MERTON SAFEGUARDING CHILDREN PARTNERSHIP

Annual Report 2021-2022

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Foreword

This report covers the work of the Merton Safeguarding Children Partnership (MSCP) during the period April 2021 to March 2022, a year which saw continued pressures on safeguarding systems as a result of the Covid-19 pandemic. In this year, the tragic deaths of Arthur Labinjo-Hughes and Star Hobson shed a light nationally on the continued challenges in safeguarding children. The upsetting case of Child Q also highlighted the serious consequences for children and families when agencies do not take a safeguarding first approach or engage in robust, professional challenge.

During 2021-22 there were some significant changes locally for the MSCP. We were delighted to welcome on board our Young Scrutineer, Halima Mehmood, who has enabled us to start to scrutinise in depth how well we meet our ambitions to put children and young people's voices at the heart of what we do. Halima has worked closely with our Independent Scrutineer, Sarah Lawrence during the year to provide holistic and child-focused scrutiny on some key topics. The appointment of our interim Independent Person during 21-22 (Aileen Buckton), who also chairs the Adults Safeguarding Board, has helped us forge stronger connections with our Adults counterparts and progress our work around supporting a 'Think Family' approach and ensuring effective transition.

With the appointment of a new permanent team to support the Partnership from April 2021, the MSCP has been able to deliver significant progress against the priorities set out in the MSCP Business Plan. New data sets and dashboards were developed to help the Partnership monitor the impact of its work with families, supported by a multi-agency data lead.

The Partnership's Executive Board saw some changes with NHS representation, with Julie Hesketh Director of Quality, SWLCCG being replaced by Gloria Rowland, Chief Nurse, SWL CCG who is

represented by Justin Roper, Director of Quality. In addition the responsibilities of the SWL CCG transferred to SWL ICB (Integrated Care Board) on its establishment in July 2022. The ICB has responsibility for the development of the Integrated Care System (ICS), which will support improvements in health and wellbeing across SWL. Owain Richards, Superintendent, was also replaced on the Board by Detective Superintendent Andrew Wadey in July 2021.

In what has been another challenging year, safeguarding partners in Merton have worked together to continuously improve our safeguarding systems and strengthen the voice of the child in our Partnership. We welcomed the recognition from Ofsted in their inspection of the Local Authority's Children's Services that in Merton '*strong and respectful safeguarding partnerships act to protect children from harm'* and that locally excellent services are '*making a positive difference to enrich the daily lived experiences of children, while making them safer*[1]'. The inspection found that Children's Services in Merton are Outstanding.

We are proud of the work of all our partners who work tirelessly with families to keep them safe and promote their welfare and wellbeing. We also remain highly ambitious for our children and families and hope the year ahead will bring further opportunities to improve how children and families experience our services.

Justin Roper
Director of Quality, SWL ICB on behalf of Gloria Rowland

Andrew Wadey
Head of Safeguarding, Public Protection, Southwest BCU

Jane McSherry
Director of Children, Schools and Families, London Borough of Merton

[1] 50182669 (ofsted.gov.uk)

Introduction

The Children's Social Work Act 2017 and Working Together to Safeguard Children 2018 requires each Local Authority area to establish arrangements for safeguarding and promoting the welfare of children. The Merton Safeguarding Children Partnership fulfills this role for the London Borough of Merton. More detail on our local arrangements can be found in our Partnership Agreement.

Every 12 months the safeguarding partners must prepare and publish a report on what the safeguarding partners and relevant agencies for the local authority area have done as a result of the local safeguarding arrangements and outline how effective those arrangements have been in practice.

This report provides an overview of the impact of the MSCP's work on the safety and wellbeing of Merton's children and families, as well as an update against the Partnership's key priority areas outlined in the partnership's business plan. These priorities are:

- Strong Leadership and Strong Partnership
- Early Help and Neglect
- Domestic Abuse and Think Family
- Contextual Safeguarding

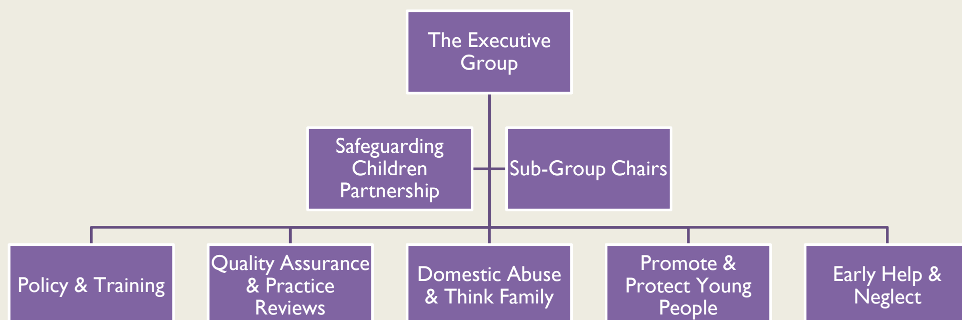
Under the first priority area, the report will also include how the Partnership learns from scrutiny, audits and learning reviews (local child safeguarding practice reviews) to embed a culture of continuous improvement in our local safeguarding arrangements.

Strong Leadership and Strong Partnership

Governance and Oversight

In May 2019, the MSCP formally adopted changes ushered in by the Social Work Act 2017. These are outlined in the MSCP's Partnership Agreement, which we refreshed in December 2021 following consultation with partners. Changes include an additional Full Partnership meeting, holding them termly to have more regular engagement with our wider partners (especially schools). Executive meetings would include the three statutory partners as core members and be held monthly to enable more agile decision making.

Business is prioritised and organised in the Biannual Business Plan and functions delivered through Sub-Groups which meet quarterly. Agency engagement with sub-group meetings has been strong overall, and strong multi-agency engagement in the delivery of statutory and non-statutory processes demonstrate continued commitment from partners. Sub-group chairs also meet monthly to ensure that the work of sub-groups is coordinated and effective and support with leading strategic updates to the Executive.



The Partnership also has three independent posts to support with our core duty to promote the welfare of children and monitor the strength of partnership working.

- An Independent Person, to act as chair
- An Independent Scrutineer, and
- A Young Scrutineer

Following the departure of the MSCP's Independent Person during 20-21, an interim Independent Person, Aileen Buckton was recruited. Aileen also chairs the Merton Safeguarding Adults Board and has provided challenge to our Partnership when chairing the Executive and the Full Partnership. She has also facilitated closer, more joined up working with the Merton Safeguarding Adults Board. This has enabled the MSCP to work more closely with the Merton Safeguarding Adults Board, for example in delivering a joint conference on Think Family and Transition. It has also supported closer working together in preparation for new requirements around the Mental Capacity Act and Deprivation of Liberty Safeguards.

Sarah Lawrence has been our Independent Scrutineer since February 2020, and during this year the MSCP prioritised appointing to the Young Scrutineer post. The MSCP was delighted to see this post filled by Halima Mehmood, a young Merton resident, who also worked as a Young Inspector for the London Borough of Merton.

Scrutiny Activity

The MSCP's Independent Scrutineer and Young Scrutineer work to a jointly owned workplan and report regularly to the Executive. The workplan uses best practice models for Independent Scrutiny including the 'Six Steps to Independent Scrutiny'.

At the MSCP's Full Partnership meeting in February 2022, our Young Scrutineer, Halima, presented the findings of the Merton Young Residents Survey, a survey of over 2,000 children and young people living and learning in Merton, with particular reference to

'Staying Safe'. She highlighted how young people still turn to informal support from family and friends in favour of professional support, and that many young people do not think they have a say in decision making.

"Young people want to feel safe locally, with a better relationship with the police"

"If there were more people to help… young people when getting sexually harassed because when it does happen it makes young people feel uncomfortable, scared, and panicked"

In follow-up to this session, Halima attended all of the MSCP's sub-groups to look at how we can better engage children and young people in the day-to-day work of the MSCP. It is hoped that we start to feel the impact of this work in 2022-23 as the Partnership's workplans are reviewed to reflect our Young Scrutineer's feedback.

During 21-22, the Scrutineers also undertook a thematic review on sexual harassment in schools, following concerns raised by the Everyone's Invited testimonials and the subsequent Ofsted report, which recommended safeguarding partnerships improve their working with schools and colleges. The review included interviews with headteachers and designated safeguarding leads in a variety of education settings, as well as wider partners (Children, Schools and Families, Community Safety and the Police). Importantly, they also spoke to young people living and learning in Merton to understand their lived experience of sexual harassment and how they experience the Partnership's response to the issue.

"School makes our feelings feel valid, e.g., they say 'banter' is not an excuse."

"We have to trust the people before we'd tell them or report SH. If we have a bad experience before it puts us off telling them something so personal."

Recommendations from the scrutiny work have been incorporated into the Partnership's ongoing workplans. Some examples of these are (this is not an exhaustive list):

- Refreshing Harmful Sexual Behaviour Policy with schools and college representatives, including special schools
- Develop and promote innovative ways that children can report sexual harassment and abuse
- Supporting all schools, including primary and early years, on this topic, and to share good practice

Other scrutiny activity undertaken by the scrutineers on behalf of the Partnership during 21-22, include:

- Scrutiny of the 20-21 MSCP Annual Report
- Scrutiny of the Section 11 audit submissions
- Engaging the Full Partnership and sub-groups on the voice of the child
- Feedback and challenge around nationally important issues such as Arthur Labinjo-Hughes, Star Hobson and Child Q

Reflections from Independent Scrutineer & Young Scrutineer

"We have worked together, with children, practitioners and with the MSCP during this year to assess how well the partners work together to protect children. We have carried out scrutiny work as this report describes which has enabled us to assess the level of success and impact that MSCP has had in doing this.

We have been very privileged to be able to speak directly to children in the Borough gaining their views about safeguarding and what they would like to see happen to support them to stay safe. We are also grateful to the practitioners and system leaders that have contributed to our work.

Our reflections fed by our work this year are, on the whole, very positive and while we have identified learning and improvements that can be made in some key areas, we feel confident that the MSCP is a mature and developed safeguarding partnership that can continue to respond to ever present challenges that face children and families at this time. We feel the feedback given by Ofsted reflects the strength of the MSCP accurately. They said:

"Partnership working is strong, both at strategic and operational levels…a culture of professional accountability, respectful challenge and mutual support [exists] across the partnership. Consequently, almost every child in Merton has access to good or outstanding support'.

The need for safeguarding services that respond to the needs of children and families is ever evolving and demand is growing. Learning from Merton and national safeguarding practice reviews of tragic cases this year have highlighted this starkly. It is evident to us that the high level of trust and cooperation between safeguarding partners in the borough will enable services to adapt in response.

Nevertheless, stubborn challenges on some key safeguarding topics remain for the partnership, some of which were reflected in feedback to MSCP from our scrutiny work. We feel confident that MSCP is able to act on such issues and has prioritised them in future planning for multi agency work. For example, children have clearly vocalised ways that partners can improve the level of trust they have in reporting abuse and harassment and we will continue to monitor and evaluate responses to these concerns through our scrutiny work in the coming year, while supporting MSCP with its priorities.

Sarah Lawrence
Independent Scrutineer MSCP

Halima Mehmood
Young Scrutineer MSCP

Learning Reviews and Audit

Learning Reviews

During 21/22, the partnership oversaw the publication of three local child safeguarding practice reviews (*Jason, Baby Grace*, and *Ananthi*). We also published our partnership review on Eddie and undertook a local learning review on Sudden Unexpected Death in Infancy (SUDI), following the death of two babies in SUDI circumstances. There were no serious incident notifications during 2021/22. All our learning review full reports and 7 minute learning briefings can be found on our website at the relevant webpages.

Child F / 'Jason' – LCSPR

The events surrounding '*Jason*' led the MSCP to commission a Local Child Safeguarding Practice Review (LCSPR). Jason had been missing for the first two weeks of April 2019, during which time he was involved in selling drugs (county lines) in a large town many miles from his home. On his return he presented as traumatised and disclosed that he had been assaulted and threatened that he would lose his life by those organising the drug-selling. He was highly anxious about his safety. The day after, Jason was taken to hospital after being stabbed in his leg and back.

The final report and a 7-minute learning briefing were published in June 2021and lunch and learn events held to share findings with the MSCP.

Baby Grace – LCSPR

Grace died in 2017, aged four weeks. Post-mortem forensic evidence showed that she had been shaken on three separate occasions and had 27 fractures. In November 2020, both her parents were found not guilty of murder, but both were convicted of causing, or allowing the death of a child. After the parents were charged with murder in Spring 2019 the MSCP agreed to commission a review to

learn lessons and to ascertain if any changes to local systems were required as a result.

The final report and a 7-minute learning briefing were published in August 2021 and lunch and learn event held to share findings with the MSCP.

Child H / 'Ananthi' – LCSPR

On 30 June 2020, emergency services were called to an address where a woman and 5-year-old child were found with serious injuries, stab wounds. They were both admitted to hospital. The child was in cardiac arrest when found and was pronounced dead at the scene, but the woman underwent surgery for her injuries. Ananthi was described by her father as '*a lovely child. She was very confident at cycling, and you were going to remove the stabilisers on her bike. She was good at school and liked learning spellings and doing well in spelling tests.*'

The final report and a 7-minute learning briefing were published in November 2021 and lunch and learn event held to share findings with the MSCP.

Child E / 'Eddie' – Partnership Review

In May 2019, a child, referred to in this review as 'Eddie', took an overdose of 9 Ibuprofen following an argument with a friend on the phone and following negative comments from his father. Following a Critical Incident Notification from the Youth Offending Team, this was escalated to the MSCP Quality Assurance Sub-Group and then to Statutory Partners to consider whether the incident met the criteria for a Local Child Safeguarding Practice Review under Working Together 2018. At an Extraordinary Meeting of the MSCP in June 2019, it was agreed that the case did not meet the criteria for a LSCPR but did warrant further investigation through a Partnership Review.

The final report and a 7-minute learning briefing were published in November 2021and lunch and learn events (jointly with the Jason review) were held to share learning with the MSCP.

SUDI Review

The MSCP received a recommendation from a Joint Agency Response (JAR) meeting to undertake a Partnership Review on two cases of Sudden Unexpected Death in Infancy (SUDI). Although neither of the SUDI cases met the criteria for a Serious Incident Notification, the JAR identified that there could be learning for multi-agency partners. The review took the form of two learning events, chaired by an independent lead reviewer using an appreciative inquiry approach.

The review found good practice of agencies providing information to families around risk factors for SUDI, including safe sleeping, addressing smoking and drinking alcohol, and monitoring birth weights. Following learning from Baby Grace, it was also positive to find that routine enquiries had been made for both babies. There was good information sharing and evidence of timely decision making.

The review identified some areas for improvement, which included strengthening the relationship between Children, Schools and Families and Merton Housing Services to ensure early, proactive support for families at risk of experiencing homelessness or overcrowding. The review also identified learning around how Early help services, midwifery, health visiting and the Children and Families Hub work together, the importance of undertaking agency checks and use of professional curiosity by agencies. Several recommendations were made and will be implemented by the MSCP.

The report was published in February 2022 and lunch and learn was held to share the findings of the report with the MSCP in March

2022, along with a Safer Sleep event to raise awareness in coordination with the Lullaby Trust.

What we did in response to the reviews

Sharing Learning

The MSCP took a range of actions in response to the reviews outlined above. In addition to final reports for each review, the chair and lead author for each review helped develop learning materials for dissemination across the partnership, which are published alongside the full reports on the MSCP website. We also launched 'Lunch and Learn' events to share the learning from our reviews and audits. These provided an opportunity for report writers and practitioners to explore the themes and recommendations from the reviews and embed the learning into their future work and practice. The MSCP also worked with agencies to embed learning from reviews into multi-agency and single agency training and events such as delivering presentations at the Early Help Summit and Children Schools and Families Practice Week.

The MSCP's Section 11 audit 2021/22 identified that disseminating and embedding learning from reviews was a particular strength for the Partnership, demonstrating the impact of this work.

Informing our Strategy and Practice

Learning from the practice reviews has directly impacted on the strategic work of the MSCP and its training programme.

- During 21-22, the MSCP continued to implement its contextual safeguarding strategy and action plan, as highlighted in the below contextual safeguarding section to respond to issues raised in the Jason and Eddie reviews.
- The practice reviews highlighted the importance of addressing trauma, and recommendations around trauma-informed approaches were made in both the Eddie and Jason reports. As a result, the CCG (now Integrated Care System ICB) funded CAMHS to deliver trauma-informed training to the MSCP to help embed trauma-informed approaches. Partners are also delivering trauma-informed practice across Merton. Asked what difference delegates thought the training would make to their work with children, young people and families, comments included:
    - *"Reinforce the importance in foster carers to be trauma informed; to better serve the needs of our children in care."*
    - *"I would feel confident with supporting families/teachers with the approach to managing trauma."*
    - *"Allows greater knowledge of how trauma has affected the person and its impact on younger sibling members."*
- To respond to concerns around disproportionality, the multi-agency Youth Crime Prevention Executive Board has focused on disproportionality as a priority, particularly in relation to young people open to the Youth Justice Service. Given learning around use of stop and search in Jason's story, a local stop and search pilot in Merton has been in place to identify where further interventions can be made to support young people who are stopped and searched. 66 young people were referred for further interventions to a range of partners offering support as a result.
- Following the 'stop and search' pilot and the national learning from Child Q, the BCU has adopted a policy whereby all children who are stopped and searched

receive a Merlin[2] which will then be followed up through appropriate pathways, e.g., MASH checks and Liaison and Diversion Panel. A Stop and Search workshop was also held to support better relationships between young people and the police, and to support better awareness raising of young people's rights. One young person said as a result of the workshop:

> *'I feel like I will definitely complain in the future now if the police treat me badly, I think I would have more understanding now.'*

- In response to Baby Grace, the MSCP has commissioned the ICON programme to ensure it can be embedded systemically across the Partnership. Further work on implementation will continue into 2022-23. Health partners have shared learning from the Baby Grace report widely, for example, at the GP leads safeguarding forum in March 2021 and delivering targeted training on issues arising from the review, for example, having difficult conversations and routine enquiry.
- The MSCP has commissioned Inner Strength Network (ISN)to speak to the Full Partnership about difficult conversations in the context of Baby Grace. ISN will also be delivering training sessions on this area during 2022-23. Although our Non-Accidental Injury (NAI) audit found good evidence of routine enquiry, our audit on the lived experience of Domestic Abuse undertaken in November 2021 found there is still some further work to do on these themes.
- With 'Think Family' being a feature of several of our learning reviews in children and adults practice (including the MSCP Ananthi and Eddie reviews), the Partnership focused on 'Think Family' as a priority at the Joint Conference with the Adults Board. The Domestic Abuse and Think Family sub-group will be following up further actions in 22-23. The MSCP are also planning some follow up scrutiny work on family networks to support with this further in 22-23.
- Several areas of learning from the local child safeguarding practice reviews were followed up with reassurances in our Section 11 audit for 21-22.

Learning from national reviews

During 2021-22 there was also considerable learning for safeguarding partnerships nationally, with the publication of the Child Protection in England report following the tragic deaths of Arthur Labinjo-Hughes and Star Hobson.

The Merton Safeguarding Children Partnership undertook reassurance with partners to ensure that the learning from these reviews were embedded. Responses were sought from across the Partnership and reported to the Executive. Several areas of improvement were already underway. For example, the MSCP are in the process of reviewing the local bruising policy to ensure it is up to date and includes risks to older children. Bruising was considered as a topic at the Full Partnership in February 2022, and some additional training and awareness raising sessions are being developed for 2022-23.

[2] The Merlin system was created as a vehicle for police officers to deal with vulnerability. This allowed the recording and sharing of concerns with partners in order to effectively safeguard members of the public. An MPS employee records their findings in a Merlin which is then processed according to the type of report written.

In March 2022, the sad case of Child Q in Hackney reminded us of the ongoing concerns around the adultification of Black children and the importance of professional challenge across partnerships. The MSCP published our statement on Child Q to help reassure professionals, children and families. As a Partnership we reviewed partners' processes and practice with reports to the Executive and the Full Partnership. Given the importance of this topic and the feedback locally that adultification of Black children can be less well understood among professionals especially outside of safeguarding roles, the MSCP has commissioned training from Listen Up to be delivered during 2022-23. We have also asked our Scrutineers to undertake thematic scrutiny on this topic during 2022-23.

Child Death Overview Panel (Summary of Caseload 2021-22)

The Merton Safeguarding Children Partnership works alongside the Child Death Overview Panel, which reviews all child deaths in Merton. A full report of activity of the Child Death Overview Panel can be found in the CDOP annual report.

A national consultation concluded that for CDOPs to be effective, reviews need to cover a sufficiently wide geographical area to produce meaningful data on the cause and demographics of child deaths. South West London (SWL) Child Death Review partners implemented this guidance and started regional operations in September 2019. The amalgamation of panels provides a larger cohort of information to enable better detection of themes, analysis of trends and learning to prevent future child deaths in line with national trends. Therefore the data provided is on a SWL level.

In 2021-22 there were 64 new notifications of child deaths for SWL, which is a reduction of 16 deaths from last year's 80 notifications of child deaths (2020-21). Nationally there were 3,068 notifications of child deaths for 2020-21 which is 361 fewer deaths than the previous year. One identified trend was a marked reduction over the winter months, which may have been due to social distancing and other public health measures put in place in response to the Covid-19 pandemic. This trend is also reflected in SWL.

In terms of the management of the CDOP process, as of 1 April 2022, there were 64 open cases, with 81 Child death reviews in 2021-22 being completed and closed. This is similar to the previous year of 78 completed child death reviews being closed and 61 open cases. Each case is kept open until all investigations are complete and then the case is reviewed by the CDOP Panel for closure. This means that some cases may remain open for an extended period of time until coroners inquests, serious incidents etc. have been completed.

Learning from audit

During 21-22, the MSCP launched a new audit programme to further embed its commitment to continuous improvement, and to ensure it meets expectations set out in Working Together 2018 to learn from multi-agency audits.

Section 11

The MSCP undertook a Section 11 audit during 21-22 (one of the recommendations/requirements of Working Together) to help organisations in Merton undertake their own quality assurance processes to safeguard and promote the welfare of children. 16 organisations submitted an online audit tool response and attended a peer review session with our Scrutineer and Young Scrutineer.

The Section 11 found that there were significant strengths in Merton with regards to safeguarding children and young people. This included clearly stated organisational safeguarding responsibilities, clear accountability frameworks, awareness of

information sharing procedures, and Safer Recruitment practice and LADO[3] processes.

The audit found less confidence from partners in embedding a culture of listening to children and taking into account their wishes and feelings. There were also other areas where agencies felt there could be further development, including: assurance in addressing issues of Equality and Diversity; practitioners' confidence in engaging with professional healthy challenge; and analysing and reporting the impact of training on practice and outcomes for children and young people.

During the Section 11 process, several multi-agency and single agency actions were identified, and these will be followed up in a further peer review meeting with the scrutineers in 22-23. More information can be found in our Section 11 learning summary.

Multi-agency audits

During 2021-22, the MSCP also developed a modest audit programme, with a rotating chair to share ownership across partners, and overseen by the QA sub-group. All audit briefings are published on our website to support dissemination of learning.

The first pilot audit was held in August 2021 on Non-Accidental Injury[4] and followed on from learning from the Baby Grace review and our Scrutineer's thematic scrutiny on NAI earlier in the year.

The pilot audit concluded that agencies had

- acted promptly to safeguard children
- worked collaboratively with the family
- provided an enhanced offer of support
- and that there was appropriate use of routine enquiry.

However, the audit identified some possible areas for improvement, including the need for senior managers to be available in the Out of Hours (OOH) service, which was followed up with this service.

The second audit on Domestic Abuse and the lived experience of young people was held in November 2021. The audit found several areas of good practice, including agencies acting promptly to make referrals, resulting in timely interventions to protect children. It also identified strong communication and information sharing between agencies, including with neighbouring boroughs. There was also evidence of additional needs being proactively identified and acted upon.

Learning for the Partnership included reviewing how robust interventions are in addressing domestic abuse and to ensure there is proactive engagement with parents. The audit also identified that there is more we can do as a Partnership to ensure the voice of the child is recorded. The recommendations from the audit are being overseen by the QA sub-group, and relevant actions have been added to the workplan for the Domestic Abuse and Think Family sub-group.

Due to the Children's ILACS inspection in March 2022, the third audit on contextual safeguarding has been rescheduled to July 2022.

[3] Local Authority Designated Officer (LADO) – for more information see the MSCP website: Managing allegations against adults who work with children (LADO) - Merton Safeguarding Children Partnership (mertonscp.org.uk)

[4] Non-Accidental Injury is **a term that is used to describe a number of different physical injuries or abuse to a child**. The term describes any injury that is said to have been inflicted. This means that it cannot simply be an injury that occurred unintentionally or unexpectedly.

Learning and Development

Training Programme 2021/22

The MSCP training programme continued to be overseen by the Policy and Training sub-group. Following a disruptive year in 2019-20, which impacted the delivery of training in that year.

With ongoing uncertainty around Covid advice to stay at home, the MSCP continued to deliver the majority of its training programme for 2021 virtually. The MSCP was able to deliver more events and attendance at events was considerably higher than the previous year. Feedback from partners indicated that the option to access training remotely enabled more partners to participate in the training.

The training programme is mostly delivered in house, by a range of partners across the MSCP. Courses and training themes are derived from sub-group work plans and recommendations (via Policy & Training Sub-Group), as well as from learning from case reviews. The training programme for 21/22 included training modules on our three thematic priorities, as well as a range of core safeguarding training. It included new courses to respond to emerging concerns, for example Understanding Eating Disorders course and targeted safeguarding training for local Madrassahs.

During 21/22, the MSCP also introduced 'Lunch and Learns' to share bitesize learning from emerging themes from our learning reviews, which have been successful in engaging higher numbers of delegates from a wider range of partners.

In 2021, the MSCP also delivered an Early Help Summit to formally launch the new Early Help Strategy and Effective Support Model, alongside the Effective Support for Families training (highlighted below in Early Help and Neglect).

The MSCP also delivered a joint conference with the Merton Safeguarding Adults Board on the themes of 'Think Family' and 'Transitional Safeguarding'. These themes were jointly agreed by representatives from the MSCP Policy and Training sub-group and the MSAB Learning and Development sub-group.

In addition, during 21-22, the MSCP also oversaw delivery of the Reducing Parental conflict e-learning training and are working with the provider to identify impact. This work will be further developed under the Domestic Abuse and Think Family sub-group during 22-23, with further training courses on reducing parental conflict to be delivered via a train-the-trainer approach.

Impact of our Training Programme

During the 2021/22 period, the MSCP offered 51 occurrences of 34 separate events. We offered a total of 1,399 training places; we had 1,032 bookings and 760 attended, an attendance rate of 74%. This brings the MSCP back in line with pre-pandemic training delivery (in 2019-20 there had been 77 occurrences, attended by 601 people).

The services with the highest number of attendees at MSCP training events during 2021/22 were London Borough of Merton Children Schools and Families (Education and Children's Social Services), Central London Community Healthcare Trust (CLCH), the Voluntary and Community and Faith group sector (VCS) and Education (schools, colleges and nurseries). The Policy and Training sub-group monitors attendance at training by agencies regularly and follows up with agencies where take up is lower.

Evaluation

The Policy and Training sub-group continues to use its Training Evaluation and Impact Analysis Framework, as endorsed by the London Safeguarding Board as good practice. Improving the rate of return for evaluation forms was a priority during 21-22. To date, 56

evaluation forms were returned via the Learning Management System. To help improve the return rate, completion of the evaluation form is now a mandatory requirement for receiving certification but work to encourage completion of evaluations will continue into 22-23. The MSCP ensures continuous improvement by providing summaries of evaluation feedback to trainers, so it can inform the development of the training programme.

Feedback from participants indicated that courses met their needs and participation was encouraged. Of the 56 evaluations returned through the Learning Management System, 98% of participants stated that trainers were well informed and encouraged participation. 95% agreed or strongly agreed that the training course met its aims and 87% agreed or strongly agreed that the course gave them a better understanding of the subject. The majority of participants strongly agreed that the course would help inform future practice. Below are some extracts from comments received.

> *"I work within sexual health and everything I learnt can be applied to my day-to-day role".* (Key Principles in Responding to Young People's lived experiences of Sexual Violence)
>
> *"I know of services Merton has to offer. I feel I can recommend and refer to services now. I feel more comfortable if I need to speak to a victim.* (Domestic Violence and Abuse)
>
> *"Greater knowledge and understanding of contextual factors that children and young people experience in their lives"* (Contextual Harm)
>
> *I highly recommend this course because it equips you with the knowledge on how to deal with certain situations. These situation are nerve wrecking at the start but you gain confidence once you learn the process and realise there is support.* (LADO)

The joint conference with the multi-agency safeguarding children partnership and adults board was attended by over 100 people. It provided an opportunity to share practice between children and adults' practitioners, particularly on Think Family and transitional safeguarding. Some of the feedback from delegates about how it would support their practice are as follows:

> *"By thinking about how MDT models around families really help and how the teenage brain develops in neurotypical as well as atypical young people. Another excellent course, thank you."* (Integrated Safeguarding: Working Together to Safeguard Adults and Children)
>
> *"Having a greater awareness of how my organisation can work with partners to enable effective adult safeguarding."* (Integrated Safeguarding: Working Together to Safeguard Adults and Children)
>
> *"I have a better understanding of The Think Family Model and how to work with young people acknowledging their brain development and the impact it has on their decision making."* – (Integrated Safeguarding: Working Together to Safeguard Adults and Children)

The themes, content and scope of the MSCP training programme, and the sub-group workplans, is developed with a close association to the multi-agency data and its analysis. It is also informed from multi-agency practice from audits and learning reviews. From the 2021-22 year, each of the sub-groups conduct performance monitoring as standing items on their agenda in a move to ensure that trends and themes identified are better developed, understood and responded to. Where training gaps are identified the Business Support Unit will work with the Policy and Training sub-group towards finding suitable training.

Improving Dissemination of Learning

During 21-22, the MSCP also reviewed and developed ways in which we can share learning with the wider Partnership. This included a review of the MSCP website to ensure content for professionals is up to date, accurate and reflects best practice. The MSCP also launched a new bi-monthly news bulletin to help share local, regional and national safeguarding news and best practice with partners. Partners have fed back that they find this helpful and use it to keep up to date with the MSCP's training offer and to understand learning from learning reviews and audits.

Early Help and Neglect

One of the MSCP's priorities for 2021-22 was Early Help and Neglect. A dedicated sub-group, comprising a range of partnership agencies progressed actions to improve our early help offer and response to neglect.

What have we achieved this year?

We launched our Early Help Strategy and Effective Support for Families Model guidance and documents in 20-21 and focused on embedding the approach with partners during 21-22. Our Early Help strategy was informed by stakeholder engagement and feedback from children, families and practitioners.

The new integrated 'Children and Families Hub' went live in October 2021, integrating the way in which the Council responds to children and family needs at targeted Early Help and statutory levels. To support the new arrangements the MSCP held an Early Help Summit in November 2021, chaired by our Independent Person. It was attended by over 70 delegates from across our partnership and provided partners, stakeholders and practitioners an opportunity to reflect on the strategy and early help priorities and how to embed these in practice.

We also used evidence and information from local and national data to develop our vision. As part of our Early Help strategy, we are focusing on three priority outcome areas:

1. Fewer children and families require support from specialist services (and reduction in number of children in need).
2. More babies/children meet the expected stage of development for their age
3. More children/young people attend school regularly and fewer are excluded

During 21-22, we developed our early help performance dashboard to ensure we are able to monitor our progress against our three priority outcome areas and the impact on children and families. Our Early Help Performance Dashboard reports to every Early Help and Neglect Sub-group, using predictive 'turning the curve' modelling.

Multi-agency partners also reviewed the MSCP's Neglect Strategy and toolkit, which supports partners to identify and recognize neglect of children and young people. It included engagement with practitioners specifically on adolescent neglect, as this is recognized as a less well understood area. The Partnership launched the new Neglect Strategy and Toolkit at the February 2022 Full Partnership. The Neglect Toolkit aims to support practitioners in the early identification and assessment of neglect and in recognizing the impact of the cumulative harm caused by neglectful experiences on children and young people.

What difference have we made?

With our focus on embedding our "Effective Support for Families in Merton" model and guidance we delivered a comprehensive training programme during 2021-22. We delivered 9 sessions to the Partnership, with over 100 attendees from a wide range of partners. Feedback from this training has been positive and encouraging, with the majority of attendees saying that the training was either very or extremely relevant to their role (80%) and would recommend the training to their colleagues (93%).

Participants told us how it had made a difference to their work with children and families:

"It has helped me think more deeply about the trauma and patterns families have and how this can impact the young people we work with"

"My team are now more aware of what support for families is in the borough."

"A family is now being given the right support due to myself and the school understanding the procedures and who to refer to"

"Having the training has helped me to empower families to access the extra support they may need."

In February and March 2022, Merton's Children's Services were inspected by Ofsted under the Inspecting Local Authority Children's Services (ILACS) framework. The findings evidenced the impact of the MSCP's early help strategy and effective support model.

"Children and their families benefit from responsive well-coordinated universal and targeted early help services, helping to reduce harm. A recently updated coherent multi-agency strategy underpins the delivery of these services. This supports a system-wide relationship-based professional practice approach that is aligned to the social work model. Skilled and specifically trained early help practitioners use a variety of tools to build relationships with children and help them to express their wishes and concerns."

<u>What will we do next?</u>

Priorities for the Early Help and Neglect sub-group in 22-23 will be:

- To continue to embed and promote the Effective Support for Families Model. We will also review the impact of the Early Help strategy and Neglect Toolkit, and refresh the strategy and guidance as required.
- Develop our multi-agency early help approach further, using resource secured through grant funding, e.g. Supporting Families, Reducing Parental Conflict and Family Hubs.
- Continue to develop our Data Maturity work through the Insights to Intervention Project
- Develop further our work with partners to improve school attendance as part of our Early Help key priorities
- Embed the ICON programme across Merton's safeguarding system
- Strengthen our governance arrangements and alignment with key strategic work across our Partnership

Domestic Abuse & Think Family

What have we achieved this year?

The MSCP's Domestic Abuse and Think Family sub-group has oversight of work on domestic abuse from across the Partnership. This has included regular reporting from representatives from the Multi-Agency Risk Assessment Conference (MARAC) and Violence Against Women and Girls (VAWG) Boards. The group has also overseen and driven forward actions from the MSCP's 'Baby Grace' LCSPR, which featured learning for the Partnership on identifying and addressing risk of domestic abuse and promotion of Clare's Law.

April 2021 saw the Domestic Abuse Act 2021 receive Royal Assent, which brings in some significant changes. The Act provides a statutory definition of domestic abuse for the first time and explicitly recognises children as victims of domestic abuse. The MSCP has worked with Safer Merton, who are leading a dedicated group overseeing the implementation of the Act locally with a dedicated Domestic Abuse Act Officer and working with Housing colleagues on progressing the Housing Duty.

Merton's multi-agency MARAC panel coordinates the partnership's response to the most complex/high risk domestic abuse cases using a range of statutory and non-statutory agencies.

The sub-group have developed a dedicated multi-agency performance dashboard to help monitor outcomes in this area, including regularly reviewing MARAC data.

What difference have we made?

In 2021/22 the MARAC considered 636 high risk and complex cases involving domestic abuse, 639 children were identified as part of these discussions.

There has been a continued increase in the number of cases discussed at MARAC since 2020 to date, an increase of 35% since 2019-2020. The rise in repeat cases being seen by MARAC across the three reporting years has also continued and we believe this was due to COVID lockdowns and DA increasing during this period. The number of children identified as in the household for 2021-22 is also the highest when compared to 2018-19 and 2019-20.

Figure 1: An overview of MARAC cases 2019/20 – 2021/22

Year	Number of Cases Discussed	Number of Repeat cases	% repeat cases	Number of children in the household
2019-20	410	162	39%	376
2020-21	576	234	41%	557
2021-22	636	301	47%	639

Multi-agency partners continue to deliver a strong response to domestic violence over the period, initiatives have included:

Independent Domestic Violence Advocates [IDVA's]

The work of Merton's IDVAs continued throughout 2021-22. Having introduced a case worker within the Multi-Agency Safeguarding Hub (MASH - now Children and Families Hub) the three IDVAs and Complex Needs IDVA in the community have seen an increase in case referrals. This arrangement remains under review and reports regularly to the Domestic Abuse and Think Family sub-group.

The IDVAs role includes sourcing safe/emergency accommodation, referrals to Safeguarding and/or MARAC, accompanying service users to court, information provision around criminal justice system, signposting for legal advice including clients with no recourse to public funds, and emotional support. It is

recognised that the IDVA role plays a pivotal role in supporting and managing domestic violence issues.

As a result of the pandemic, the One Stop Shop confidential weekly drop-in service for people experiencing domestic abuse was forced to close due to social distancing rules. However, it did manage to operate on a virtual basis during the pandemic and has reopened in November 2021.

The IDVA service received 769 referrals between April 2021 and March 2022 (compared to 691 the previous year), of which 283 were high risk. 93 of the total referrals came from Social Care services. In addition:

- Intensive support to 5 clients by the MASH DV caseworker during April 2021 to March 2022, representing 6 or more significant contacts, e.g., appointments, joint appointments, telephone-based RIC and ISSP completion.
- Medium support the MASH DV caseworker provided 63 clients with 2-5 significant contacts
- Single contact and advice provision was provided to 7 clients by the MASH DV caseworker
- 3 clients were uncontactable and 1 client declined support

Domestic Abuse Disclosure Scheme – Clare's Law

The overall aim of Clare's Law is to help people to make a more informed decision on whether to continue a relationship and provide help and support when making that choice; or have recently separated. Learning from Merton's Baby Grace Review suggested that Merton would benefit from increased promotion of Clare's Law locally. As a result, the MSCP has worked with other partners to deliver awareness raising activity, promoting the law in our newsbulletin as well as raising awareness of local training coordinated by the Police.

280 professionals attended the Police-led training and, since the training, 43 Clare's Law requests have been made in Merton.

Operation Encompass

Has been implemented successfully at many schools in Merton and informs school settings of incidents of domestic abuse involving children on roll in order that Designated Safeguarding Leads and key staff are aware of this context when supporting and working with their children.

Training

Over the course of 2021-22, the MSCP Training programme also delivered two Domestic Violence and Abuse virtual training courses, attended by 14 participants. This is slightly lower than the previous year. However, the MSCP plans to return to quarterly delivery of training in 22-23, which should see numbers increase again. For those who attended the training sessions, the feedback was very positive, with all delegates saying they would recommend the course to a colleague.

> *"I know of the services Merton has to offer. I feel I can recommend and refer to services now. I feel more comfortable if I need to speak to a victim."*

The Domestic Abuse and Think Family sub-group also supported the planning of a Joint Conference with the Merton Safeguarding Adults Board. One of its themes was 'Think Family'. The first half of the conference focused on family safeguarding and the importance of adopting a 'Think Family' approach to safeguarding. The MSCP heard from Sue Williams from Hertfordshire County Council, and Programme Director for The Centre for Family Safeguarding Practice, on the family safeguarding model. It also provided an opportunity to consider the Think Family themes that have arisen from local reviews such as Eddie, Ananthi and Basita (Domestic Homocide Review, DHR).

There has been some highly positive feedback and partners have told us they would welcome further resources to work with their staff on developing think family approaches. As such, the Domestic Abuse and Think Family sub-group are developing further training resources that can be shared across the Partnership.

Ofsted's inspection of Merton's Children's Services highlighted the positive impact 'Think Family' work is having for Merton's families. Following the findings from our learning reviews, we acknowledge that there is still further work to be done locally, and we will continue to progress with our plans during 2022-2023:

"Assessments using Merton's strengths-based social work model help identify the impact of parental mental illness, domestic abuse, substance misuse and the neglect of children.

Thoughtful and sensitive work with children during the assessment is supporting them to cope with and navigate entrenched parental difficulties. Trauma-informed therapeutic practice that assists professional thinking and approaches through systemic reflection and evaluation is augmented effectively by good-quality management direction and specialist consultants.

Exceptional examples were seen of social workers sensitively using bespoke direct work tools to evaluate the impact of parental vulnerabilities, while keeping a clear focus on children's need to remain safe. Social workers act to routinely involve fathers in assessments and plans. Care is taken to understand parental and family histories, cultural heritage and each child's unique and diverse needs."

What will we do next?

In 2022-23, the Domestic Abuse and Think Family sub-group will be further developing and embedding our work around 'Think Family'; working with Safer Merton in the preparation for and implementation of the Domestic Abuse Act locally; and taking forward actions from our recent domestic abuse audit.

Contextual Safeguarding

<u>What have we achieved this year?</u>

The Promote and Protect Young People (PPYP) sub-group has led on the Partnership's work to support a coordinated, embedded approach to contextual safeguarding. In addition to operational innovations, the partnership oversaw the development and monitoring of a multi-agency Contextual Safeguarding Strategy and Action Plan. This has led to several positive developments locally including:

- Clarifying referral pathways for adolescents via promotion of Merton's thresholds and referral routes through a comprehensive training programme (Effective Support Model).
- Delivery of regular training on contextual harm to safeguarding partners through 2021-22.
- Continuing to develop and promote our work on online safety, through regular training and refresh of our policy and resources.
- Identifying and training four contextual harm champions
- Developing and establishing the new Multi-Agency Child Exploitation (MACE) panel to replace MARVE, as outlined in the Pan-London Child Exploitation Operating Protocol (2021). The MACE Panel went live in November 2021 and helps to ensure swift identification of children at risk using screening tools. It is also supporting leaders locally to understand trends in the borough, which are regularly reported to the PPYP for oversight. Ofsted recognised that these multi-agency meetings were '*used constructively to share information*' and that '*management decisions are clear about next steps*'.
- Contextual Safeguarding working group for Designated Safeguarding Leads in schools and rolling out St. Giles Trust workers in schools to support relationship building and confidence.
- Delivery of child sexual exploitation day event with over 50 attendees, who heard directly from a Merton Young Resident about her lived experience of CSE.
- Development and publication of a refreshed parents pack, in conjunction with other Southwest London boroughs to support parents whose children have experienced exploitation.

Multi-agency panels to support children and young people at risk of contextual harm (MACE, pre-MACE and Missing Panel) have retained strong multi-agency membership, engagement, partnership and attendance. The focus continues to consider the needs of young people, not just the criminal and protection elements. As a partnership, we identified patterns and peer networks through mapping and intelligence sharing, which underpins joint interventions.

As a partnership, we consider the young person's journey and support networks, which informs our wrap around plans and support for families. For high-risk young people, we explored emerging themes, locations and trends. Further development is taking place to strengthen the voice of young people, how this might reflect their concerns compared to professionals, demonstrate where they lead contextual harm plans.

During 2021-22, the PPYP worked with Performance colleagues to develop a comprehensive performance dashboard, which regularly reports to the sub-group. This helps the PPYP understand the contextual risks to children and young people in Merton, including child sexual exploitation and child criminal exploitation, children missing education and also missing (from home or placement) among others. The improvements in multi-agency data collection and

performance reporting have also supported our multi-agency panels such as MACE.

While there have been lower numbers of referrals/young people discussed at MACE, it is expected that the Pre-MACE and MACE panel arrangements will enable the most high-risk young people to be presented. The highest category theme for MACE referrals continues to be child criminal exploitation. Referrals for child sexual exploitation have recently decreased, which may not be due to risk decreasing but issues of understanding and identification of CSE. As a result, training and consultation sessions have increased to address this.

Merton's Children Social Care service continues to develop its contextual safeguarding approach, having previously been successful in its bid to the London Scale Up project. An approach which develops safety planning has been developed and is in consultation with partners, which will be a priority into 2022/23. New assessments and tools are continuing to be embedded and this is supported by MSCP delivered training on contextual harm.

Following the abduction and murder of Sarah Everard and the establishment of the 'Everyone's invited' online platform for testimonies of sexual harassment, abuse and misogyny in schools, the MSCP continued to proactively respond to safeguarding concerns regarding sexual violence and harassment.

In June 2021, Alison Jerrard, Headteacher at Ricards Lodge High School, spoke to multi-agency partners at the Full Partnership about the challenges faced by schools. The MSCP's Scrutineer and Young Scrutineer undertook thematic scrutiny activity on sexual harassment in schools during 2021, which identified strong practice in schools in Merton, and identified some recommendations for improving practice. The findings are due to be finalised and fed back to the MSCP in 2022-23 and the partnership will then take forward any recommendations.

What difference have we made?

The new multi-agency MACE has enabled partners to better understand practice and risk for young people. We have identified:

- Emerging evidence of good information sharing across boroughs and between partners. Evidence that professionals can confidently tell the child's story, identify exploitation and risk and strengthen interventions with families.
- Consistent lead professional attendance at pre-MACE and improved communication with partners via contextual harm newsletters and better systems for updating screening tools.
- For a small number of young people open to Pre-MACE for extended periods, this reflects changing patterns of risk and the need for more time for these young people to build relationships and embed plans.
- The need for some reviews of strategic boards to reduce duplication, which will take place in 22-23.
- Case studies showing significant positive change – for example, one young person who was at significant risk of exploitation and involvement with Police. Following a strong partnership approach, and integrated, wraparound support for the young person, he was stepped down following positive outcomes.

Merton Safeguarding Children Partnership were pleased to see the work of Children's Social Care, alongside its partners, recognised by Ofsted in their inspection of Children's Services:

"Work with vulnerable adolescents and those at risk of exploitation is helping to keep them safer. Emerging risks to

young people are identified early using screening tools. Effective multi-agency arrangements ensure that there is swift identification of children at risk. Evidence of individualised skilful direct work is helping children understand risks posed to them, helping them develop strategies to exit harmful situations. Established professional partnerships and good management support strengthen the response to risk across communities and are helping practitioners engage young people in danger of extra-familial sexual and criminal exploitation. While contextual risks remain very real for young people, there is evidence of professionals persistently making an impact with their work."

What will we do next?

The Partnership will continue to develop and embed its approach to contextual safeguarding in 22-23, with a refreshed strategy focusing on making improvements in the following areas:

- Our practice
- Our data and systems
- Our partnership and risk management forums
- Our quality assurance

Looked After Children and Care Leavers

When a child comes into care, the council becomes their 'Corporate Parent', the term means the collective responsibility for providing the best possible care and safeguarding for the children in our care.

Children in Merton are less likely to be in care when compared to other boroughs. In 2020/21, 30 out of every 10,000 children in Merton are in care, compared to 47 in London and 67 Nationally.

Merton continues to buck the trend in increases of the number of children entering care nationally. The children-in-care population in Merton has been declining over the last four years. The number of unaccompanied asylum-seeking children in our care, has also declined, but at a lower rate to Merton residents.

Provisional data shows more boys are in care than girls (55.7% vs 44.3%). We also know that proportionally more Merton children enter care at a later age when compared to London and national averages. Provisional data for 2021/22 also shows Black/Mixed children are over-represented in our care population. On 31st March 2022, the percentage of black/mixed-race is 43%; this compares to one in ten under-18s in Merton's general population. By contrast, only 6% of our children in our care are from an Asian background. This compares to just under 20% of Merton's under-18 population.

There are many reasons why a child may become looked after, in Merton for 2021/22, the main reasons for entering care are abuse or neglect. This has remained static for the last 6 years. Absent parenting is the second biggest reason why a child became looked after in 2021/22.

For care leavers, provisional data shows, as at 31st March 2022, 96% of our care experienced young people between the ages of 19 and 21 were 'in touch' with the Local Authority; this compares with 91% nationally as of 31st March 2021. The percentage of young people in suitable accommodation increased substantially from 66% in 2015 to 89% in 2021, faring better than London and national comparators. Provisional calculations show performance remains in line with last year.

74% of our care experienced young people, according to provisional reports, were in education, employment or training during 2021/22. This is an increase from 61% at the end of last year.

Merton's Corporate Parenting Strategy 2019-22 offers an overview of strategic multi-agency priorities.

In their recent inspection of Merton's services for children in need of help and protection, Ofsted said of children in care and care leavers:

"Children in care and young people leaving care in Merton receive outstanding care and support. Teams of highly committed, ambitious and determined professionals work extremely well together to help children to remain safe and achieve in life."

Annex 1: MSCP Budget and Spend 2021/22

MSCP Budget 2021-22 – Contributions by agency

London Borough of Merton	84,750
Merton CCG	55,000
Metropolitan Police	5,000
Total	**144,750**

MSCP Spend 2021-22

	Spend	Budget	Variance
Staffing:			
Salaries	89,882.57	88,970	912.57
Independent Posts	17,420.31	20,000	-2,579.69
Training	6,445	13,710	-7,265
Learning Reviews	3,889.28	3,890	-0.72
Supplies and Services (Office costs)	15,173.18	18,180	-3,006.82
Total	**132,810.34**	**144,750**	**-11,939.66**