more efficient and effective way.

Telford & Wrekin Clinical Commissioning Group (CCG) *written by Christine Morris,*
Executive Nurse

How has your organisation contributed to delivering the TWSCB's priorities for 2018-19?

The Chief Executive Nurse continues to provide strategic leadership to safeguarding children, young people and adults, working with multi-agency partners to ensure the highest possible standards are achieved for our population. The Chief Executive Nurse is the key statutory health professional on the newly arranged Strategic Safeguarding Children sub group of the board that includes the police and local authority strategic executives with equal accountability and responsibility for children and young people service delivery in Telford and Wrekin. The Designated Safeguarding Children & Young People and LAC professionals support the Chief Executive Nurse by providing expert specialist knowledge to deliver LSCB priorities via numerous committees, sub groups and panels.

The CCG Executive Nurse and Designated Nurse for Safeguarding have contributed to national Working Together to Safeguard Children Guidance (2018) and Child Death Statutory Guidance (2018) with local change plans submitted nationally and published on both Shropshire and Telford and Wrekin CCGs and LSCBs to meet new statutory requirements with Local Safeguarding Children's Board (LSCB) and relevant sub groups from July 2019.

There is ongoing high media interest in Telford and Wrekin Child Sexual Exploitation (CSE) past and present multi- agency activity with Local Safeguarding Children's Board (LSCB) partnership responses and local CSE training events. The Independent Inquiry Telford Child Sexual Exploitation/Abuse (IICSE) have appointed Tom Crowther, QC to lead Telford Inquiry and Terms of Reference for Telford have been completed with QC and Commissioning Solicitors meeting with all health NHS commissioners and providers. All NHS providers have been instructed by the CCG to retain relevant information related to IICSE/A with detailed checklist provided.

During 2018-19, what are the key areas of development in your organisation that have impacted on safeguarding children and young people? What impact have they had?

The Designated Nurse for Safeguarding Children offers advice, guidance, and training across the health economy to professionals including dentists, pharmacists and GPs. Children and adult safeguarding including Prevent training has also been implemented within the CCG.

Local Safeguarding Children's Board (LSCB) Ofsted inspection with partner agencies was carried out in June 2016. The final report has been published by Ofsted with Telford and Wrekin LSCB, receiving a good effective rating for partnership working. The Child Death Overview Panel (CDOP) sub-group, across Shropshire and Telford and Wrekin, was also identified as an effective good working panel across agencies to prevent child deaths locally. The Designated Nurse chair's CDOP continuing to review local cases with a low number of reported deaths to date for this year. Annual Report & Quarterly Reports produced. Also, active member on Child Sexual Exploitation, Partnerships, Neglect, Safeguarding, Review and Learning including Training subgroups. Completes CCG learning reviews including recent Significant Incident Learning Reviews.

The Care Quality Commission (CQC) team inspected the area and CCG in September 2016 and Shropshire CCG in 2018. The CQC final reports has made quality recommendations for the health and social care system to improve safeguarding and looked after children's arrangements in Shropshire and Telford and Wrekin. The majority of the CQC recommendations sit with NHS health providers to improve local service provision. The CCG has requested that local NHS providers develop their own CQC recommendations/action plans with regular progress updates to the CCG clinical quality review meetings, and action plans have identified lead professionals to implement key actions/recommendations.

The recent Care Quality Commission (CQC) Report of Shropshire and Telford NHS Hospital Trust Inspection reported 'inadequate' service provision on key areas and national improvement intervention now in situ with 'special measures' status. Maternity is a key area of on-going service improvement with on-going independent scrutiny including more recently the national Healthcare Safety Investigation Branch (HSIB) team from November 2018 into 2019.

An Independent Review of how SaTH reviewed/learnt lessons from some neonatal deaths was undertaken in 2017 and Ms Ockenden maternity independent report has been leaked to the press week beginning 19th November 2019 (awaiting full final report). The report identified clinical failings over a period of 40 years following an investigation of at least 42 baby's cases and three mothers at Shrewsbury and Telford Hospital Trust (SaTH) between 1979 and 2017. In the report, Ms Ockenden concluded many of the cases included clinical failures of "knowledge, team working and approach to risk", as well as a failure by hospital bosses to investigate errors, spot key risks and communicate properly with families. In total, more than 600 cases are now being examined and hundreds still to be looked at with toll expected to grow.

The Maternity Transformational Action Plan is on-going work in progress with Shrewsbury and Telford and Wrekin NHS Trust (SaTH) with NHS England/ Health Improvement & CCG strategic monitoring and quality assurance meetings taking place on a monthly basis. An interim Chief Executive/ Director of Nursing, a new Chief Executive/ Assistant Director of Nursing/ Medical Director and Director of Midwifery have been appointed and NHS England/ Health Improvement support in SaTH to move forward lessons learnt and promote a change in culture.

A regular update on perinatal mortality for the Shrewsbury and Telford Hospital NHS Trust is given by Anthea Gregory-Page, Deputy Head of Midwifery and neonatal focused CDOP Panels are attended by a Consultant Neonatologist from the Shrewsbury and Telford Hospital NHS Trust. The national Perinatal Toolkit system is being implemented at SaTH and public health campaigns on safer sleeping, improvements in perinatal mental health support and identification of foetal movements in pregnancy and warning of risk of nappy sacks/ button batteries to babies and infants are ongoing.

Oversight has continued over the last 12 months around provision of health services for children in care to ensure improvements in timeliness and data reporting. Positive achievements have been seen in the overall data for review health assessments of looked after children 0-18 years.

The dashboard and Local Quality Requirements for Looked after Children in Telford & Wrekin have been reviewed for 2019 to 2020; requirements have a main focus around quality and improved outcomes for children in care with the provision of health passports for children in care, quality assurance of health assessments and GPs contributing to health assessments.

The 0-19 from the end of August 2019 will no longer contain Looked after Children Review Health Assessments, only contribution to the monitoring of health plans; Shropshire Community Health Trust will no longer conduct this process internally and are recruiting a Nurse to completing this component of work.

Telford & Wrekin Council and the LAC Health Team have continued to review system errors to ensure that both systems are reporting the same health data. There have been ongoing discrepancies between both sets of data in relation to children with up to date health plans. This has improved over the course of the last year.

What are your organisation's plans for 2019-20 in relation to your responsibilities to safeguard children and young people?

- CCG Named GP appointed with GP forum commenced to lead safeguarding GPs in medical practices in Telford and Wrekin;
- Care Quality Commission recommendations actioned and monitored across the whole health economy via Clinical Quality Review monthly meetings with NHS providers;
- Child Adolescence and Mental Health Services (CAMHS) intervention and monitoring to safeguard children locally and out of area;
- Independent Inquiry into Child Sexual Exploitation;
- Independent Inquiry and Scrutiny in local Maternity Services;
- Maternity Reviews and implementation of transformational local plans;
- Support Children's Continuing Health Care nurse case management to include safeguards;
- Children's Commissioner update of contracts, dashboards and service specifications including 0 -19 years and family connect services with public health;
- Child Sexual Exploitation involvement in relevant work streams;

- Contribute to policy and procedures/ threshold document updates and major contributor to LSCB sub groups;
- Multi-agency learning following case file audits, child deaths and significant incident reviews;
- Multi -agency and single agency safeguarding training to health professionals and other relevant organisations and agencies
- Child Death Overview Panel (CDOP) Reviews and Learning Disabilities Mortality Reviews (LeDeR) completion with learning lessons actioned and on-going multi-agency training, e.g. advanced care planning, safe sleep, suicide prevention, home and road safety, accident prevention, etc.;
- Safeguarding incident recording for themes and trends in area;
- Safeguarding performance monitoring via dashboard completion by NHS providers with CCG Team scrutiny to improve services;
- Looked after children quality assurance development and monitoring;
- Safeguarding children supervision by Designated professionals to named professionals;
- On-going programme of Mental Capacity Act (MCA/Deprivation of Liberty/Safeguards Liberty (DoLs) training;
- To further understand the landscape of Residential settings in Telford & Wrekin / Shropshire; and
- To support plans for robust service delivery around the 0-19 component of review health assessments.

How has your organisation contributed to delivering the TWSCB's priorities for 2018-19?

The Council continues to play a proactive role in all aspects of the LSCB both in terms of leadership and delivery of the Board's thematic priorities.

Child Exploitation

Support for young people at risk of Child Sexual Exploitation (CSE) continues to be a strength, through the CATE (Children Abused Through Exploitation) Team. Our approach towards working with young people through robust risk assessments and structured work, overseen by a multi-agency risk panel, is successful in helping them take action to reduce risk. Where this is not possible, our child protection processes are used to help keep them safe. In 2017/18 we increased capacity and strengthened independence for Return Home Interviews. As a result, Children and young people who go missing are now seen more quickly after returning home, and by an independent person. Our innovative approach encourages young people to engage with services and is helping them to understand and reduce risk

We have worked to ensure that all foster carers have received appropriate training in relation to CSE.

Working with the Police, the Council has established a Serious and Organised Violent Partnership which includes a focus on children who are criminally exploited. The intelligence from this group and the features of cases within Children's Services revealed emerging pattern of child exploitation. In response, the Child Exploitation sub group has commenced the development of a child Exploitation Pathway, building on the positive work of the existing CSE pathway.

In the spring, the Council unanimously agreed to commission its own independent inquiry in to child sexual exploitation in response to calls from victims and survivors in response to media coverage of non-recent cases. Following a comprehensive tendering process, the commissioning body Eversheds Sutherland LLP were the successful bidder and were appointed in November 2018. In June 2019 Eversheds Sutherland, the independent commissioning body for the Independent Inquiry – Telford Child Sexual Exploitation announced the appointment of Tom Crowther QC as the independent Inquiry Chair.

Neglect

Our Strengthening Families service has continued to work with our new Community Participation Team to help build resilience into communities in order to meet needs at the lowest level and safely manage demand for safeguarding service. This will help ensure safeguarding services are able to focus their work on those children and young people with the most complex needs and who are in need of protection.

Domestic Abuse

The Council has undertaken a data "deep dive" exercise to understand and paint a detailed picture of domestic abuse across the borough bringing data together from a range of partners, in particular to understand the scale and contributing factors. In response we have focussed on supporting the development of DA policy and support for victims of children and young people, with the development of a perpetrator programme.

The Council continues to raise awareness of domestic abuse as a “White Ribbon” town championed by a Cabinet Member.

During 2018-19, what are the key areas of development in your organisation that have impacted on safeguarding children and young people? What impact have they had?

Through 2018/19, the Council’s Safeguarding & Early Help Services have continued to focus on delivery of our Service Improvement Programme. Supporting this, the Council has invested nearly £8m in the Safeguarding Service since April 2018, including £4.1m of ongoing budget growth, £2.8m of one off contingency monies set aside over the period and one off funding of £1.1m to be spent on specific initiatives and projects.

As a Council we work hard to understand our areas of strength and development. Our services are subject to OFSTED inspection which tests this understanding. In September 2018, during a focused OFSTED, Inspectors looked at our arrangements for permanence and permanency planning for our children in care. Inspectors noted the following impacts and outcomes:

- Almost all children looked after now have a permanency plan by their second review.
- Managers recognise the value of connected persons placements and take prompt action to ensure that these are considered
- We are also active in considering applications for SGOs, with 15 made in the last 12 months
- For most children who require adoption, plans are timely, and children are placed with prospective adopters quickly.
- The majority of children who remain in care are placed in stable long-term fostering placements. Many of these children have been formally matched with their carers.
- We are active in considering extended family as connected carers, and, in some but not all cases, consider whether special guardianship orders (SGOs) are appropriate long-term outcomes.
- Where children are in safeguarding teams with plans for adoption, life-story work is completed quickly
- Children looked after reviews are timely and include appropriate multi-agency support and contributions. Some young people attend reviews, and the need for advocacy is discussed on a regular basis, with advocates being provided where a need is identified. IROs in many but not all cases visit between reviews

We have reshaped our Corporate Parenting Strategic Group which works with partners to ensure that our responsibilities to looked after children and care leavers are effectively discharged. As part of this review we have a care leaver champion as part of this group to ensure the voices of care leavers and children in care are impacting on strategic planning.

What are your organisation’s plans for 2019-20 in relation to your responsibilities to safeguard children and young people?

Children’s Safeguarding and Early Help Services will continue to work with children and young people and their families in order to improve outcomes and help to ensure that wherever possible, they can continue to live at home safely. Where this is not possible, our role is to act as corporate

parents for those children, ensuring they are safe and well cared for and supported through to adulthood.

Recognising that one of our main concerns is our numbers of children in care and subject to child protection plans, we successfully applied to be one of the 20 local authorities involved in the rollout of the DfE Strengthening Families, Protecting Children programme. We will be part of the first cohort to work alongside Hertfordshire and achieve the whole system change which we are confident will realign our thresholds between s17 and s47 and enable us to provide more robust support to families where there are complex needs and safeguarding issues. This will include the appointment of a senior manager to lead on the change program.

Following changes to statutory responsibilities as set out in Working Together following the Wood Review of LSCB's, we will be implementing new safeguarding partnership arrangements with West Mercia Police and Telford & Wrekin CCG. These will ensure that the three partners are able to discharge their responsibilities efficiently and effectively through the creation of a new Safeguarding Partnership Executive which will initially be chaired by the DCS.

Telford & Wrekin Council Education *written by Cathy Hobbs, Group Manager: Access and Inclusion*

How has your organisation contributed to delivering the TWSCB's priorities for 2018-19?

The TWSCB priorities have been disseminated to all newly appointed designated safeguarding leads and safeguarding governors. They are shared widely as part the raising awareness of child protection training through links to the TWSCB website.

During this time we have trained 65 newly designated safeguarding leads and 27 safeguarding governors.

The designated safeguarding lead biannual refresher training has been revised to strengthen the learning outcomes.

Keeping Children Safe in Education requires all staff to attend child protection training every three years. During the period of 2018-19 we delivered training in 52 schools.

We have developed the termly designated safeguarding lead updates to include safeguarding governors. During the period of 2018-19 we have had 326 attendees at these updates. The updates are held three times a year and have a different focus at each session. The themes of these updates over the past year has included:

- Samaritans support for schools;
- Vulnerability and Exploitation Training;
- GCP2;
- Serious Violence Strategy;
- Exploitation;
- Ofsted inspection of Safeguarding;
- Revision to Keeping Children Safe in Education;
- Private Fostering;
- Early Help Assessment;
- Telford & Wrekin Threshold Guidance;
- Parental Conflict training;

- Safeguarding Partnership Arrangements;
- Operation ENCOMPASS;
- MACFA Audit Findings;
- Family Connect Request for Service Form;
- Family Connect Multi-Agency Enquiries; and
- Transfer of records.

We have worked with a range of internal colleagues and external agencies to deliver on these priorities, including Family Connect, Police, Samaritans, Loud Mouth Theatre in Education Company, social care, LSCB, Ollie training team, Strengthening Families Team, CPOMS and Information Governance.

Exploitation

We are working closely with all schools and education settings to ensure they access the Vulnerability and Exploitation training. All education staff have attended the training. We are promoting parent Vulnerability and Exploitation workshops via schools.

The exploitation training content in raising awareness of child protection training has also been revised.

CATE team referral pathway is referenced in the revised TWSCB child protection policy for schools.

Domestic Abuse

The domestic abuse training content in raising awareness of child protection has been revised. There are now more specific information on the indicators of children witnessing domestic abuse and MARAC.

Education triage representatives attend monthly MARAC meetings to provide and receive updates in relation to children to help promote integrated working.

Education are leading on a current review of Operation ENCOMPASS due to a low number of successful alerts being shared with schools. There will be a pilot in September and October 2019 to consider new pathways for information sharing with schools.

Neglect

GCP2 is now promoted in all safeguarding training and there are education representatives trained to deliver briefing sessions of the audit tool. Two single agency briefing sessions have been delivered to school.

Education representative participated in the MACFA to review the impact of GCP2 and the outcome from this has been shared with all schools.

The neglect training content in raising awareness of child protection has been revised.

Children Harming Children

We have provided bespoke consultancy to school for cases of children harming children, specifically incidents of sexual violence and/or sexual harassment between children in schools. In addition a bespoke training unit has been developed for designated safeguarding leads and school leaders in

managing sexual violence and sexual harassment and provided this as part of designated safeguard lead refresher training.

The peer on peer abuse and sexual violence and sexual harassment training content in raising awareness of child protection has been revised.

Managing sexual violence and sexual harassment between children in schools has been a focus of sample section 11 audit visits this year to help review the arrangements in place across our borough.

The TWSCB template child protection policy for school has been updated to improve schools awareness of safeguarding issues of children being homeless and their responsibilities to liaise with the local housing authority.

The Education Safeguarding Team have developed their communication systems to improve the way information is shared from the TWSCB to schools in a more timely and informative manner.

We have contributed to the development of the multi-agency performance dashboard using information about the effectiveness of safeguarding in school.

During 2018-19, what are the key areas of development in your organisation that have impacted on safeguarding children and young people? What impact have they had?

All maintained schools and academies inspected in this time have judged to have effective arrangements for safeguarding by Ofsted.

We have developed strong relationships with independent school sector to monitor and improve their arrangements for safeguarding.

A network opportunity has been created to assist safeguarding governors in their roles and responsibilities, which they have commented has been positive and valuable to them in their role.

The revision of all training content now ensures that all staff in schools and education settings can access training that meets the requirements of Keeping Children Safe in Education.

The revision of the TWSCB template child protection policy now ensure that school have access to a policy that meets the requirements of Keeping Children Safe in Education.

All evaluations of training of the training provided is positive and all report increased knowledge of all areas of safeguarding and child protection, including Exploitation, Domestic Abuse, Children harming children and Neglect.

The MACFA audit of four files, demonstrated that staff in schools and education settings have an awareness of GCP2 and/or contribute to the GCP2 audit tool in partnership with other agencies.

Schools have accessed the new Telford & Wrekin Threshold Guidance and Early Help Assessment training. This training has been actively promoted by the Education Safeguarding team. The impact of this is that schools remain the second highest agency to complete Early Help Assessments after the local authority Strengthening Families Team.

Partnership working between education, internal service areas and other agencies remains high, this is demonstrated through the range of multi-agency attendees who attend training to provide and disseminate information to schools.

The impact of training to schools is demonstrated through the % of safeguarding referrals to Family Connect and use new Telford & Wrekin early help and referral processes.

Selected schools have signed up to a pilot to improve the effectiveness of Operation ENCOMPASS alerts.

What are your organisation's plans for 2019-20 in relation to your responsibilities to safeguard children and young people?

Following a revision of Keeping Children Safe in Education the template TWSCB policy is being revised to ensure it meets all requirements for schools and education settings.

The current section 11 audit model for schools is being revised under section 175/157 of the Education Act 2002 to improve the effectiveness of the audit roll out the audit to independent schools. A further review will be conducted on the effectiveness of the section 11 audit sampling process to enable the local authority on behalf of the TWSCB to monitor the effectiveness of safeguarding in schools.

All training content is being reviewed to help ensure staff receive training content as required by Keeping Children Safe in Education and in line with the TWSCB priorities.

New training units will be made available to schools, including exceptional pupil movement and off-rolling and extending the roll of managing sexual violence and sexual harassment. The revised raising awareness of child protection will be rolled out to schools.

Training on supervision is being made available to schools. We have arranged for Caroline Eyre, an independent consultant who advises CAPE (Child Protection in Education), the DfE and Safer Recruitment Consortium to lead train the trainer training to support this. This was identified as an outcome in the MACFA neglect audit. The Education Safeguarding Team will then be able to deliver training for schools.

The Operation ENCOMPASS pilot will be rolled out and evaluated with a view to implement the new information sharing procedures for all schools by January 2020.

There remains an ongoing commitment from education to the multi-agency safeguarding hub to support schools and Family Connect to work together effectively.

Termly updates for designated safeguarding leads and governors will be tailored to emerging needs and local priorities.

All education staff will receive an update on raising awareness of child protection and managers within the service area will receive an update on safer recruitment processes.

An action plan will be implemented to support the findings of the section 11 audit sample visits. This includes developing and delivering training on the requirements of the single central record to improve safer recruitment processes and supervision training for schools to help improve the monitoring and oversight of safeguarding in schools.

How has your organisation contributed to delivering the TWSCB's priorities for 2018-19?

Peter Stone, Assistant Principal and Caroline Welson, BeSafe Manager have continued to represent Telford College on Telford and Wrekin Safeguarding Boards for both Adults and Children.

- Telford and Wrekin Safeguarding Partnership
- Telford and Wrekin CSE Strategy Group
- Telford and Wrekin Neglect thematic subgroup: children/adults
- Telford and Wrekin CSE
- Telford and Wrekin Channel Panel
- Telford and Wrekin PREVENT

During 2018-19, what are the key areas of development in your organisation that have impacted on safeguarding children and young people? What impact have they had?

Ensuring all students know how and where to access safeguarding and support within college. This is evidenced by BeSafe hotline and email address printed on the back of badges, and a safeguarding talk as a part of Principals welcome talks attended by all students.

Termly information sharing meetings in place attended by BeSafe Manager, Student Services Director, Kickstart representative and Inspector Gary Wade.

Strong links have been forged with the Child Sexual Exploitation team in Telford and information has been shared to support police intelligence. This is evidenced by Jade Hibbert delivering outstanding workshops to most staff and students within college, resulting in increased awareness of the key indicators associated with CSE and CE.

Increased number of Designated Safeguarding Leads (DSLs) ensures incidents are dealt with quickly by trained staff.

DSL's attend termly updates delivered by Telford & Wrekin Council to ensure important Safeguarding messages are disseminated to all staff.

Working with multiple agencies via the Early Assessment framework has enabled us to forge stronger links and in turn safeguard our young people.

Increase in the number of young people accessing support regarding safeguarding disclosures and concerns.

What are your organisation's plans for 2019-20 in relation to your responsibilities to safeguard children and young people?

Continue to raise awareness of County lines, CSE, CE neglect and domestic violence by means of the following:

- West Mercia Police: CSE/CE/County lines awareness sessions for staff and students.
- Loudmouth performances.
- Focussed activities/themed weeks highlighting the above through our Enrichment programme.

How has your organisation contributed to delivering the TWSCB's priorities for 2018-19?

- Reviewed and amended safeguarding and public protection policies to reflect the new arrangements.
- Updated our sharing of information procedures to include GDPR.
- Undertaken self – evaluation of our work on the exploitation of children and vulnerable adults.
- Despite resource challenges prioritised attendance at safeguarding boards and subgroups.
- Responded positively to the issues raised by Her Majesty's Inspectorate of Probation to the findings of our safeguarding practice by implementing Quality Development Managers and undertaking monthly case audits.

During 2018-19, what are the key areas of development in your organisation that have impacted on safeguarding children and young people? What impact have they had?

Quality audit of safeguarding and public protection work by Quality Development Managers. This has improved the work of Offender Managers in their safeguarding practice including liaison with Children Services. Practice has shown an investigative approach being taken not only by Probation Officers (PO) but also by Probation Service Officers (PSO). Audit results are reviewed on a quarterly basis, benchmarked and reviewed monthly during clinical supervision with Offender Managers.

Delivered a Voluntary Perpetrators Programme at our offices in Shrewsbury for men involved in intimate partner violence who have not appeared before the Courts. This programme has been evaluated by Chester University and the findings have shown that participants have shown improved attitude and behaviour change. They have become more aware of their actions and the impact of their behaviours on their partner and children.

In response to the Counter Terrorism and Security Act 2015 WWMCRC delivered Prevent awareness training in identifying and managing those at risk of being drawn into terrorism, including those with extremist ideas that can be used to legitimise terrorism and are shared by terrorist groups. Prevent awareness training has been rolled out to all CRC staff and will continue in 2020.

What are your organisation's plans for 2019-20 in relation to your responsibilities to safeguard children and young people?

- To continue with the case audits to improve safeguarding and public protection practice.
- Prevent awareness training to continue.
- Ensure information security and information sharing training and compliance is embedded in PO and PSO practice.
- Undertake case audits on cases involving domestic violence and safeguarding children.
- Review partnership and practice arrangements on young people.

How has your organisation contributed to delivering the TWSCB's priorities for 2018-19?

Neglect

In Telford, we maintain a Specialist Department which investigates any reports of Child Neglect. Working closely with partner agencies we are able to provide Specialist Officers during the week and weekend to deal with any immediate safeguarding concerns and commence an investigation.

Along with the training these Specialist officers received, West Mercia Police have also provided training and Digital Learning to encourage 'Front Line Officers' to look beyond the obvious when considering vulnerabilities and in particular identify signs of neglect.

Officers continue to use their powers under the Children's Act to protect and safeguard children where it is believed that a Child is likely to suffer significant harm and work closer with partners to ensure the child is protected in the short and long term.

We attend Child Protection Conferences to assist in the information sharing and decision making process surrounding the long term provisions for care for children who are at risk or have suffered neglect.

During this time period a number of significant investigations have resulted in suspects being charged and now awaiting Trial.

These include the serious assault of baby aged 8 weeks, where Detectives investigated this matter resulting in her mother being charged and remanded with the offence of wounding with intent, the investigation demonstrated excellent partner working with Children's Services and medical professionals, the victim is currently in foster care but has been left with life changing injuries.

A further example being an allegation of rape of a child aged 13 by her father. He was arrested and bailed and following a breach of these police bail conditions, robust action was taken resulting in a further arrest and charge to Court where this awaits trial.

Exploitation

The Child Sexual Exploitation team is now the Child Exploitation team which has resulted in a realignment of police resources in this critical area of business. The uplift in the police team mirrors the approach of the local authority. This empowers both organisations to better understand the scope and nature of the problem in the borough.

An important part of this work is the early identification of children at risk of CE along with management of the perpetrators and locations associated.

12 Child Abduction Warning Notices have been issued to suspected perpetrators in the past year, one of which has resulted in a male being convicted of the abduction of an extremely vulnerable young person.

A significant operation took place in South Telford around concerns that adults were using children to deal drugs. Joint visits were conducted to twelve families to offer both support to safeguard their children whilst also using disruption tactics to offer the children a way out.

The LSCB Child Exploitation sub group has significantly evolved in the past year, Real effort has been made by all partners to increase the joint focus upon developing threats associated within the criminal exploitation of children, and has led the creation of a new Child Exploitation pathway, being

developed. The Police are key participants in the Child Exploitation Panel which occurs every fortnight.

We have continued to operate a County Lines investigation team which has pursued and disrupted offenders who were exploiting children or young persons, both from Telford and outside of the Policing area. A number of significant operations have disrupted persons engaged in child exploitation and the team have undertaken involvement in National disruption weeks working with partners. These activities have included Licence checks and stops on Taxis and other Public Transport including popular Train routes for youth gangs from West Midlands in conjunction with the British Transport Police.

During this period Telford Youth Engagement have developed engagement with schools within the Borough, providing awareness sessions around safeguarding and education involving relevant risk areas such as County Lines, exploitation, drug/alcohol misuse and online safety.

The team have linked in with other initiatives and offered support such as with OP SCEPTRE (knife crime) where they complement the Steer Clear programme by giving deliveries in the school educating pupils and staff. The team continue to promote the effective way of sharing information and ensuring education establishments report things in correctly to the police or relevant partner (e.g. Family Connect).

Operation AIDANT is the NCA focus on Modern Slavery / Human Trafficking. Through the MATES programme we have been able to run a number of operations in the area. Through this work both offenders and potential victims have been identified. Through the NRM process relevant support is then considered and applied. Recent work involves Ops around the local car washes and nail bars, the partnership strategy allows a holistic safeguarding approach.

Domestic abuse

West Mercia Police remains committed to tackling Domestic Abuse and in Telford we maintain a Specialist Department who investigate High risk domestic incidents and robustly deal with perpetrators.

Within this department we have Domestic Abuse Risk Officers who work closer with victims ensuring that risk is appropriately managed and that the victim is directed to support and advice. Our Design Out Crime Officers are also able to make visits and offer safety advice as well and installing other safety measures including Personal Attack Alarms.

Telford Police continue to Chair the Multi Agency Risk Assessment Conferences (MARAC), and work closely with partners to ensure the management of risk and support to Victims.

Uniform Officers continue to attend Domestic incidents taking a proactive and robust approach towards the arrest and process of perpetrators to safeguard victims.

An increased use of DVPN's and identification of a full time single point of contact for attending court has ensured best practice and ensured that the applications for such orders are more often successful and are used as a disruption and safeguarding policing tool.

During this time period the Domestic Abuse Detective Inspector chaired Domestic Abuse Scrutiny Panels internally where timely reviews were made of investigations and the victims thoughts on Police action considered. Any organisational learning was suitably delivered in local training sessions.

Our Safer Neighbourhood teams continue to oversee Domestic Risk Management plans by making regular personal visits and contact with victims of Domestic Abuse. Recording their interactions, interventions and management of which is fully auditable.

In 2019, a significant Telford investigation resulted in a male perpetrator being convicted for Domestic Homicide with a firearm being used for the Murder. This has been subject to a Domestic Homicide review which has returned with recommendations and organisational learning.

There has also been a successful charge for a Domestic Stabbing and Attempted Murder following a period of Stalking by the perpetrator which is currently listed for Court this year.

During 2018-19, what are the key areas of development in your organisation that have impacted on safeguarding children and young people?

Our Exploitation and Vulnerability trainer has delivered the Child Exploitation awareness training to professionals and community members from an array of organisations, backgrounds and institutions, delivering to 13,759 delegates from September 2018-2019 into 2020 people within Telford and Wrekin.

A few examples of organisations who have received the awareness training are: college staff, early years/primary and secondary school staff, transport organisations, police officers / PCSO's, social workers, health care professionals, taxi drivers, hotel staff and faith groups.

Detectives from CID offered training presentations to all Secondary Schools in Telford covering how to remain 'Cyber Smart' focussing on the exchange of indecent images between peers, CSE and Sextortion (Blackmailing for Sexual Images). The majority of Education Establishments accepted the offer throughout 2018-2019.

The Steer Clear project is one element of this work which has worked with children and young people suspected of carrying knives. Working with families and the young person, workshops have been held involving West Midlands Ambulance Service, Social Workers, Youth Workers and Police Colleagues educating attendee's on the realities involved with carrying knives, which have been linked to violence associated with child exploitation, both nationally and locally.

Our CSE team have now changed to become a CE team which is working closely with our partners and other Policing Departments such as Proactive CID and the Serious Organised Crime Unit to target those who exploit children for criminal gains. This has seen the commencement of a number of significant Operations and Investigations into Criminal Child Exploitation across Telford.

An innovative approach of the use of Community Protections Notices to intervene and engage with Children and their Parents believed to be involved in the dealing drugs was undertaken in partnership with Child Services. These notices have seen some children be re-directed away from this activity and safeguarded them from harm and appears to have had a positive impact.

An emerging trend in Urban Street Gangs lead towards a number of Police lead problem solving meetings resulting in an Operation which was focussed on the gathering of intelligence to inform a local picture with this work continuing up to this date.

West Mercia Police also gave significant training to all Officers in all roles reference Domestic Abuse, including inputs on honour-based violence and violence against children.

Within this training Domestic Abuse Champions were identified who were given enhanced training to serve as points of contact and advisors in all areas of Policing.

What are your organisation's plans for 2019-20 in relation to your responsibilities to safeguard children and young people?

West Mercia Police continue to undertake our obligations and responsibilities which align with 3 of our Force Priorities:

Child Exploitation – Safeguard Victims by knowing the indicators of victimisation and identifying how technology facilitates CE.

Serious Organised Crime – Establish a single whole-system approach to reduce the level of SOC affecting our communities including Modern Slavery and Human Trafficking.

Our Exploitation and Vulnerability trainers will continue to deliver Child Exploitation awareness training. This work will continue to be supplemented by the Youth Engagement Team and Steer Clear project to ensure harmonised approach to training and education for adults and children.

Internally with an uplift in new Uniform Officers and Supervisors we are seeking to find opportunities for them to spend some time in our Specialist Child Departments to improve understanding and assist with engagement on the frontline with Children in our communities.

We will continue our commitments to involvement in the Thematic Subgroups; providing Senior Police Leaders to attend, along with a nominated Deputy.

Finally, we are seeking new innovative means of identifying Children at Risk with discussions being undertaken with Information Technology suppliers with regards to risk matrix software which could receive data from partners in order to identify those children.

We are also looking at the potential of piloting Domestic Abuse perpetrator programme, which would be an added tool in keeping families and children safe.

West Mercia Youth Justice Service *written by Keith Barham, Head of Service*

How has your organisation contributed to delivering the TWSCB's priorities for 2018-19?

WMYJS has a key role in safeguarding young people, in terms of assessing and reducing the risk of harm to young people either from their own behaviour or the actions of others and reducing the risk of harm they may pose to others. As such the service contributes to the priority issues for safeguarding identified in the borough, in particular exploitation and children harming children.

During 2018-19, what are the key areas of development in your organisation that have impacted on safeguarding children and young people?

Following the pilot inspection (April 2018) maintaining and improving the quality of assessment and planning remained a focus for the service. Research into the prevalence of childhood trauma and adverse childhood experiences in a cohort of young offenders was completed and awareness training was delivered to practitioners. Other key areas of development were training for staff in

mental health issues and the agreement of a new model of joint decision making for out of court disposal which will be implemented during 2019/20.

What are your organisation's plans for 2019-20 in relation to your responsibilities to safeguard children and young people?

In 2019/20 the service will be training practitioners in AIM3, an evidence-based assessment and intervention programme for young people demonstrating harmful sexual behaviour. The service will be further embedding trauma informed approaches in practice. The new joint decision-making arrangements for out of court disposals will be implemented, which will seek, where appropriate, to divert first time offenders from justice system sanctions through the offer of informal programmes of intervention.

Wrekin Housing Trust *written by Phil Heywood, Neighbourhood Manager*

How has your organisation contributed to delivering the TWSCB's priorities for 2018-19?

- 100% attendance and contribution at TWSCB meetings;
- Resource committed to Family Connect, to support our multi-agency approach to children's safeguarding;
- Member of the Multi Agency Safeguarding Hub (MASH) strategic group, sharing good practice and considering all options for developing working processes in connection with overall safeguarding; and
- Internal sharing of all relevant literature and campaigns.

During 2018-19, what are the key areas of development in your organisation that have impacted on safeguarding children and young people?

- Continued staff awareness for frontline staff of all safeguarding issues, both from the person and the property perspectives;
- Consistent approach to dealing with cases with a safeguarding element. The approach is via a multi-agency partnership, utilising our Family Connect resource;
- Scrutiny of our safeguarding cases internally via our Board; and
- Basic preventative work carried out on a day-to-day basis via routine housing and tenancy management. This includes pre-tenancy advice and support, rapid response repairs service, dealing with anti-social behaviour (ASB) and general nuisance, offering money matters and welfare advice, and support with domestic abuse issues. All of the services offered have the ability to deal with issues that can impact upon safeguarding.

What are your organisation's plans for 2019-20 in relation to your responsibilities to safeguard children and young people?

- Continued monitoring and updating of all policies and procedures;
- Continued support via a dedicated resource working from Family Connect;

- Continued training and awareness as necessary with regards to all elements of effective tenancy management, incorporating safeguarding elements. There is to be a revised Domestic Abuse policy introduced following the sign up to the 'Make a Stand' pledge; and
- A full review and implementation of a group wide Safeguarding policy.