Suffolk Safeguarding Partnership

2021-21 Annual Report

Reporting Period April 2021 – March 2022

We start with a quote from a care leaver turned apprentice, reflecting on their own lived experience and the role of the Partnership in reducing abuse and neglect:

"As a young person who was once in the care system, I didn't know what safeguarding meant until I became an apprentice. Once I started my apprenticeship, I started to learn what safeguarding meant.

Safeguarding means to protect vulnerable adults, young people, and children from harm. From what I have seen/heard within the work environment not only does safeguarding mean to protect people from harm, but it also means to find out where things have gone wrong in situations, and what things could happen to stop the same thing occurring again.

Since learning what safeguarding meant, I have been more aware of the harm people can put you through. I always think twice before meeting someone new or being online. Safeguarding doesn't always mean safeguarding someone physically, it also means safeguarding people online."

Apprentice Care leaver

The Independent Chairs Foreword

"Working through the pandemic has proven once and for all that working together drives improvement for all. We need to ensure that partnership working continues to be a foundation for next steps."

Martin Edwards,

Chief Nurse, Suffolk GP Federation

The year spanned the mid-point of the Covid pandemic to its current status as another permanent pressure point in society which can affect anyone at any time. Connected to this timeline, the Suffolk Safeguarding Partnership (SSP) absorbed a much higher demand for its services throughout the year. There were more requests for case reviews: more requests to support agencies with improving their safeguarding performance: more enquiries about the availability of learning materials; and a steep increase in requests for advice about individual situations. The Partnership team responded to everything put in front of them for which I give my thanks. I also commend them on behalf of all those partners who were supported to carry out increasingly complex safeguarding tasks. Increasing complexity is hard to measure but when everyone involved says something is more complex, it is highly likely it is more complex.

As the quotes from partners throughout this report show, the Partnership excelled at times. In other respects, more has to be done, an example of which is the need to improve our measurement of the impact of what we do and its outcomes. We know too little about that. If high quality input is either disregarded or not even known about, it is usually not worth doing. We will always need to go back to the drawing board on a regular basis to stay relevant. Safeguarding will be a local, national, and global priority for many decades to come, if not centuries.

Some of the achievements reported by NHS Norfolk and Waveney Clinical Commissioning Group:

- *The NHS has embraced new technology and accessed meetings remotely and remained connected to the wider system, overcoming the challenge of isolated working across a large geographical area.*
- *Looking forward to the new way of working under the ICS to help ensure people lead healthy, longer, and happier lives.*
- *Developed and delivered the vaccination programme, ensuring equity in access to those lacking the mental capacity to consent.*
- *Designed a safeguarding training programme delivered remotely, allowing for multiple professionals to maintain their knowledge base and stay connected with subject matter experts.*

Gary Woodward, Adult Safeguarding Lead Nurse
NHS Norfolk and Waveney Clinical Commissioning Group

Significant achievements in 2021/22 included the greater embedding of the Suffolk Safeguarding Adults Framework, including publication and the mass distribution of a new pocket-sized guide. Since a critical independent review about local multi-agency working relationships in 2017, this has been a continuing concern. Evidence now shows recent improvements in working together across adult health and care

services. This also tells us that many profound changes take years rather than months to embed. This is an important lesson when we are all under huge pressure to deliver quick fixes.

We updated our threshold matrix for children's social care which has given a greater clarity about the level of support children and families should receive. We changed the process in hospital discharge teams to make discharges safer. This is significant because too many people at risk are still being discharged back home without care and support services being properly organised.

In common with many organisations, our meetings are held exclusively on Teams which has allowed a great number of colleagues to join when previously they would not have been able to do so due to the travel time involved. We did stage a large in-person conference in September 2021 which sold out. This showed the appetite our sector still has for coming together physically from time to time, to share the intensity of safeguarding work with close colleagues. We found out that many virtual risk assessments and triage processes were too superficial to spot risk. Plans are in hand for child protection conferences to be held face to face again, partly to ensure families are able to participate in the way they nearly always prefer. So, a hybrid model in future, with the balance determined equally by function and what is in the best interests of children, young people, and adults at risk.

Finally, like most readers of our Report, I am worried about the threat to the emotional health and well-being of people in Suffolk as a result of profound changes in wider society including the lingering, adverse consequences of the Covid pandemic and now the cost-of-living crisis. The dramatic rise in referrals to mental health services for people of all ages show how fear, worry and anxiety are close to stalking the land – an epidemic of mild anxiety and depression perhaps. This needs a whole system response, not just from mental health services. Specialist mental health services are struggling due to the well-publicised problems in the local mental health Trust. A number of agencies are struggling to recruit and retain staff, such as the care home sector. We have to make safeguarding, caring, and supporting vulnerable people in Suffolk a job and career of choice for many more people through talking openly and inspirationally about our work. The best protective factor in a local area is a suite of well-led organisations staffed by a mix of highly experienced and newly qualified staff, who work together seamlessly. Next year, I hope to be able to report we have made a contribution to creating the conditions for outstanding safeguarding practice. Safeguarding is never 'done'. It needs constant vigilance and renewal. That is the point of all statutory Safeguarding Partnerships, to make a difference and to add value to a big issue no single agency can deal with on its own.

Relationships between agencies within the Partnership are such that we can challenge and put questions to one another if we have queries about practice. The partnership offers both support and challenge to myself and my organisation that provokes thinking about matters in different ways and areas where we need to develop. I have learnt so much from my colleagues in other agencies that I can take back to my own organisation and share.

Allison Hassey, Head of Child Safeguarding Suffolk County Council

My thanks to our partners as well as our team members. All agencies have shown great commitment to keeping people in Suffolk safe, saving countless lives in the process. The commitment to joint working and the incredible efforts made every day to keep services – and people – afloat, have been a local triumph.

Anthony Douglas CBE
Independent Chair, Suffolk Safeguarding Partnership

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The Statutory Basis for this Report

- Safeguarding Partnerships were established by the Care Act (2014) for adults and the Children and Social Work Act (2017) for children. These are the latest types of partnership, which first started as an overarching governance arrangement in the 1970's.
- The Care Act 2014 requires the Safeguarding Adults Board (SAB) to publish an annual report. The Care Act 2014 states that the SAB report should be submitted to the Chief Executive, Leader of the Council, the local Police and Crime Commissioner and the Chair of the Health and Wellbeing Board. Working together to Safeguard Children 2018 requires safeguarding partners to publish a report at least once in every 12-month period. This requirement is being reinforced for new Integrated Care Boards.
- The report should cover what has been done during the year to achieve the Partnership's main objectives and to implement its strategic plan: what each member has done to play their part in collective improvement and how effective our work has been in practice, including how well we have implemented the learning from safeguarding practice reviews.

Equality, Diversity, and Inclusion Statement

- The Partnership puts an emphasis on equality, diversity, and inclusion because the children and adults at risk who we work with are always treated unequally. We make a presumption of exclusion unless we learn otherwise. People's individuality and diversity are too frequently unknown, and they are excluded from the positive experiences that most of us take for granted. Safeguarding victims are usually the last people to draw the attention of others to what is happening to them. Unless abusive and neglectful behaviour is called out and challenged, nothing changes.
- Many of the children and adults at risk we have become aware of this year were 'hidden in plain sight', often despite the involvement of many professionals. Without exception, our case reviews showed that child and adult victims had an unequal status within their families and within their local communities. Their diverse needs were largely ignored. For the first time ever, campaigns like Everyone's Invited – which invited survivors of abuse and neglect, especially rape - to come forward and tell their stories, began to reach a mass audience. Another review with a profound message this year was that of Child Q, a black teenage girl who was strip-searched in a school by police in Hackney without foundation and without safeguards and who as a result was traumatised. It is important that we see these stories of abuse and neglect of people of all ages who were living outside Suffolk as being potentially relevant inside Suffolk. Our job is to reduce and mitigate the risk of abuse and neglect happening here. Our Annual Report will highlight stories from each year in question and we will also report back on what actions we took in relation to contemporary risks.
- This is especially the case as we welcome this year's Ukrainian refugees into our county who have lived through the trauma of war, including displacement. Whilst the responses by agencies to traumatised individuals and groups from all over the world has been supportive, it has become clear through our work this year that many individuals from these groups have unmet needs which have not been previously assessed and which suddenly become apparent through a personal crisis or a family crisis. Most asylum seekers need extra help, at least initially. Many have safeguarding issues, including for some a heightened risk of being exploited.
- This equality, diversion and inclusion statement applies to all categories of people who are excluded in Suffolk in any way, or who may be victimised, discriminated against, suffer disadvantage or who are harmed or at risk of harm just through being 'different' We will not list each group at risk. It is our responsibility to embrace the uniqueness of each individual in Suffolk and to play our part in promoting an ***equal, diverse, and inclusive Suffolk.*** In our work as a Partnership, this means we will take active steps to live by, to act within and to promote these values. This also correlates with protecting the Human Rights of individuals and the freedom to live their lives without having any of their rights infringed or compromised.

"The past year has been incredibly challenging but as a partnership we have exemplified collaborative leadership. We have demonstrated strength in our diversity and set the bar high for safeguarding in Suffolk"

Georgia Chimbani, Director of Adult and Community Services
Suffolk County Council

Changes to How we Have Worked This Year

- These are the main changes we have made to adapt to the changing context described above:
- We rationalised our structure of meetings, aiming to get the intervals between meetings right – infrequent enough to allow for work to be completed in between meetings yet frequent enough to sustain momentum and teamwork.
- The independent Chair moved to chairing all meetings to strengthen the links between the various statutory functions of the Partnership. He was supported by co-chairs for the Case Review Panel for children and adults respectively. He also attended the Suffolk Safer and Stronger Communities Board to ensure the cross-over between the two statutory Boards was understood and joint actions co-ordinated.
- Our quarterly locality forums were well-attended and were seen as an important way for local professionals to take stock and identify safeguarding issues of common concern.
- We extended our partnership working with the community and voluntary sector, including participation in many events aimed at making volunteers in the smallest local services feel part of the wider safeguarding network in Suffolk and in policy developments such as a planned Community Consultation Line for the community and voluntary sector to be able to talk to the MASH about worrying situations.
- We integrated the work of the Child Death Overview Panel (CDOP) more into the work of the wider Partnership e.g., through dovetailing reviews, action plans and actions between the various services within the Partnership charged with taking a learning point forward.
- We strengthened family inclusion in reviews by more systematically considering how best to do this in each review and by appointing a partnership team member to act as the specialist liaison officer when working with families in distress.
- We were the first local service to offer apprenticeships to care leavers under a new Suffolk County Council programme. We gave two care leavers their first experience of work.
- We changed our risk register into an issues log so that, at any one time, members of the Partnership can see the issues we are taking forward, in what way and with what risks those issues bring with them.
- We extended invitations to selected webinars and learning events to system leaders in the Eastern Region.
- We made more use of poster campaigns e.g., promoting the Safeguarding Adults Framework to professionals including QR

"As a true partnership, we have been able to achieve meaningful progress and outcomes for many cases in the context of both adult and child safeguarding in longer term reviews and learning, as well as working through day-to-day issues and situations.

The membership have a strong professional working relationship which has allowed us to continue to evolve and understand our respective areas of business better, with support and direct joint working being given to each partner agency where needed to achieve the best possible outcomes for the public. Each and every adult and child safeguarding situation presents individual requirements needing a bespoke response – I am proud of how our teams across the partnership support one another to reach the best outcomes possible in each case"

Detective Superintendent David Giles, Suffolk Constabulary

Prior to the Pandemic, West Suffolk Council (WSC) had created an environment to allow safeguarding to be embedded in day-to-day business practice, rather than focusing just on making referrals. The Council has increased safeguarding participation by empowering leads in each business area. This has provided opportunities to explore policies, working practices and explore how best we can support our residents. We have utilised the pandemic experience to embed our safeguarding practices across the Council. One area flagged through the safeguarding leads' network is the Council's contracts process, and as a result we are now developing our contract review and procurement process to ensure it supports our safeguarding policy.

With regards to our partnership with the Suffolk Safeguarding Partnership (SSP), we have a close working relationship with Tracy Murphy as our Professional Advisor, we are present in the community here in the West and we often bring things to the SSP for additional clarification and support. We have also been pleased to see the return of the District Safeguarding Leads Meetings where we can explore wider learning opportunities. Thanks to Tracy for this.

Will Wright, Families and Communities Team Leader
West Suffolk Council

code links, and the beginning of plans to publicise the Herbert Protocol within communities which will be further developed in 2022/23.

- At the time of writing this report, as we go into 2022/23, we are looking at ways of strengthening the local safeguarding system further, by increasing the constructive, collaborative oversight of children and adult services provided by the statutory partners – the County Council, Health, and Suffolk Constabulary.

Case Reviews and Learning

- Some case reviews from around England and Wales during the year became headline news nationally. A number of vulnerable adults with a learning disability were abused and neglected over many years at Cawston Hall, a private hospital in Norfolk close to the Suffolk boundary 'looking after' adults with learning disabilities and autism. A Safeguarding Adults Review (SAR), published in September 2021 about Cawston Hall was a timely reminder that past abuses in hospitals and care homes such as Whorlton Hall in Durham, Winterbourne View near to Bristol and, nearer to home, Yew Tree Hospital in Essex, cannot be said to be a thing of the past. The risks are still with us. Child Safeguarding Practice Reviews and court cases about Arthur Labinjo-Hughes in Solihull: Star Hobson in Bradford; and Logan Mwangi in Bridgend, showed that children are still being murdered by their parents and by their partners, meaning that violence to children has to be guarded against at all times in Suffolk.
- Over the course of the year, referrals for us to consider a Case Review rose by 133% for children's and the same for adults. The number of cases considered by the Child Death Overview Panel (CDOP) throughout the year was 16% lower than for 2020/21. The CDOP numbers do not correlate with an increase or decrease in safeguarding concerns as the causes of the vast majority of child deaths are generally not related to safeguarding. They are mostly babies or young children who die of medical conditions. Tragically, one such baby lived for just fifteen minutes. Suffolk is fortunate to have a team of Child Death Review nurses who work with families who are grieving as well as taking the actions and learning points from individual deaths forward on behalf of the Partnership. A small number of suicides and one case of serious neglect showed that whilst county lines and gang affiliation has had a lot of publicity in relation to victims and perpetrators, the number of children about whom this was a serious concern to the Partnership fell over the past year.
- Our case reviewing process changed considerably over the year. The Safeguarding Adults Board (SAB) is collaborating with the Social Care Institute for Excellence to develop a new process to enable learning to be turned around more quickly than usual through a Safeguarding Adults Review (SAR). This new process is referred to as a SAR In-Rapid-Time.

What is a SAR In-Rapid-Time?

- A SAR in Rapid Time aims to turn-around learning in an approximately 3–6-week timeframe, following the set-up meeting. The set-up meeting is held after the decision has been made to progress with a review. An outline of the process is depicted below.
- The learning produced through a SAR in Rapid Time concentrates on 'systems findings. Systems findings identify social and organisational factors that make it harder or easier for practitioners to do a good job day-to-day, within and between agencies. Standardised processes and templates support an analysis of a case within this framework.

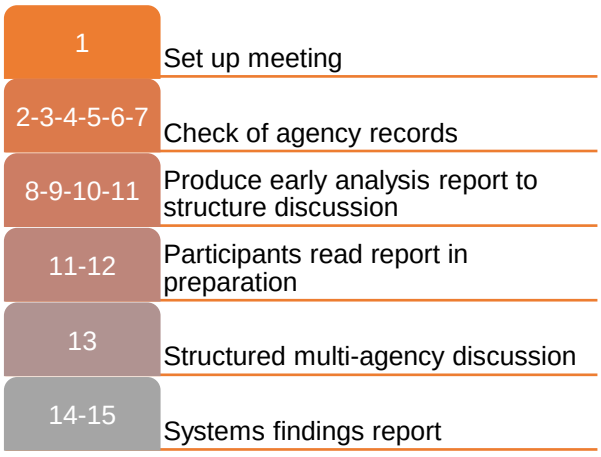


Figure 1 Outline of a SAR in Rapid-Time

- The way we conducted children's case reviews also changed in line with our own experience and with the direction of travel set by the National Child Safeguarding Review Panel. This meant we made more use of Rapid Reviews, in which all of the relevant information is gathered within 15 days, with conclusions reached as a result. There is often little else to find out about a situation, even if you review it for months or years. The key issue is to learn the important lessons quickly and to apply that learning in new situations straightaway. In addition to Rapid Reviews, we sharpened our practice with subsequent learning events, webinars, full Child Safeguarding Practice Reviews where this was needed or less intensive partnership reviews. We also expanded our pool of internal reviewers, using the strengths of staff in the local system to carry out reviews, building into the process sufficient objectivity and independence for their conclusions and recommendations to be robust.

- We also carried out two thematic reviews, one for adults and one for children, the latter beginning as the year under scrutiny ended. Thematic reviews consider a number of situations together where there are common themes. The first involved 5 adults whose deaths or serious injury contained significant lessons for the local system, even though each in their own right fell short of the criteria for a statutory Safeguarding Adults Review (SAR). The second is a review of three babies, two of whom died and one of whom was injured. The circumstances of their deaths and injury were sufficiently similar to look at how agencies assessed and intervened in all three families and what lessons need to be learnt and embedded into changes in working practices.

Our Most Important Reviews In 2021/22

- Our reviews are published on our website. Part of our commitment to transparency this year was to introduce a presumption of publication rather than over-thinking the reasons why we should not publish. We draw the reader's attention to two reviews in order to illustrate the complexity of the situations we review. One is a children's case, the other an adult's case.
- The Two Sisters were 10 and 7 when the full extent of the abuse and neglect they had been suffering at the hands of their mother and their mother's partner came to be understood. Over a three-year period, the school recorded over 30 concerns. Whilst some Early Help support was offered, the threshold for defining this as a child protection investigation was never met because the cumulative impact of the girls' lived experiences was not considered. When professionals thought neglect was reducing, they did not realise that the mother was keeping the girl's cleaner in order to groom them for their abusers and that as well as being neglected, the girls were being sexually abused. Many lessons were learnt from this case, particularly the recurring theme set out below of people at risk being 'hidden in plain sight' to all agencies. 'Hidden in Plain Sight' became the focus of the conference we held in September 2021, which was face to face, well-attended and the first time many safeguarding professionals had been in the same physical space as each other since the pandemic started in March 2020.
- May Miller was an elderly lady who was physically assaulted by a male fellow resident in a Suffolk care home when she was hit over the head with a metal walking stick. She died with the assault playing a part in this, according to the coroner's findings. The key issue was that the male resident's challenging behaviour at his previous supported housing placement was not briefed to the care home when he was admitted. As a result, the care home staff knew nothing about the potential risks he posed. The lack of information sharing was partly caused by the fact the man was self-funded so did not go through a more rigorous, assessed admission process. Predictably, the main lesson from this situation was the need to strengthen information-sharing and the Partnership followed this up by strengthening the inter-agency information sharing protocol as well as hosting a webinar and a learning event about May's death.

Large-Scale Enquiries Undertaken or Being Followed Through

- We followed through the recommendations from the 2020 Stella Maris Inquiry which were aimed directly at the Partnership, such as extending involvement in the Partnership and providing training and support to housing providers.
- The Chair of the Partnership carried out an Appreciative Inquiry into the impact of Covid on safeguarding services in Suffolk, including the lived experience of children and adults at risk, their families and on professionals, many of whom were exhausted by the time of the inquiry in the autumn of 2021. The methodology involved holding a small number of interviews with those directly affected rather than a data-led Inquiry. As such, the Inquiry was a snapshot only, though it was still able to make evidence-based conclusions and recommendations. Thirteen recommendations were made (see the link below). Four personal stories are set out below to illustrate the main conclusion that practice experience varied from brilliant multi-agency work to individuals feeling abandoned and let down.

Below are 4 stories featured in the Inquiry:

Petra's Story

Covid drastically changed me for the better. It was a massive mirror put up in front of me. It helped me to see myself and to upgrade my life. I had to face myself. I went from being an addict in denial with deep addictive patterns to looking at my own behaviour and recognising why I was making self-destructive choices. I could only make this change with support. My best friend and I left podcasts for each other to listen to, for company, to cheer us up and to inspire each other. We told each other there was no pressure to reply but we always did. That's the thing about support. And when I reached a point of feeling suicidal because of everything I was dealing with, she was there for me. Another friend put me in touch with the recovery (from addiction) programme at my local Buddhist Centre. I met a woman there who became my fairy godmother. She insisted on meeting me weekly and keeping me on track. She would not let me out of her sight. She helped me to understand co-dependency. I had a turbulent, unpredictable childhood which pre-disposed me to addiction. My mum was an addict. Once I had to stop her from stabbing her boyfriend. Our relationship was toxic at times and fantastic at times, but we never completely gave up on each other. The Ipswich Anti Loo Roll Brigade offered support and a sense of community and friendship to me at a lonely time. They are one of many Next-Door type groups that popped up during the pandemic and are still going. Loneliness used to make me contemplate suicide, but I am now through my bleakest moments like when I was bar hopping. I am now in a loving relationship. I feel loved. I feel secure. I am more wholesome.

Being an ITU Nurse during COVID

You can tell we're permanently tired by the ten-mile stare on our faces'. 'We had to switch onto automatic pilot'. 'We were numb throughout' - the words of Joe, an ITU nurse describing a cumulative mental and physical exhaustion as well as an amazing dedication to saving lives. This commitment included sometimes working double shifts with minimal breaks and with constantly changing guidance from the NHS nationally, about PPE for example where nurses might be given one type of PPE at 7 in the morning and another with a different set of instructions at 2 in the afternoon. The goalposts in terms of advice were changing every day. Covid was different from any other respiratory illness he had known. Adapting to it was intense and frightening. Dealing with the unknown was hard. To begin with, nurses were told that the air change times in theatre were every 20 minutes. Later on, they learnt it was every 5 minutes, making them feel exposed, vulnerable, and not cared for properly themselves. Patients felt utterly exhausted. Dying from Covid was for them a case of being dismantled. At the end, every breath was a struggle, beyond the point of comprehension. For Joe, who caught Covid himself, he became progressively more tired, falling asleep every evening which he never used to do. He enjoys life less. Having been in the military before, he thinks and feels that Covid leaves you with a form of post-traumatic stress and that hospital resembled a war zone. His main concern at the moment is that 'I wish that people would realise we're not out of it yet. It will take the NHS 5-10 years to recover, as we are now so far behind. For example, the backlog for elective orthopaedics is 3-5 years. The attrition rates on the staff he knows have 'gone through the roof'. Most questioned whether they could carry on and the vast majority of staff he worked with have left, leaving a huge hole in the nursing workforce. Despite everything, Joe is proud that he and his teams responded to every emergency, saving countless lives.

Overstretched families, overstretched services

Unable to secure any support for her 17-year-old daughter with an eating disorder, a mother who understood what her daughter was going through because she herself had an eating disorder eighteen years earlier, turned their home into a specialist NHS unit. The mother became the specialist nurse in the absence of paid services materialising. The mother's frustrations grew as the only contact she had with the local eating disorder team was fortnightly phone calls inquiring about her daughter's weight. The calls started but only after 5 months without any contact at all. Her daughter's weight never got to the threshold of danger the team said would prompt an intervention. She was never observed and never had blood tests despite fainting and becoming very ill. In the end, the mother turned to self-help as the only viable service. This reminded me of a frustrated dental patient in Suffolk who, unable to secure an NHS service, tried to extract his own teeth rather than continue in excruciating pain (East Anglian Daily Times, 26th August 2021). This sense of 'self-help Suffolk' came through strongly from many people during the Inquiry, especially those who were experiencing deteriorating mental health.

The mother established the same regime that had helped her nearly twenty years before when, as she said, 'there were hospital beds back then'. She conducted random room searches of her daughter's bedroom for food. She turned her clothes out to make sure she wasn't hiding food. She did not allow her daughter to use the bathroom without being supervised. Her daughter was not allowed to go out on her own. Her daughter found this regime highly invasive at the time but now thinks it was necessary and helped to save her life.

Inevitably, other family members were caught up in these events though there are positive outcomes. The girl herself is much better now and coping with daily life again. After many months of pleading, she is now on medication which is helping her. Her school has been supportive throughout and that has been a lifeline. Her parent's relationship is stronger having gone through a make-or-break phase during the crisis.

Her mother told me, "I have been asking for help for so long, it is just not there. I begged for help. I knew I was going downhill'. Weakened by what happened, the mother herself began to relapse and started to experience another eating disorder for the first time in nearly two decades. It was only when she fainted that the Eating Disorder Service realised help had to be provided.

There are always other sides to the same story. One of the Suffolk Eating Disorder nurses worked all weekend to keep a child safe, working with her family. Another nurse moved into a local B and B so she could be closer to work.

In truth, hardly anyone felt supported enough, despite everyone supporting those around them 24/7.

Niru's Story

In February 2020, Niru came into care after her parents, both heroin addicts, could no longer look after her and her brother. After a period with a single foster carer, where she struggled to manage the transition away from home, and where she felt isolated and 'just another person in care', she moved to new foster carers later in 2020. She is happy now. She feels secure and stable, so much so that she is planning her future with new-found confidence. She has gone from feeling it is 'me against the world' to feeling she is able to recover from the traumas she experienced. Lockdowns were hard for Niru. She did not speak to her only friend for 8 months. Yet she survived and she is now prospering. As well as her foster carers, she has a 'brilliant' social worker who keeps in touch with her every 3 weeks and visits her every 6 weeks. Niru caught Covid in the summer (2021). She still feels tired, and her breathing is not as strong – a limiting factor for a budding musician. She sees her parents and brother for contact but, crucially, she feels she is being protected, looked after and now has her own world and space. Her cat eventually joined her, though as her social worker joked, 'it was harder to get agreement (from the Council) to the cat moving as it was for a child to move'!' Niru's story shows that many vulnerable children were supported to go through complex transitions in their young lives during and despite the pandemic. These quiet emergencies for people at risk are equally urgent. Lives cannot be put on hold

A full copy of the report is available for download: https://www.suffolksp.org.uk/about-us/appreciative-inquiry/

Single Agency Audits and Multi-Agency Audits

Adults' Audits Undertaken In 21/22:

Organisational abuse

A multi-agency audit was undertaken in March 2021.

The main findings were that further work needs to take place to help people understand what an organisational abuse enquiry is and to help remove fearful responses and stigma around it. We will gain insight and feedback from homes that have been part of an enquiry to get their perspective on how it felt and what it was like from their perspective.

Older people and domestic abuse

A Mult-agency audit was undertaken in August 2021.

The main findings were that discussions were needed to define what the circumstances are where MASH would ask for health information on the alleged perpetrator when they are elderly as it could significantly affect decision making and ensuring a proportionate/appropriate response is given, taking into account issues of capacity and context.

Self-neglect & hoarding

A multi-agency audit was undertaken in November 2021.

The main findings were that there is evidence of effective use of case conferences. We also found a case study example of good practice which is being written up and will be shared with practitioners through Safeguarding Champions Forums and drop-in sessions.

Application of the Safeguarding Adults' Framework

A multi-agency audit undertaken was in January 2022.

The main finding was that the framework is fit for practice and, if it had been used appropriately (or at all), it would have supported people to make the right decisions. The key action from the audit was to further raise awareness of the Framework and its use more widely.

Children's Audits Undertaken In 21/22

Neglect

A Partnership Audit was undertaken in March 2021

The main findings were that the history of parents and their childhood should be captured in recordings and used to inform cases, supervision records to be more reflective, analytical and offer more challenge and where a Graded Care Profile (GCP 2) assessing neglect has been undertaken, it should be discussed in supervision to inform progress on the case.

Waiting Times for the Emotional Well-Being Hub

A Partnership Audit was undertaken in July/August 2021

Children and families from this audit had been on the Emotional Well Being Hub waiting list for an average of 8 to 10 months. Many were waiting for much longer. None of the children and families had been given any indication whilst they were on the waiting list as to when they might be seen. If they were contacted by the Hub, it was often to be told what they already knew i.e., they were still on the waiting list. For over half of the children, their conditions had worsened. The children's schools had been the most supportive agency although social care and early help services had offered help and support to several children. However, over half of the children were not accessing any services for their condition. The majority of parents were of the view that the waiting times were the result of pressures from Covid and although many parents remained positive that their child would be seen soon, many were exasperated, worried for their child and unsure of who to turn to.

Home Educated Children

A Partnership Audit was undertaken in February/March 2022

The main findings were that there was considerable concern regarding the suitability of home education for over half of the children and the education was deemed not to be suitable or adequate in nineteen of the cases. The Elective Home Education (EHE) Team worked tirelessly and persistently to make contact with parents and establish the content of the education provision, however, they were often met with resistance, obstruction, and evasion by some parents. Half of the children were isolated with very few services or agencies working with them and for eighteen of the children, concerns and referrals were raised with the MASH. Good communication and joint working took place between the EHE advisers and Social Care/Early Help.

Indicative Audit timeline for 2022-23

Audits for 22/23 will reflect the priorities and major themes arising from case reviews and other SSP work. Where possible, audits will be all ages, and the approach will be multi-agency and single-agency audits again, along with softer quality assurance from the Professional Advisors. An early indication of some of the themes are:

- Record keeping within health agencies
- Effectiveness of existing policies (e.g., Position of Trust)
- Appropriate information sharing between agencies
- How families are being supported when experiencing domestic abuse and coercive control
- Exploitation & County Lines - audit the effectiveness of interventions jointly with the Community Safety Partnership
- 'Soft' audit with partners within the SSP around their waiting lists, and if they are proactively keeping people safe while waiting for services
- Develop an audit framework of how we might begin to measure the effectiveness of the reviews we carry out
- Children and adults in the system we are worried about, and how well services are responding to keep them safe
- S11 audits
- Joint audit with Merida of safeguarding practices for children in new, planned, and commissioned Tier 3.5 provision.

Learning Programmes

The Partnership delivered various online learning events and materials for professionals working with children and adults in 2021/22. Some of these were case review events to explore the learning from specific cases, and others focused on key areas of safeguarding. The events delivered and materials produced were as follows:

Collaborative working to contribute and produce webinars for all our partners to access have been really successful events. Professional Advisors attending our health meetings have facilitated a better understanding of roles and where support is needed. There has been joint planning of training ideas and topics and used health safeguarding leads expertise in the development of the revised threshold document.

The SSP Independent Chair continues to chair the CDOP and learning from deaths is disseminated across the partnership through the CDOP action plan.

Items of systemic learning are brought to the LIG by the Designated Nurses.

Caroline Holt, Designated Nurse Safeguarding Children

- Child G – an exploration of the learning from a non-accidental injury case. Approximately 150 professionals attended.
- Two Sisters – exploration of the learning of a case following the abuse and neglect of two sisters. Approximately 80 professionals attended.
- Child Q – an event with Police and school DSLs to look at the findings from the national case and review practice and any implications and learning for Suffolk. Twenty education professionals attended.
- Neglect – A webinar led by the three key partners (Health, Police and Social Care) to explore how neglect is addressed within each agency. Over 100 professionals attended.
- Professional Curiosity – three repeat sessions delivered in partnership with the University of Suffolk. A total of 60 professionals attended across the three sessions.
- A Day in the Life of Astra – delivered by young people from Volunteering Matters and explored the issues of exploitation, online safety and safeguarding in the life and story of a young person from the young person's perspective. A total of 82 professionals attended.
- Safeguarding Children and Young People Online – learning from the voices and experiences of children and young people. This was delivered by Dr Peter Buzzi. A total of 68 professionals attended.
- May Miller: Sharing and escalating risk – a webinar sharing learning from May Miller's Safeguarding Adults Review and highlighting ways to take forward the recommendations / best practice advice.
- Hidden harm during COVID – Podcast episode with Anthony Douglas, highlighting the key findings from the Appreciative Inquiry into safeguarding during COVID.
- PowerPoint learning packs for statutory safeguarding leads – slides containing case review summaries and key agency learning provided to statutory partners to disseminate within their organisations for Joe Pooley, May Miller, and Abbey.
- Publication of 7-minute briefings for the Hospital Discharge Process, and the Role of A&E

2021/22 showed the power of events which can change people's thinking. This was true of all sectors and the reporting year ended with a far-reaching conference staged by Community Action Suffolk.

"This has been a year of developing and building upon partnerships with increasing opportunities for the Voluntary Community and Social Enterprise Sector (VCSE) and Statutory Partners working together to raise the profile, understanding and reporting processes for safeguarding in Suffolk. Community Action Suffolk (CAS) co-led a national safeguarding campaign #AreTheySafe last year. A major achievement was the delivery of the national rural safeguarding conference: Hidden in Plain Sight in March 2022. CAS developed and delivered the conference in partnership with Suffolk Safeguarding Partnership, the Police and Crime Commissioner for Suffolk, the Home Office, the Department of Health and Social Care, Rural Coffee Caravan and NWG among others. Feedback from delegates included:

'This has to be one of the best online conferences I have attended - all presenters brought something to the table.'

'Very dynamic and engaging conference, a landmark in raising awareness and skills.'

'A wake-up call to look after our community neighbourhood.'

'Phew! I'm not sure how that could be bettered. Simply brilliant event in every way. Well done all.'

Jacqui Wilkinson, Community Action Suffolk

Supporting Safeguarding Agencies

Police

We supported the police in many of their programmes which were aimed at improving the level of response and service to people at risk. We took up with them the problems they were facing both with adolescents with challenging behaviour and adults in distress who needed specialist help due to a vulnerability rather than them being arrested. The police strengthened their own capacity with developments such as appointing their own mental health co-ordinator. The police consulted with safeguarding partners on every case which is not always the case with local police forces. The exceptionally high level of joint working during the pandemic was noteworthy given how everyone was so stretched.

We also supported the police's wish to implement the Herbert protocol in Suffolk. This protocol aims to convey essential information about a vulnerable missing adult to everyone with a need to know without delay. Whilst it was launched a few years ago, it has never been used reliably so we will be joining with the police in a campaign to ensure the protocol is adopted this time round.

Going forward, it is likely the Partnership will need to increase its campaigning activity jointly with the police, putting an emphasis on straplines like 'see it, say it, report it'.

Health

The single most important piece of joint working this year was in relation to the hospital discharge process. Tensions between agencies about how, when, and where to discharge patients safely has been a bone of inter-agency contention since the issue of 'delayed discharges' was raised at the national level in the 1980's. The 'discharge to assess' model meant that too many assumptions were made about assessments taking place at home in a seamless transition. The public and private furore about discharges of patients with Covid into care homes in the first lockdown marked a low point in joint working. Since then, the hospital discharge process and procedures have changed in hospitals and there is now far more rigour about the multi-disciplinary input into the transition between hospital and the community.

"The pandemic has led to some dynamic ways of working, however the complexities of some of the needs of our children and young people have led to challenges across the multi-agency platform which has to improve to support these young people in crisis."

"The gaps in suitable placements for CYP with emotional and mental health issues continue to be a challenge and over the next year health and partner agencies need to collaborate in new ways of working."

Norfolk and Waveney Designated Safeguarding Looked After Children Team

Joint working on suicide prevention and on the emotional and mental health levels in the community were also a great area of focus with the Partnership inputting into the major programme to reduce the waiting list for the Emotional Well-being hub. Considerable time and effort was expended on improving the situation for people with a mental health problem and their families, particularly through liaison meetings with the local Mental Health Trust. This did have the effect of producing better responses to a number of crises, yet it has not improved the underlying concerns about the quality and quantity of provision. Plans for the future set out by the CCG did not - in the opinion of the independent Chair – materialise into improvements for people at risk on the ground.

The stronger integration of the work of CDOP into the wider Partnership meant that the action plans from each death were absorbed into the cumulative action log held by the Partnership for all relevant recommendations. This helped with the delivery of actions and with the avoidance of duplication where two wings of the Partnership were taking forward the same issue, ignorant of each other's work.

Schools

As reported last year, the Partnership successfully bid for £40,000 to make progress with the national objective of reducing permanent exclusions from schools because of the adverse consequences for young people. Quarterly returns were submitted to D of E throughout the year. A key objective was to make the funded changes sustainable.

Prior to starting, a decision was made to add the 40K resource into existing work to prevent exclusions rather than to begin a separate project in isolation.

31 schools – out of over 300 - signed up to pilot the Inclusion Quality Mark. Some pursued this as a whole school policy and worked intensively with Suffolk County Council. A small number of these were targeted because of high numbers of exclusions but this was not a comprehensive targeting. One of the main objectives of the project, to develop a mandatory multi-agency pre-exclusion conference, is still not in place, though something of that nature is planned. Despite this, some excellent work has been undertaken with individual children, young people and with some schools. Some individual schools and Academy Trusts have programmes in place to help their staff understand the meaning of a child's behaviour, rather than saying 'I'm not going to put up with it' or 'I'm not going to teach them'. Having said this, the Independent Chair is worried that the numbers of permanent and fixed-term exclusions are rising very significantly year-on-year.

Since September 2021 we have brought the safeguarding records for all of the individual specialist services into one place, under the My Concern platform. All staff are able to log concerns and we have a small, trained team of designated safeguarding leads who support staff with the concerns raised. This has enabled swifter and safer follow-up and connectivity where more than one service may have a concern about individuals. We have also developed a section where unsafe practice in schools can be appropriately followed up, such as not checking badges, or unchallenged access to buildings.

We have been supported by the partnership to bring into Suffolk schools the Inclusion Quality Mark, which is a framework for ensuring inclusive practice across a school setting. 31 schools are currently participating, and this seeks to ensure that more children are able to participate in the life of the school and create better partnerships and inclusivity between the school, its children, families, and the community.

We are working on the development of the response to permanent exclusions, by working closer with the whole school inclusion team to promote inclusive practice prior to exclusion. We have managed to enable several alternatives to permanent exclusion, thereby improving the life chances of individual children.
By being involved in more muti-disciplinary forums and panels we are increasing children's access to timely early intervention. We now participate in the NDD panel, the DSR register discussions and the Tier 4 bed meetings to enable better co-ordination with our most vulnerable children.
We are still embedding a graduated response to early support for children in settings, with pre-booked no name consultations so that education professionals can engage with specialist teachers for advice and guidance early when a child is struggling, enabling them to stay included in school life.

Commentary by Maria Hough, Independent Chair at the end of the Partnership's DfE-funded programme 'Engaging schools to reduce exclusions'

School Exclusions

Primary (Perm/Fixed)	Secondary (Perm/Fixed)	As % Population (Perm/Fixed)
•2020/21 - 5/482 •2021/22 - 19/999	•2020/21 - 44/1646 •2021/22 - 54/4,009	•2020/21 - 0.05%/2.3% •2021/22 - 0.07%/5.3%

Pupils Electively being Home Educated

Primary (Total/No with EHCPs)	Secondary (Total/No with EHCPs)	As % Population
•2020/21 - 528/27 •2021/22 - 465/27	•2020/21 - 751/57 •2021/22 - 858/69	•2020/21 - 1.23% •2021/22 - 1.36%

Note: The above data on Exclusions and EHE is for the financial year not the academic year.

Suffolk County Council: Childrens and Young People Services (CYPS) and Adult Care Services (ACS)

We have worked with CYPS on a number of projects. The Partnership supported the development of the new learning conversations work with the Signs of Safety Team, Health and CYP staff. The initiative offers agencies a space to review cases collaboratively facilitated by the Signs of Safety Learning Team.

We have also worked with the Missing Children Co-ordinator and Volunteering Matters to support Independent Return Interviews undertaken by young people who are already working with Volunteering Matters. This has offered learning, challenge, and new perspectives to the Return Home process using a secure base methodology.

The Partnership led on the review of the children's threshold matrix, ensuring consultation and collaboration with all agencies. This is now on the SSP website and has also been produced in hard copy format, available to any professional.

We have worked with the Head of Safeguarding and MASH to support agencies to resolve concerns regarding how referrals were being dealt with.

The children's Professional Adviser has supported the CYPS Quality Assurance Team with auditing in a number of thematic audits such as the Connect audit with NSFT, the Strategy Discussion/S47 audit, Personal Education Plan (PEP) audits and the audit of plans in Early Help. The Professional Adviser also attends the Child in Need and CP Steering Groups to pick up any issues or concerns that the Partnership should be aware of.

Much has been done to improve the breadth and quality of the data Suffolk County Council provides both in context and meaning to analysis and scrutiny. In turn this has enabled us to focus on customer outcomes as well as the quality of work undertaken.

The past year has been challenging and has presented all care services with unique circumstances and dilemmas. Staff across the Suffolk Social Work Teams should be proud of their achievements in meeting these demands and maintaining a high standard of professionalism during challenging times

Partnership working is a vital part of safeguarding adults. I am especially proud of our Adults MASH Team who work hard to ensure we achieve shared outcomes and objectives in a mutually supportive process

The partnership has worked closely together to ensure a consistency of approach and that decisions made consider the different positions of stakeholders. This has been evident in the hard work of the Central Safeguarding Team who not only respond to organisational abuse concerns, but work with the providers concerned to prevent further harm taking place.

Paula Youell, Head of Safeguarding Adults
Suffolk County Council

The adults Professional Advisor has provided dissemination of case review learning and resources to Safeguarding Champions both within ACS, as well as to the newly identified Champions, one from each care home.

The Partnership co-ordinated a review and update of the Safeguarding Adults Framework, mainly consisting of amendments from the Adults MASH and Central Safeguarding Team, and further production of hard copy formats available to all professionals.

Continued support from the Partnership to development of the Signs of Safety work programme and the emerging trauma informed practice model.

Development of Internal Reviewers within ACS, upskilling, and knowledge sharing.

Support to Workforce Development (WFD) on a review of available safeguarding training on offer for professionals supporting all ages, and a refresh of the Competence Does Matter multi-agency document prepared by WFD.

Policy Developments

A greater emphasis on co-production

Whilst our Partnership is a co-production in law between the 3 main statutory safeguarding partners – the two CCGs, Suffolk County Council, and Suffolk Constabulary – we have taken steps to extend involvement in our partnership to a host of organisations with a safeguarding role, including other councils, individual schools, care homes, as well as charities and village halls. There should be 'no wrong door' for safeguarding or personal distress so every door needs to have a safeguarding sign on it – and a bell which is answered.

We collaborated throughout the year with Healthwatch Suffolk who have funded a major development programme called 'Commit to Co-production': https://healthwatchsuffolk.co.uk/co-production/committocopro/

The Partnership will be a signatory to Healthwatch's 'Commit to Co-production' programme which will enable us co-produce much of our work with those affected and identify what this means in individual situations or cases.

> *"The Healthwatch Suffolk Co-production Team have been encouraged by the SSP's desire to start the co-production journey, as it will bring fresh perspectives about how to work together with families in equal partnership in order to help shape services and experiences for the future. Our Co-production Ambassadors have enjoyed supporting the teams to produce a first ever 'Openness Statement' to provide more clarity on the transparency of safeguarding processes".*
>
> **Andy Yacob, CEO, Healthwatch**

We made a start by introducing a presumption of a child, adult, or a family's involvement in case reviews. The presumption in reviews is often to involve a family by exception, especially in agency internal reviews. Family members always have significant information and opinions to consider and include. This does need handling sensitively, not just because of the powerful emotion's family members feel, but because of the importance of objectivity in determining what happened in a particular situation and why. The reviewer must ensure that defensive contributions, either by professionals or by family members, are steered towards learning points. Generally, we place accountability within a learning framework. Whilst it is important in a review to establish whether abuse or neglect was intentional or not, it is preferable to place the emphasis on prevention of a re-occurrence and on the learning needed to bring this about.

In recognition of the difficulty some children, adults and family members face in participating, we decided to appoint a specialist liaison officer for every review, to support family members and guide them through the process. This is usually a member of the core Partnership team, the lead Reviewer, or a professional who knows the family already.

We have started to extend co-production into other issues the Partnership deals with, such as the suicide prevention action plan and into our programme of webinars and podcasts so that people on the ground or 'at the coalface' are always presenters and contributors in some form. Another area for development may be to revise assessment procedures to allow more self-assessment, especially for people waiting for a service, so that more professional time can be spent on providing a service than belatedly assessing for it.

For us, co-production means asking this question routinely when any activity, review or event is planned – ***what form should co-production take this time***?

Working with Healthwatch, we produced a policy statement about openness and transparency – see below.

https://www.suffolksp.org.uk/assets/About-Us/Communications/SSP-Openness-Statement-Nov-2021.pdf

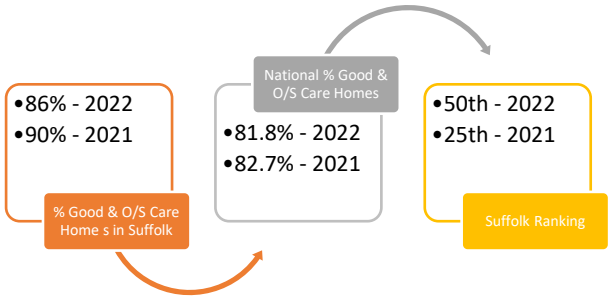
Trauma-informed practice

The Partnership has been working with Suffolk County Council (SCC) and Public Health to support the Trauma Informed Practice model that has been developed by the Signs of Safety Team in SCC. The Partnership will work with SCC, Public Health and the Health and Wellbeing Board to ensure that the model that is rolled out and communicated in Suffolk is a system-wide trauma informed one.

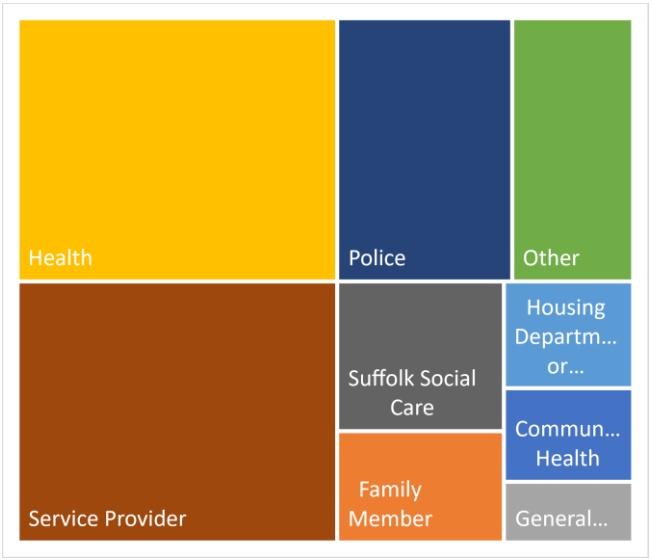
Headline Data

Headline Data in Adult Safeguarding

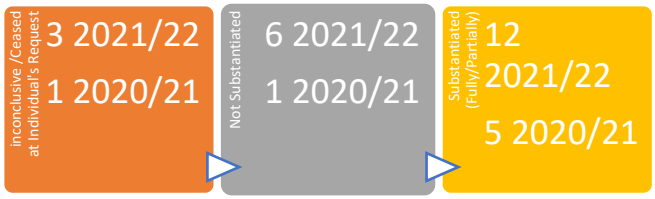
Care Home Ranking



Referral Rate by Abuse Type

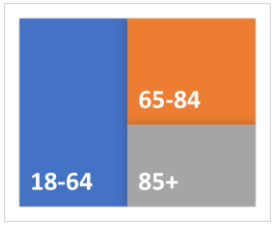


Organisational Abuse Concerns

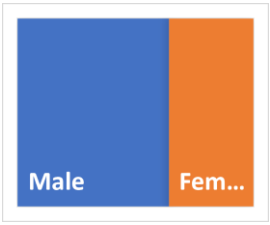


Safeguarding Referrals by

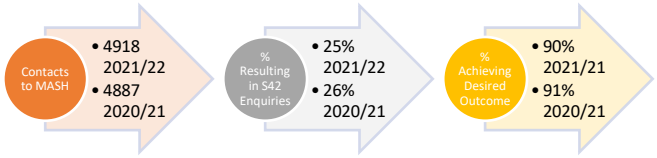
Age



Gender

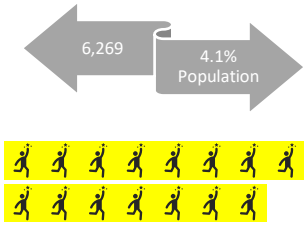


MASH Safeguarding Referrals

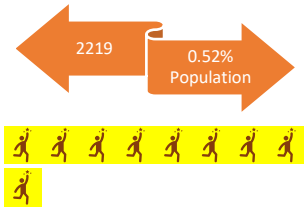


Partnership Wide Abuse Reports Vs Population Demographics*

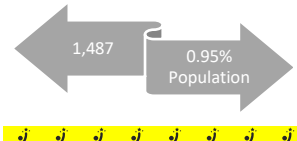
Under 18s



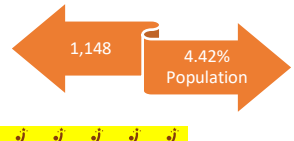
19 – 65



65 – 84



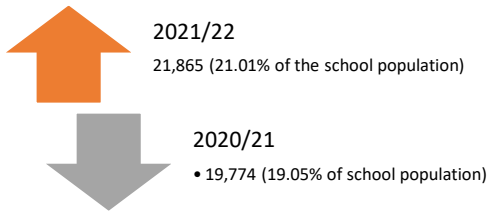
85+



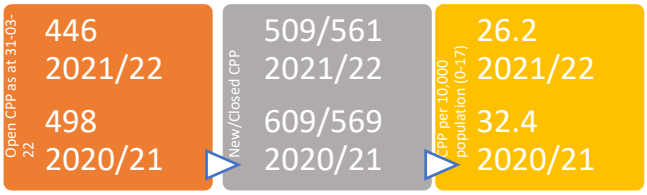
**Percentages represent proportion of the total Suffolk population, not proportion of individual demographics.*

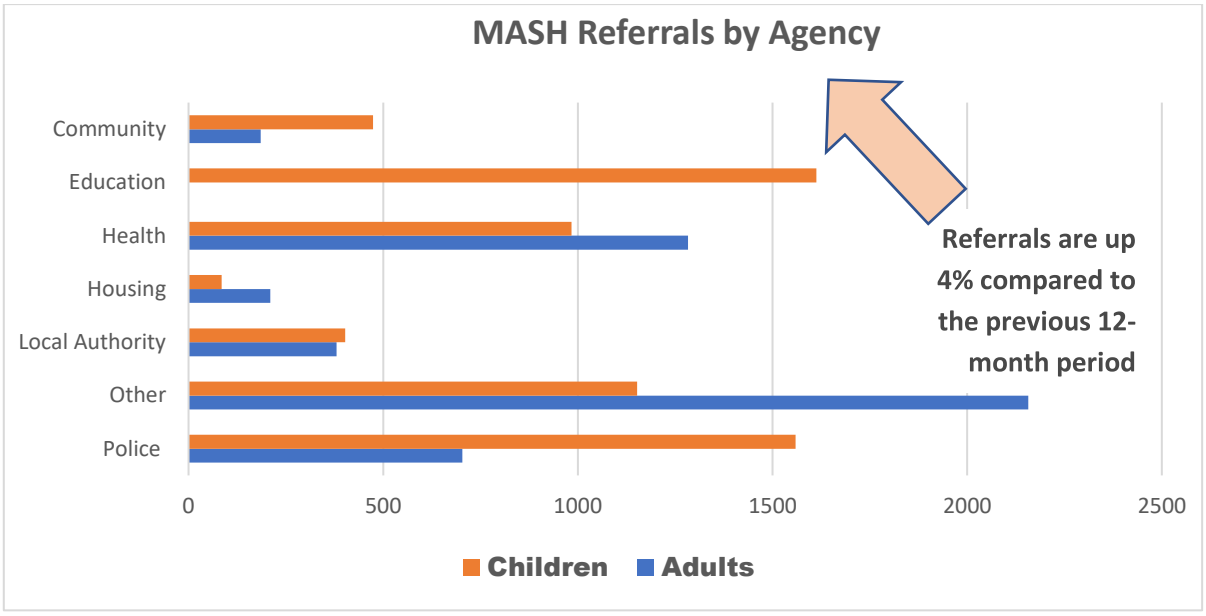
Headline Data in Children's Safeguarding

Children Accessing Free School Meals



Children on Child Protection Plans (CPP)





Adults Summary

- The total number of MASH referrals across both children & adults services increased by 4%.
- However, the number of referrals received by the Adult MASH service has remained stable between reporting years with no significant rise or fall in the numbers reported.
- Although there has not been a significant change in the number of adult referrals received during 2021/22, when we look at demography by age there has been a 9% rise in referrals within the age group 85+
- For the second year running, Suffolk County Council remains above the national average in relation to care homes with a CQC rating of good or outstanding.
- Suffolk CC has seen a rise in the number of organisational abuse concerns reported. This figure rose from 7 reported during 2020/21 to 21 during 2021/22
- The percentage of cases where it was reported that individuals achieved their desired outcomes fell by 1% between years.

Children's Summary

- CYP Referrals to Social Care increased by 6% compared to 2020-21.
- 48.5% of CYP referrals received in 2021-22 were from police or schools, 24.8% & 23.7% respectively.
- The percentage of children accessing Free School Meals has increased from 19% of the school population as of 31st March 2021 to 21% as of 31st March 2022.
- The percentage of the school-aged being educated at home (EHE) has remained relatively stable.
- There has been an Increase in the percentage of fixed term exclusions in 2021-22 – it has increased by 3% compared to the previous year.
- The number of children subject to a CPP as of 31st March decreased by 52 children (10%)

Overarching Summary

The data shows that whilst it feels as if there is substantially more pressure for front-line staff, the safeguarding casework element has only increased by relatively small percentages. In the Partnership last year, we reviewed a number of cases where teenagers took their own life which along with the generally accepted deterioration in children's mental health during the pandemic, made it seem as if suicides were increasing. However, the data does not show that so there is more to be done to understand the apparent increases in complexity of cases and tiredness of staff which may explain why safeguarding work feels so much more pressured.

Holding To Account, Scrutiny and Challenge

Waits and waiting lists

As the year progressed, we became concerned about increases in waiting lists and wait times across a number of services on whom people at risk depend. The worsening external situation, including the rise in fuel poverty, added to our concerns, which were two-fold. Firstly, we were worried that people on various waiting lists might experience a cumulative impact which would be hidden because the impact of multiple intersecting waits is not assessed. Secondly, we were worried that many triage processes were superficial and tended to exclude or de-classify need as a way of managing the waiting list down. At the time of writing, we are considering whether there might be a positive role for the Partnership in supporting organisations to manage their waiting lists with more emphasis on safeguarding issues individuals might be facing.

Pressure care management

A number of case reviews highlighted the need for improved pressure care management. Some individuals died because their carers, either at home or in residential care, left their wounds unattended to the point where they developed sepsis and died. Reviews found that the impact of pressure care problems was not well-understood, particularly the risks of rapid deterioration. This was the second year running we have carried out reviews reaching the same finding. As a result, senior health leaders in the CCG's are undertaking improvement work over the next year to address the findings from individual reviews and the issue as a whole.

The proposed Sizewell C development

We highlighted to EDF and the planning inspectorate our concerns about the potential impact of the development on vulnerable children and young people. This included the risks of child and adult exploitation, including pop-up brothels and substance misuse and the extra time that carers will need to take between their visits in that part of East Suffolk. We were satisfied those local agencies including the police were aware of the risks and that they were ready to put remedial strategies in place if and when the time comes.

Additional areas to explore next year:

A. Is the threshold used by the MASH set at too high a level of need, leaving many children and adults not assessed for care and support?
B. Could NSFT set up a consultation line for people with a mental health problem and their carers to be able to talk with someone who understands what they are going through?
C. The unlawful detention by the police of vulnerable adults – and occasionally children – has increased because of placement shortages. Clearer standards about detention need to be considered in all settings. A linked issue is the use of physical restraint behind closed doors.
D. We identified a need for a multi-disciplinary meeting for more people on the edge of care or in a full-blown crisis.

The 2021/22 and 2022/23 Budgets

The proposed budgetary framework and financial allocation for 2022-23 was approved by the Partnership's Executive which always has to be the case for a multi-agency budget with an equal multi-agency statutory responsibility.

Budgeting for the Suffolk Safeguarding Partnership is managed using Suffolk County Council's corporate finance software, Oracle Fusion. The multi-agency nature of the budget means any underspend is transferred into the Partnership's operating reserve rather than absorbed back to the County Council's central budget. The reserve stood at circa 100K at the end of the 2021/22 financial year, which is a prudent figure in accountancy terms because it equates to 3 to 4 months expenditure which is necessary in the event of a collapse in financial income and operating viability. This is a theoretical risk only given the partners all hold multi-million-pound budgets which would need to be used in the event of a crisis in the Partnership.

The long-established principles of a partnership budget are that it is jointly set and jointly constructed to reflect the priorities of each statutory partner as far as their multi-agency responsibilities are concerned. These responsibilities are ever-increasing as more duties about working effectively together are set out in law or regulation by successive Governments. For example, how domestic abuse and vulnerability is responded to has quite rightly risen up each agency's priority list and agenda.

Partners intend to move towards a more impact and outcome-focused budgetary framework in time for the 2023/24 budget discussions and allocation. Several developments will inform this, such as the outcome of various inspections due in 2022 and the start of the new Integrated Care System in the local NHS. One intention is to strengthen inter-agency management oversight in line with the findings of the National Child Safeguarding Panel's recent review into the deaths of Star Hobson in Bradford and Arthur Labinjo-Hughes in Solihull. The review, which the Government has accepted, emphasised the importance of local multi-agency child protection units. The same compelling argument applies to adult protection in Suffolk. Our proposed expanded oversight would not go as far as specialist teams, but it would strengthen senior leadership teamwork across agencies.

As part of this work on the 2023/24 budgetary framework, the current spend on Signs of Safety will be reviewed both for value for money and for its effectiveness. Additionally, a stocktake of spend on reviewing will be carried out in the light of the recent dramatic rise in requests for reviews. Carrying out case reviews is a central requirement in law for Safeguarding Partnerships. However, there is flexibility about how this is done and a stronger emphasis now on applying the learning from reviews and making sure it is embedded – and that it continues to be embedded. Increasing spend on this activity is likely to be a high value high impact decision.

The spreadsheet below shows that the spending requirement for 2022/23 is 11% lower than in 2021/22. This mostly reflects not continuing with some areas of one-off spend and being aware of a greater need for strategic budget-setting rather than either rolling items forward or agreeing some requests for additional spend without sufficiently rigorous business cases. We have in mind the need for us to show initiative in re-setting the system, not just to address the increased pressures within it.

	21/22 Commited	22/23 Proposed
Income		
East Suffolk District Council	£12,000.00	£ 18,021.09
Ipswich Borough Council	£ 6,000.00	£ 9,890.61
Mid Suffolk & Babergh District Council	£ 12,000.00	£ 14,154.07
Norfolk & Suffolk CRC/Probation	£ 4,600.00	£ 4,000.00
Suffolk CCGs	£ 117,800.00	£ 117,800.00
Suffolk Constabulary	£ 117,800.00	£ 117,800.00
Suffolk County Council	£ 117,800.00	£ 117,800.00
West Suffolk Council	£ 12,000.00	£ 12,934.23
approved draw on Reserves	*£ 66,000.00*	
Subtotal	£ 466,000.00	£ 412,400.00
Expenditure		
Staffing		
Staffing Costs for SSP	£ 315,902.00	£ 255,678.00
Travel & Subsistence	£ 5,000.00	£ 2,500.00
Training	£ 10,000.00	£ 12,500.00
Subtotal	£ 330,902.00	£ 270,678.15
Governance		
Activities to deliver board Priorities	£ 10,000.00	£ 15,000.00
Independent Chair	£ 61,040.00	£ 61,040.00
Service User/Lay Representation	£ 3,200.00	£ 3,200.00
Software Licences	£ 8,000.00	£ 3,500.00
Subtotal	£ 82,240.00	£ 82,740.00
Comms & Engagement		
Advertising	£ 2,000.00	£ 2,000.00
Engagement Materials	£ 5,000.00	£ -
Practitoner Conferences & Events	£ 15,000.00	£ 15,000.00
Suffolk Show		£ 10,000.00
Website (Maintenance)	£ 1,760.00	£ 2,000.00
Website (Redesign)		
Subtotal	£ 23,760.00	£ 29,000.00
Case Reviews		
Independent Reviewers	£ 25,000.00	£ 25,000.00
Learning Materials	£ 4,000.00	£ 5,000.00
Subtotal	£ 29,000.00	£ 30,000.00
Total Budget Required	**£ 465,902.00**	**£ 412,418.15**
Net Draw on Reserves	**-£ 98.00**	**£ 18.15**

Delivery on Last Year's Priorities

2021-22 Priorities & Aspirations

Supporting Recovery

Extending Sings of Safety

Information Transparency

Practice Learning

Supporting Recovery

- System Leadership across the 'Suffolk System' supports 'outstanding' Partnership Working
- Non-statutory services e.g. working groups have the capacity to resume
- A communications plan has a variety of ways Partners are engaged at least bi-monthly
- Crossover with complementary Partnerships e.g. Community Safety will have been explored to reduce duplication and improve information sharing
- Best practice will routinely be sought nationally and adapted for Suffolk

Extending Signs of Safety

- Suffolk will have an emerging omni-competent front line and greater partnership working
- The number of permanent school exclusions will be in decline
- We will have worked with housing providers to develop a model safeguarding system for them
- There will be support for young people to facilitate 'Return Home Interviews'

Information Transparency

- There will be a dynamic Policy & Procedures section on the Partnership's website
- A Transparency Standard will have been agreed and routinely used
- Greater links will have been established with active service user groups e.g. the University of Suffolk
- There will be better promotion about safeguarding to the people of Suffolk

Practice Learning

- Practice review methodologies will be aligned across adult and children's services
- The Reviews in Rapid Time Methodology will have been adapted and embedded into our portfolio of review options
- Internal reviewers will be fully supported to undertake practice reviews
- The voice of the adult or child will routinely be brought into reviews
- Professional Advisors will have the capacity to undertake horizon scanning of national learning
- There will have been an evaluation into the effectivness of learning from Reviews building on the 2019 case review learning report

What else did we achieve?

- We continued working at full capacity throughout the pandemic and also supported two apprentices which required significant additional capacity at times
- We delivered three of the four priority areas we committed to – supporting partners in their safeguarding role and function: improving information transparency within the Partnership; and developing our reviewing methodologies
- We did 'bring the voice of the child or adult' more into case reviews and wrote into Terms of Reference for reviews the need to draw out the individual in questions lived experiences. We began to take this further by year end, by thinking about the use of commissioned advocates to write non-instructed advocacy reports on the people who are the subject of SARs. This is said to have 'brought the person into the room'. Additionally, the advocates were able to challenge participants to think about the impact of their decisions upon the person who was the subject of the SAR.
- Our Professional Advisers began to scan reviews taking place in other areas so we could draw on their learning and avoid duplication if a particular scenario had already been covered extensively elsewhere in the country.

Areas we did not take forward or did not take far enough

- Extending Signs of Safety across the public sector – the focus during the pandemic on day-to-day service delivery meant few agencies had the time and capacity to undertake development work. This programme will require a significant resource commitment. We intend to re-visit the proposal if and when the situation eases. However, the commitment to multi-agency working by all agencies continues to be strong and unwavering so there is much to build on – see below.

What went well:

- *Our continued expansion of No Cold Calling Zones (15 in 2021/22) despite the pandemic challenges.*
- *Fraud/scams awareness – we have seen an increase in numbers of our Scam Champions, Scam Marshalls, and TS Consumer Champions– all promoting resident awareness and resilience to financial exploitation/abuse.*
- *Continuing to support Suffolk residents and professionals with online scams/fraud awareness training events via Teams/Zoom and phone calls to consumers who have been victims of fraud/scams.*
- *Maintaining support to businesses by having meetings online, conducting remote inspections and signposting business owners to sources of funding.*
- *Increased communications with other SCC departments and external partners – those relationships are continuing as we come through the pandemic.*

What we could do better:

- *We are increasing our partnership working capabilities with Suffolk Police and other partners in developing the Multi-Agency Approach to Fraud (MAAF). It is currently in the early stages.*
- *As always, with more resources we can do more for Suffolk residents.*
- *Improving our IT networks and ensuring we keep up to date with new technological developments, like we have done with the use of Teams.*

Lesley Crompton, Lead for Safeguarding & Scams
Trading Standards

Our Priorities for 2022/23

Supporting Increased Partnership Working

Developing a Partneship wide Trauma informed Approach to Practice

Responding to the mental health 'crisis'

Focusing on Preventative Interventions

Partnership Working

- Integration of current safeguarding provision into the ICS structure
- Multi-agency training needs stocktake and gap analysis
- Revising model for embedding the learning from case reviews
- Further development of the co-production model and practice

Trauma, Transitions & Leaving Care

- Support the dissemination of the Trauma Informed Practice model once agreed
- Work with SCOLT to inform the Suffolk Housing Strategy
- Improve multi-agency co-ordination of the key transitions for people at risk

Mental Health

- Support the rollout of the Liberty Protection Safeguards policy and training
- Increase awareness of emotional health challenges without catastrophising
- Support the development of a strong mental health service for Suffolk

Prevention

- Poverty in the context of the cost of living crisis
- Focus on the impact of coercive control on children and adults
- Work through Public Health on suicide prevention strategy and practice
- Exploitation & County Lines - audit the effectiveness of interventions jointly with the Community Safety Partnership
- Deepen further community and voluntary sector engagement
- Continued support for multi-agency engagement to prevent School Exclusions

Glossary

ACS	Adult Community Services within Suffolk County Council
CAMHS	Child and Adolescent Mental Health Services
CCG	NHS Clinical Commissioning Group
CDOP	Child Death Overview Panel
CPP	Child Protection Plan
CYP(S)	Children's Young People Services within Suffolk County Council
DfE DofE	Department for Education
EHCP	Education, Health, and Care Plan
EHE	Elective Home Education
ICS	Integrated Care System
MASH	Multi-Agency Safeguarding Hub – central point through which all safeguarding referrals are made
NSFT	Norfolk and Suffolk Foundation Trust
S11	Section 11
S47	Section 47
SAB	Safeguarding Adults Board
SAR	Safeguarding Adult Review
SCC	Suffolk County Council
SCOLT	Suffolk Chief Officer Leadership Team
SSP	Suffolk Safeguarding Partnership
WFD	Workforce Development

Suffolk
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