Sefton Safeguarding Children Partnership (SSCP)
Overview of Activity 2021/22
(Annual Report)

Contents

Section 1: Introduction

This annual report covers the period April 2021-March 2022. During this period there has been significant challenges that the partnership has faced not least of which has been the challenges faced as a direct result of COVID impact, the departure of the Director of Children Services, and the introduction of a CSC Interim Strategic Leadership Team as well as the departure of the Independent Chair and a reduction in the SSCP business unit staffing establishment from 3.8 FTE to 2.8 FTE. These significant events have inevitably affected the timeliness of the achievements as planned for the safeguarding partnership (which was laid out in the previous annual report), and suffice to say that mid-year, the agenda moving forward took on a different set of approaches and priorities.

Most notably, the safeguarding partnership arrangements were significantly revised in September 2021 alongside the re-setting of the partnership priorities (which were not ratified until early 2022). The revised priorities changed to:

1. Neglect
2. Contextual safeguarding
3. The remodelling of Sefton's 'Front Door' arrangements

As a result of the significant changes outlined, practically, a considerable amount of attention for the remainder of the annual reporting period was spent on:

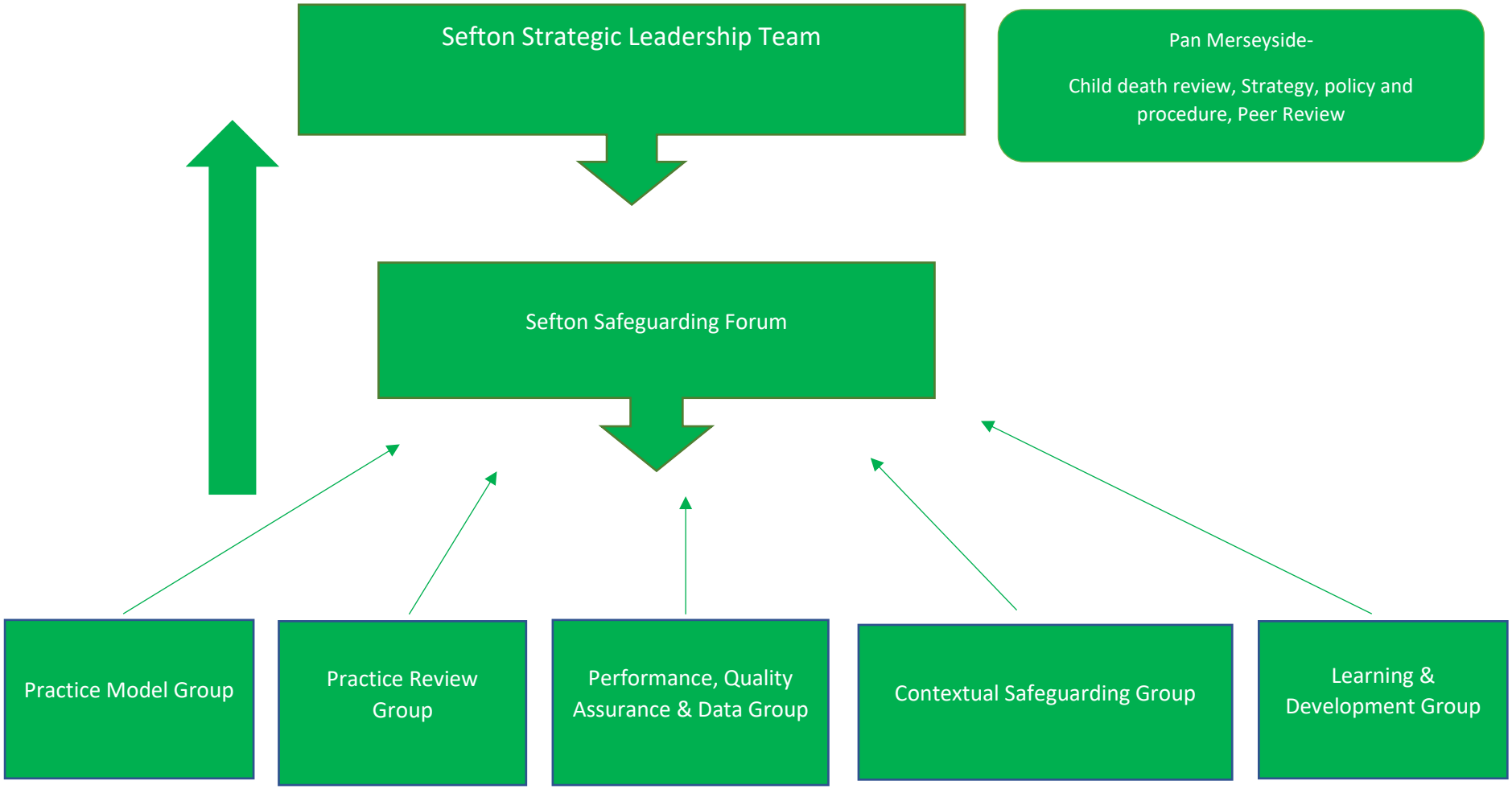
- The disestablishment of the current arrangements
- The introduction and embedment of the revised arrangements
- The introduction and action planning for the new safeguarding priorities
- The appointment of an Independent Scrutineer and;
- Increased communications on the changes made which included a whole host of briefings across the partnership

Consequently, these significant changes have had an impact on the progress of the work of the partnership. Work plans around the new priorities that have recently been agreed will now be required at pace.

Alongside all of this is a further priority piece of work which is to revise the Level of Need threshold document which was, through the Children Social Care Interim Strategic Leadership Team diagnostics, found to be in need of an uplift.

To achieve all of this, Sefton's Safeguarding Children Partnership is supported by a full time Safeguarding Partnership Manager, full time Business and Communication Officer and a part time Learning and Development Officer. It is led by senior leaders from across Sefton Council, Merseyside Police and Sefton Clinical Commissioning Groups (CCG's) working with other key agencies involved with children, young people and families who need support.

Sefton Safeguarding Children Partnership (SSCP) Structure 2021-22



The new arrangements will be further reviewed by the Independent Scrutineer as to their effectiveness in 2022/23.

Section 2: Covid-19

In March 2020, the United Kingdom was facing the impact of a pandemic following a worldwide outbreak of the Covid-19 virus. Since that time, there have been different levels of "lockdown" and other restrictions, both legal and social, to contain the crisis. The public measures put in place in the Sefton area during this reporting period were as follows:

- Mid-March 2020: All non-essential contact and travel was curtailed.
- End March: Lockdown measures legally came into force. People were required to stay at home, except for very limited purposes; certain businesses and venues were closed; gatherings of more than two people in public were stopped. Schools were closed to most children.
- Beginning June 2020: a phased reopening of schools in England began.
- Summer 2020: Coronavirus measures were mainly incrementally relaxed, although some areas were subject to 'local lockdowns'. Local authorities were given additional powers to enforce social distancing.
- Mid- September 2020, restrictions were again tightened, including the introduction of 'the rule of six' and a return to working from home.
- Early October 2020: Restrictions were extended locally, banning social mixing between households except for limited contact out of doors.
- Mid-October 2020, a new 3-tier system of covid restrictions was introduced in England. The local area was placed in Tier 3.
- Beginning of November 2020, a second national 'lockdown' began. Educational establishments, however, including schools, early years settings and universities, remained open. Clinically vulnerable people were not asked to resume shielding. They were asked instead to minimise contact with others and 'not to go out to work if they were unable to work from home'.
- At the beginning of December, national restrictions ended. The local area remained in Tier 3.
- Beginning of January 2021, England entered a third national lockdown. Restrictions in respect of leaving your home were reintroduced. All primary schools, secondary schools and colleges moved to remote learning, except for the children of key workers and vulnerable children.
- Mid-late February 2021, the government published a 'road map' for lifting restrictions.
- Beginning of March 2021, schools in England fully reopened. Teaching and socialising in 'bubbles' continued.

Throughout this period the safeguarding partnership prioritised supporting organisations and sharing key safeguarding messages. Mechanisms specific to COVID impact on agencies were put in place for the safeguarding partnership to receive updates and assurances that priority to safeguarding children remained high and efforts to identify those children most at risk and in need of agency attention was acted upon. Consistent communication through the safeguarding partnership website was key to ensuring professionals and residents were able to receive up to date advice and guidance on this specific safeguarding concern with bold reminders of how to make a referral should there be any safeguarding concerns for a child. In addition, multi-agency

safeguarding training remained active with the delivery of virtual sessions as well as an uplift of associated resources for professionals to support their knowledge and practice.

Whilst it is recognised that there are time cost benefits to now attending professional meetings virtually, the strategic safeguarding leaders are committed to ensuring that any meetings that involve the participation of children and family members will respectfully revert to face-to-face arrangements in line with good practice. As well as being monitored moving forward, where there is evidence of agencies being unable to meet this request in most circumstances this will be addressed through the Safeguarding Strategic Leadership team.

Section 3: Independent Chair and Scrutineer

The Independent Chair/Scrutineer was in post until September 2021. During this reporting period and in the 6 months of appointment, the chair continued to lead the main board and executive group as well as undertake scrutiny work.

Assurance activities included:

- Attendance at Community Rehabilitation Company and the National Probation Service Safeguarding Children Operational meeting
- Attendance at local hospital Safeguarding Case Review meeting
- Termly meetings with Designated Safeguarding Leads
- Observation of Multi-Agency Criminal Exploitation (MACE) meeting

Scrutiny activities included:

- Annual attendance at all subgroup meetings which included the scrutiny of minutes of previous meetings and feedback to the Chairs of the subgroups to share observations of business management and performance
- Meeting with Child Protection Chairs that resulted in an agreed proposal for an audit into the drift and delay in the progress of Child Protection Plans

Recommendations have included:

- **T**he Practice Review Subgroup Chair elicits clarity on the rationale for the decision made set against the criteria and the view from each member of the review group and their rationale is recorded. The statutory partners to address how the partnership can have appropriately trained people to undertake the practice reviews.
- Criteria for 'Complex Child in Need' process with expected outcome measures is provided and how this sits in current decision making and planning, with dissemination across the partnership and referenced in ongoing training.
- The 3 key statutory partners review the strategic response to high-risk adolescents due to increasing contextual risks evidenced through scrutiny work and frontline practitioner conversations.
- Presentation and 7-minute briefing to support a greater awareness of the Public Law Outline and Pre-Proceedings process to the wider partnership to be arranged.

Planned work

- An agreed area of scrutiny is to review the arrangements for children held in custody and whether the Home Office Concordat is being applied appropriately and how 'child friendly' the arrangements are, including the use of Appropriate Adult services.

- It has been agreed that a further area of scrutiny will be to revisit the learning from Serious Case Reviews and seek evidence of the improvements in practice by talking directly with multi agency practitioners.

This work will now be progressed following the successful appointment of an independent scrutineer.

Section 4: Child Death Overview Panel (CDOP)

The Child Death Overview Panel (CDOP) works across the five local authorities in Merseyside and the Isle of Man. The Panel reviews information on all child deaths, looking for possible learning and patterns with the aim of making improvements in services, policy, procedures, and communications to prevent future deaths. Merseyside/Isle of Man CDOP:

- provides oversight and assurance of the new Child Death Review processes and ensure that it meets the required statutory standards.
- reviews all infant and child deaths under 18 years of age. This includes neonates where a death certificate has been issued, irrespective of gestational age.
- identifies and highlight any modifiable factors, and bring these to the attention of strategic partners, including Health and Wellbeing Boards, Local Children's Safeguarding Partnerships and Community Safety Partnerships where necessary

During the reporting period 1 April 2021 to 31 March 2022, 104 child deaths were notified to CDOP across the five Local Authority areas. This is an 18% increase on the previous year. Of the 104 child deaths, 19 were related to Sefton Local Authority area as follows:

- 61.5% of deaths reviewed during 2021-22 were completed within 12 months [70%]
- 68% of deaths were expected [100%]
- 53.8% of deaths were children under 1 year of age [65%]
- 38.5% of deaths had modifiable factors identified [35%]

Most prevalent modifiable factors included: Maternal BMI; smoking/smoking in pregnancy; unsafe Sleeping

CDOP meetings have been conducted through a virtual platform due to pandemic restrictions. Their annual report for 2021/22 has yet to be finalised.

Section 5: Local Child Safeguarding Practice Reviews (LCSPR's)

At the end of this reporting period, the safeguarding partnership has concluded one Local Child Safeguarding Practice Review (LCSPR) and has a further LCSPR underway. For the completed LCSPR, the partnership has formulated an action plan in response to the recommendations made through the Independent Author. This action plan will now be monitored and supported through the Practice Review subgroup until completion. It is recognised by the strategic safeguarding leaders that learning from all the reviews undertaken by the partnership over the last several years have evidenced that there are recurrent themes in the safeguarding and promotion of the welfare of children in Sefton. These themes include:

- information sharing
- professional curiosity
- professional challenge/escalation

- effective supervision
- assessing risk
- disguised compliance
- multi-agency communication
- silo working
- transition from primary to secondary school

These issues are systemic and long standing. Alongside the work of the partnership to address all of the recommendations from all case reviews, the planned scrutiny work identified by the Independent Chair will further support the partnership to progress safeguarding practice through those concluding findings. The learning from all reviews has been systematically shared with strategic leaders and frontline staff to raise awareness of the key findings from the cases. There has been a significant investment in the design of training to embed the learning from reviews across the partnership.

Section 6: Multi Agency Quality Assurance and Audit Activities

Throughout the reporting period the safeguarding partnership has, despite the impact of the pandemic, managed to complete an arrange of quality assurance and auditing activity which included:

Partnership Use of, and Reporting of, Escalations Audit - Key Findings:

To better understand why agencies were not actively using the escalation policy to resolve professional disputes the partnership the partnership systematically collated monthly returns from agencies in relation to their use of the escalation/dispute resolution policy. The partnership then undertook an audit and staff survey 12 months later which highlighted the continued lack of escalation activity across the partnership. This resulted in a request that the staff commentary relating to working cultures is addressed. It was agreed that there will be no further monthly returns as this exercise was not producing the qualitative information to inform the partnership about the use of escalations and the outcome. A request will be made in 12 months' time for an assurance report from each agency to provide evidence of resolution and escalation activity. Where there is little or none at all, a rationale will be expected, and details of agency actions being taken. This will then be raised with the Strategic Leadership Team for awareness and any further action should it be required.

Child Exploitation Audit - Key Findings:

- Evidence of agencies/professionals not being advised as to the outcome of referrals or assessments or being involved or invited to subsequent meetings.
- The role of School Nurse does not appear to be securely embedded in multi-agency processes.
- Drift and delay was a feature in a number of the cases audited but challenge to ensure good safeguarding practice or timely progression was limited.
- A number of agencies were not able to advise a view on the effectiveness of the intervention, because of not being sufficiently involved in multi-agency processes.
- 'Case Closure' without consultation with partners, despite concerns remaining, was a feature.
- Changes of social worker impacted upon the progression of case work.

Public Law Outline Audit - Key Findings:

- The audit shows that the contribution by multi agencies to managing risks, through their attendance at Child Protection Review Conferences and / or Core Group Meetings is limited.
- Multi-agency attendance at Child Protection Review Conferences and/or Core Group Meetings was low.
- Agencies attending understood what required of them and received a copy of the Child Protection plan. Drift and delay were not found to be a feature in the cases audited.
- Wider agencies understanding of pre proceedings was not able to be established from the audit
- Low reporting through audit returns from agencies that attended Child Protection Review Conferences and/or Core Group Meetings that the schedule of expectations was reviewed.

Child in Need Audit - Key Findings:

- Partnership challenge to drift and delay is extremely limited.
- Minutes and plans are not routinely made available to partners.
- Systems issues resulted in dual recording and impacted on the timely transfer of information.
- 'Step up' procedures not being followed have led to examples of dual recording and poor information sharing.
- Although case activity is evidenced as having taken place, this is not always readily noted in agency records.
- Safeguarding practice issues were identified in multiple cases

Children Subject to Child Protection Plan Audit - Key Findings:

- Accounting for the views of children and young people in child protection planning is limited.
- Drift and delay is a significant feature of the audit.
- Escalation and challenge is more apparent in response to drift and delay however challenge is not always made by partners, in all cases, where drift and delay is evident.
- Progression of Core Groups are inconsistent (timescales). Child Protection Plans are not consistently reviewed or updated at core groups meetings.
- Frequent and multiple changes in social worker have led to examples, in audited cases, of drift and delay and inconsistent child protection planning.

The findings and recommendations from these activities are being addressed by the safeguarding partnership and progress will be monitored throughout the coming year. Due to the period of unsettlement highlighted in the introduction, there has been a loss of focus on the follow up work associated with the audit findings and the associated action plans now need to be re-prioritised.

Children's Social Care Performance Data & Narrative

See appendix 1.

Section 7: Multi Agency Training & Development

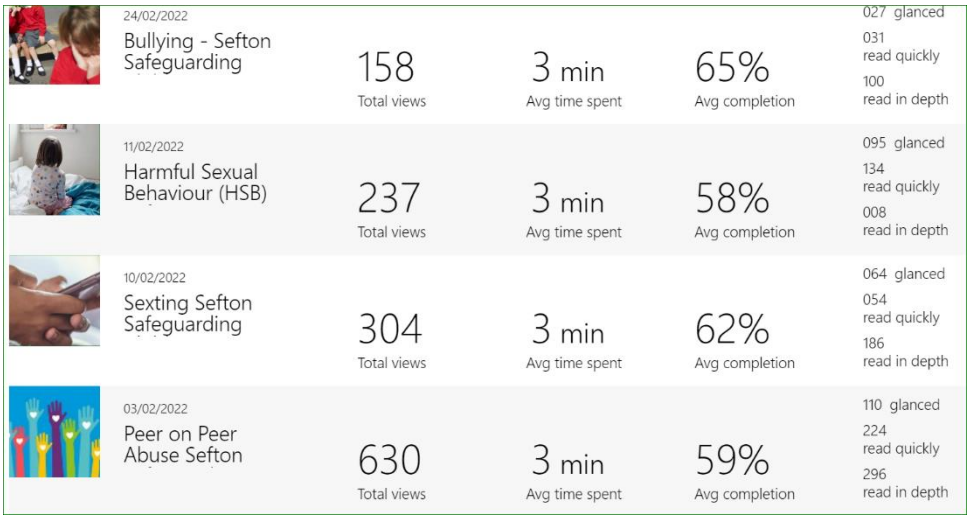
SSCP Learning and Development offer continues to gather momentum. Pace of delivery is consistent and increased from the previous year.

During the period between April 21-March 22 significant activity has taken place. There have been 37 courses offered with 854 professionals attending. Working Together to Safeguard Children has been delivered 13 times, with 381 professionals attending. In total 50 courses offered with 1,235 professionals benefiting from these learning opportunities to influence and impact upon their safeguarding children practice. The delivery of this offer demonstrates the commitment and effectiveness of the SSCP Training Pool who drive and support the work.

In addition, work has been progressed in relation to SSCP priorities, national learning, and local need.

Impact of SSCP Training

Multi-agency training delivered by the safeguarding partnership requires professionals to complete an evaluation form at the end of the training session. A specific question posed in the evaluation form is about how the training will impact their practice moving forward. Whilst this approach provides the partnership with an indication of how practice will improve as a direct consequence of the training received, there remains a challenge to secure evidence on how training improves the outcomes for children. For example, Evidence of impact following extensive training from CSA and contextual safeguarding commissioned training indicates it has been well received from across the partnership. However, this does not correlate with Child protection figures for children identified under the category of sexual abuse. Until the mechanism to do this has been realised, the partnership has started to capture professionals' attention from SWAY statistical data (illustrated below) which demonstrates longevity in professionals in accessing the resources made available to them. We will also continue to capture professional on practice issues feedback through survey monkey.



	24/02/2022 Bullying - Sefton Safeguarding	158 Total views	3 min Avg time spent	65% Avg completion	027 glanced 031 read quickly 100 read in depth
	11/02/2022 Harmful Sexual Behaviour (HSB)	237 Total views	3 min Avg time spent	58% Avg completion	095 glanced 134 read quickly 008 read in depth
	10/02/2022 Sexting Sefton Safeguarding	304 Total views	3 min Avg time spent	62% Avg completion	064 glanced 054 read quickly 186 read in depth
	03/02/2022 Peer on Peer Abuse Sefton	630 Total views	3 min Avg time spent	59% Avg completion	110 glanced 224 read quickly 296 read in depth

Next Steps

- Design and deliver an enhanced training programme specific to the partnership safeguarding priorities
- Launch the revised Level of Need Guidance across the partnership
- Provide training offers in response to audit activity across the system

- Deliver briefings for the partnership on national reviews and safeguarding research
- Hold sessions on the revised Working Together Guidance if available
- Be responsive to training needs that are highlighted in Ofsted Inspections

Section 8: Local Authority Designated Officer (LADO)

	2018-19	2019-20	2020-21	2021-22
Referrals	153	170	118	184
Contacts	29	22	44	46
Total Activity	182	192	162	230

2021-22 saw an increase in LADO activity compared with previous years. If we look at this in the context of previous years, it appears that this is as a result of an increase in cases closed as contacts. It may be that this is due to a more consistent way of reporting LADO activity in that cases which were previously recorded as advice are now recorded as contacts. In addition, this reflects the introduction of Low-Level Concerns in Keeping Children Safe in Education (2021) which has resulted in some schools in Sefton contacting the LADO to check that they can deal with a situation under those procedures where LADO threshold has not been met. The LADO welcomes schools making contact to discuss cases which they may consider to be a Low-Level Concern as it ensures that any member of the children's education workforce with multiple Low-Level Concerns raised can be considered under the LADO threshold. This also allows for discussion which improves the understanding of education settings as to what might be a Low-Level Concern or how what appears to be a Low-Level Concern might meet LADO threshold.

Primary Category of Allegation

Category of Allegation	Number of Allegations	Percentage of Allegations
Physical	67	36%
Neglect	42	23%
Sexual	23	13%
Emotional	19	10%
Other/Suitability	33	18%
Total	**184**	

There has been an increase this year in referrals under the category of 'Other/Suitability'. This was expected as this was the first full year following reintroduction of the fourth threshold criteria of: *Behaved or may have behaved in a way that indicates they may not be suitable to work with children.*

Referrals by Agency

Referring Agency	Percentage of Referrals
Education	30%
Residential	19%
Social Care	15%
Fostering	12%
Early Years	8%
Police	3%

Health	3%
Voluntary Organisations	2%
Ofsted	2%
Transport	1%
Other	6%

Referrals can be made by any agency and are not always made by the agency where the subject of the allegation is employed. This is especially true for referrals relating to the suitability criteria where the referral is usually made by Social Care or the Police. The category of 'Other' included referrals from another part of the Local Authority than Children's Services, LADOs in other areas and parents.

Employment Sector of Subject of Allegations

Employment Sector	Percentage of Referrals
Education	35%
Residential	23%
Foster Carer	18%
Early Years	10%
Transport	4%
Health	3%
Sport	3%
Voluntary Organisations	2%
Social Care	1%

The majority of allegations continue to relate to staff in Education, Residential Care and Foster Carers. This is to be expected as these are settings where children spend a high proportion of their day or where adults are providing direct care to children. With the full re-opening of education settings following COVID 19 lockdown there was a higher percentage of referrals relating to staff in education settings than in residential care compared to last year.

There were no referrals in relation to Military Cadets this year compared with previous years. There were also no referrals relating to those in the Faith Sector and low percentages of referrals in relation to voluntary organisations and sports. It is a concern that given the number of children who participate in activities in these sectors across Sefton there have been such low referrals to LADO. Awareness raising of the role of LADO and an organisation's responsibilities with regards to safer recruitment and allegation management amongst these sectors will be addressed in the LADO Annual Report.

Section 9: Conclusion

Whilst Sefton's Safeguarding Children Partnership has faced additional unplanned challenges through the reporting period, the coming year will be focused on areas for safeguarding improvements across the partnership. The partnership now has a new operating partnership structure, and of great importance, is the introduction of a separate Strategic Leadership Team who now meet on a regular basis to strengthen and support the safeguarding agenda. The effectiveness of this will be reviewed by the independent scrutineer in the coming year. Specific areas of identified work will also include:

- Refresh of the Level of Need Guidance

- Multi-agency partnership learning event to support and develop positive working relationships
- Follow on work associated with audits undertaken in the period
- Addressing action plans from local child safeguarding practice reviews
- Revise the current dataset and quality assurance approaches to better understand the safeguarding landscape and be more responsive in identifying any areas of risk or decline in practice/outcomes
- Strengthen the connectivity between the safeguarding children's partnership and other local strategic partnerships
- Address any areas for improvement identified by the Independent Scrutineer in her review of the effectiveness of the current arrangements

At the close of this reporting period Ofsted have undertaken an Inspection of the Local Authority Children's Service (ILAC). Once the outcome of the Inspection has been made available, the safeguarding partnership will need to have great focus on any areas of improvement required by the multi-agency partnership to strengthen practice and support better outcomes for our children and families.

The partnership remains steadfast in its commitment to safeguard children, to address any partnership weaknesses and to improve the lived experiences of our children and families.

Independent Scrutineer Comments:

Statutory guidance requires the three safeguarding partners (which for the period covered by this report are Local Authority Chief Executive, Chief Constable of the local Police Force and Accountable Officer, Clinical Commissioning Group, or their delegated representative) to make arrangements for independent scrutiny of the yearly report they are required to publish.

I took up the role of Independent Scrutineer in early 2022; the decision to appoint an Independent Scrutineer to complete discrete pieces of scrutiny activity was a feature of the changes made to the local safeguarding arrangements in September 2021. I was therefore only in post for the latter part of the period covered by this report and was not commissioned to undertake any pieces of scrutiny activity during that period. My lack of direct involvement in the safeguarding partnership arrangements does not however preclude me from being able to provide an objective and critical friend perspective of the content of this report against the requirements of statutory guidance

Statutory guidance requires that statutory partners address the following in their yearly report:

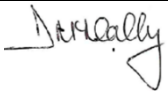
- what they have done as a result of the arrangements, including on child safeguarding practice reviews, and how effective these arrangements have been in practice.
- evidence of the impact of the work of the safeguarding partners and relevant agencies, including training, on outcomes for children and families from early help to looked-after children and care leavers
- an analysis of any areas where there has been little or no evidence of progress on agreed priorities
- a record of decisions and actions taken by the partners in the report's period (or planned to be taken) to implement the recommendations of any local and national child safeguarding practice reviews, including any resulting improvements
- ways in which the partners have sought and utilised feedback from children and families to inform their work and influence service provision.

This report details that one local child safeguarding practice review has been completed and another is underway. The statutory partners have identified thematic learning arising from the learning reviews completed and positively report that the learning from all reviews has been systematically shared with strategic leaders and frontline staff to raise awareness of the key findings. The thematic practice learning is described as "systemic and long standing" and the findings of the multi-agency quality assurance and audit activity completed during the period covered by this report would support this assertion. Feedback from practitioners who contributed their views via a staff survey conducted in respect of use of the escalation policy, indicates that there is a need to develop the culture of partnership working. The audit findings found significant gaps or barriers in the way partners work together to safeguard the most vulnerable children. Areas of concern include drift and delay, lack of professional challenge and weaknesses in the involvement of partner agencies to child protection planning and review processes.

The report does not provide information about any actions taken to address the findings/implement the recommendations of the local review that has been completed or national child safeguarding practice reviews. Similarly, there is no information about the actions taken, and the impact of those actions, to address the learning about the effectiveness of multi-agency practice with children and their families identified via the audits that have been completed. The report is transparent in reporting that this work has not progressed as required.

Linked to one of the 3 priorities agreed by the statutory partners, an Integrated Front Door was developed to address the findings about the application of statutory thresholds identified in the Ofsted monitoring visit conducted in 2021. This is evidence of the statutory partners taking action to improve the quality of service provided to vulnerable children in Sefton. The data evidences a significant increase in demand in respect of contacts made to Children's Social Care following the introduction of the Integrated Front Door. Limitations in the data and accompanying analysis, mean the report is not able to evidence the impact of these changes on outcomes for children and young people. Furthermore, a lack of multi-agency performance data precludes an evaluation of the impact of multi-agency working on the safety of children in Sefton. Such evaluation should be regularly conducted through the safeguarding partnership arrangements and should include feedback from children and families.

The report concludes with identifying a focused set of improvement activity that will be completed during 2022-23, under the leadership of the Senior Leadership Team. Based on my scrutiny of this report, I consider the completion of these activities, underpinned by a culture of shared ownership and responsibility, will facilitate the statutory partners, along with their relevant partners, to "safeguard children, to address any partnership weaknesses and to improve the lived experiences of our children and families".

Name of Strategic Safeguarding Children Lead/Role	**Agency**	**Signature**
Martin Birch, Executive Director of Children's Services	(Sefton Council)	
Dawn McNally, Superintendent	(Merseyside Police)	
Deborah Butcher, Place Director (Sefton)	Integrated Care System	

APPENDIX 1

MASH commentary against the data - (1st Apr 2021 - 31st March 2022)

During the financial year there were 9519 contacts in the MASH. The graph illustrates a significant increase in contacts from September 2021 onwards. This was due to the Introduction of the Integrated Front Door (IFD), where all referrals for Early Help and Children's Social Care came through one front door. Prior to the IFD, referrals were made for Early Help Services within family wellbeing centres across the borough of Sefton. However, the monitoring visit in 2021 highlighted that work undertaken within these settings were at the threshold for Children's Social Care.

The highest referral rate in terms of age of children and young people is between the ages of 6 and 13, with a total of 3755 referrals being received. The lowest is unborn to age 2 years which stood at 180.

In terms of gender the referrals are generally equal as there were 49.2% female and 49.7% male. 73.3% of children and young people were of White British ethnicity. 394 children had a disability which is 4.2% of all referrals and only 56 of these (0.6%) were registered disabled.

During this period 3367 referral records were closed on LCS (children's electronic records) 2235 were closed with no further action required after the child and family assessment had been completed. This is a high number of assessments completed where no further action was required so moving forward it would be helpful to request an audit of these to be undertaken by the Safeguarding Unit to explore threshold at both decision making in the IFD and at assessment outcome. 1151 ceased for any other reason, these are cases where a child in need plan has ended, or a family court order has been made. For example, a Special Guardianship Order or Child Arrangement Order.

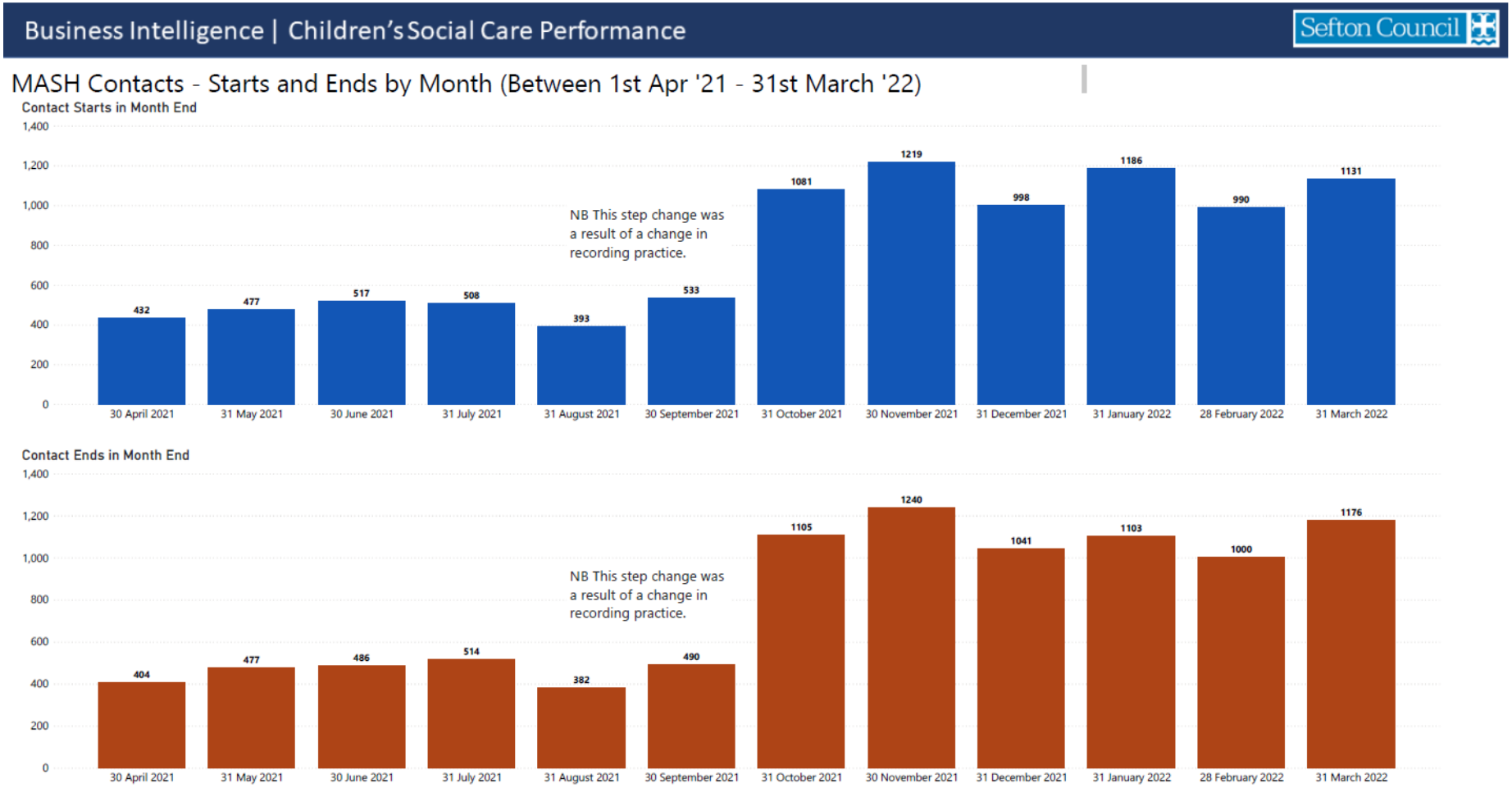
During the financial year there were 828 repeat referrals. This figure will require further analysis as there are a high number of instances where a duplicate referral is made by several agencies. Nonetheless, the figure is relatively low given the percentage on average stands at 20% each month. This is positive as it is just below the re-referral rate of our statistical neighbours and the national average.

Whilst this data demonstrates an encouraging trajectory given the significant increase of contacts into MASH, this will naturally have an impact on services to meet the increased demand. Moving forward, there remains strategic consideration of how this can be sustained in relation to the management of resources, caseloads and partnership contributions.

APPENDIX 1

Children's Social Care Performance

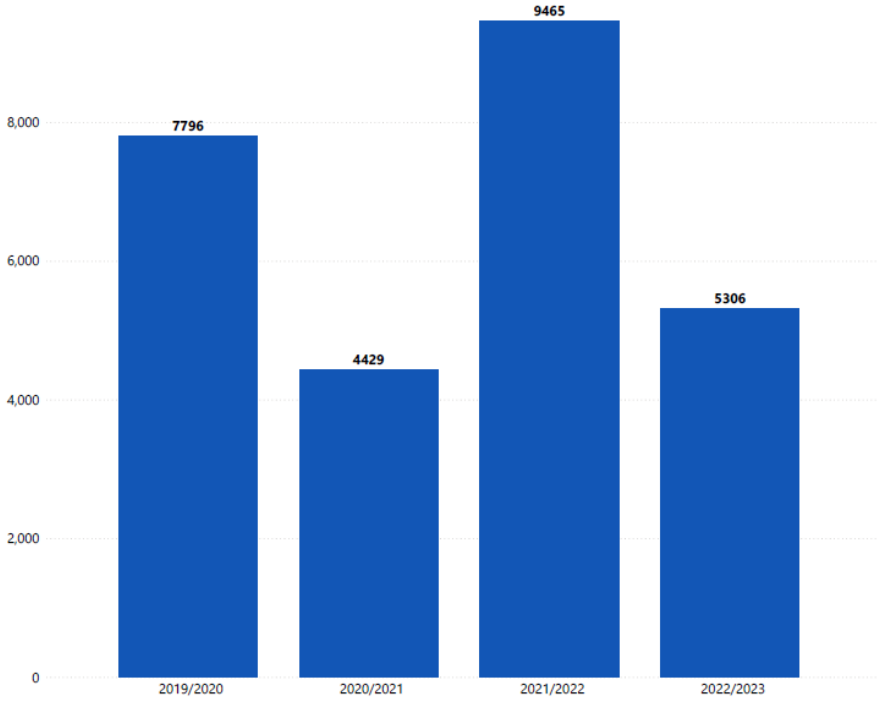
MASH Contacts



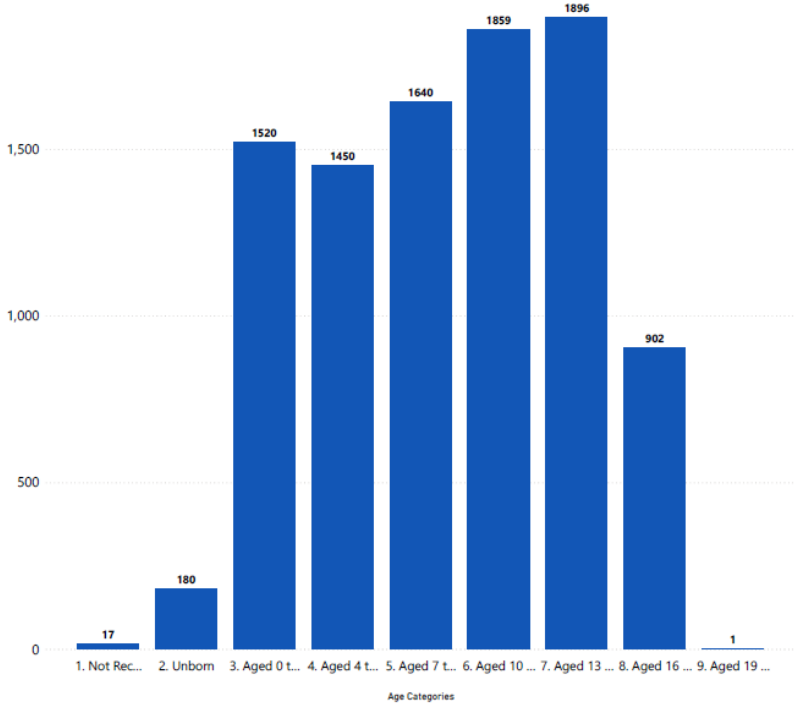
Sefton Council

MASH Contacts Person Details Overview

Total MASH Contacts by Financial Year

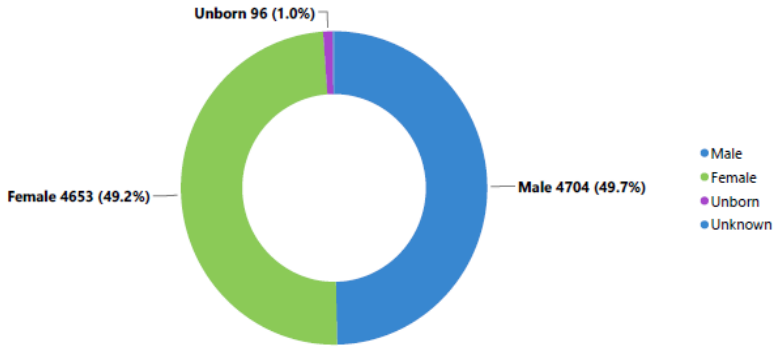


Contacts by Age (Between 1st Apr '21 - 31st March '22)

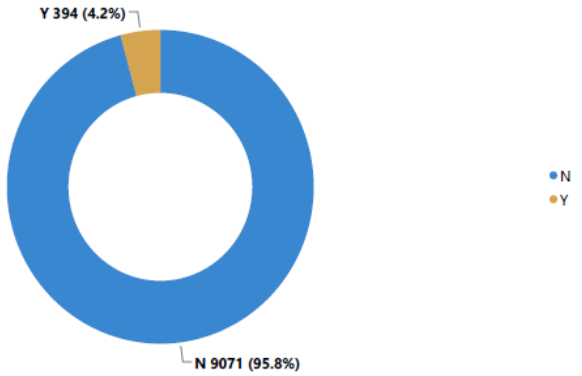


MASH Contacts Person Details Overview (Between 1st Apr '21 - 31st March '22)

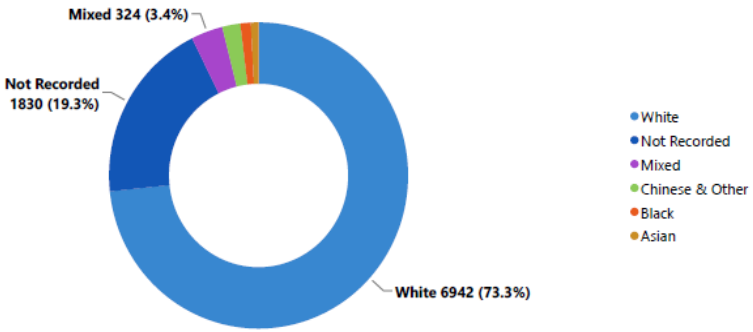
Gender



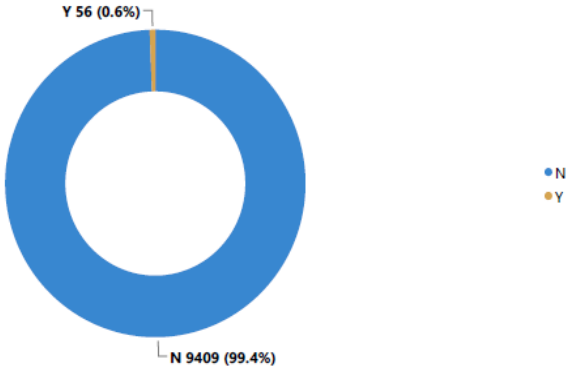
Is Disabled



Ethnicity



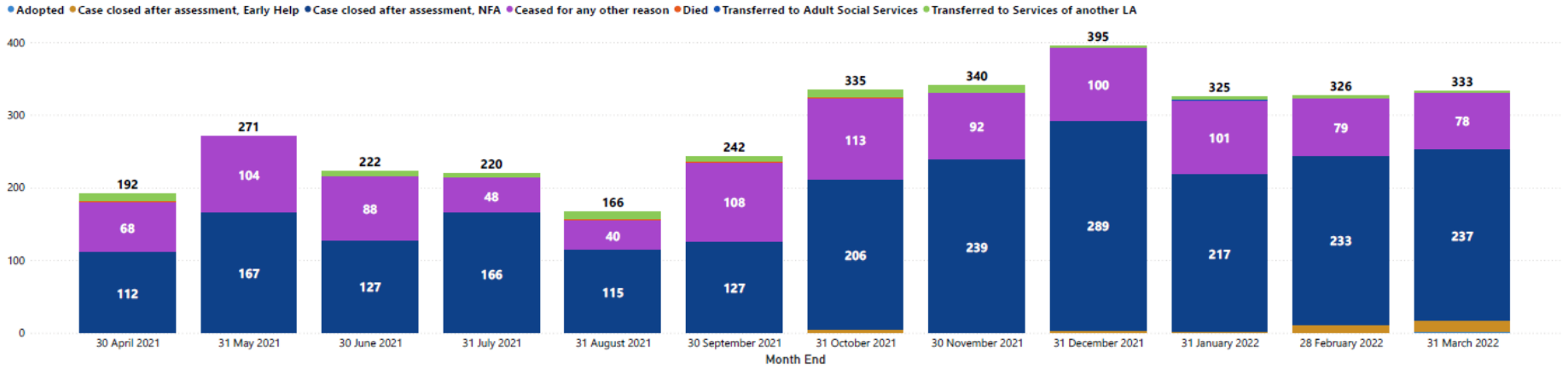
Is Registered Disabled



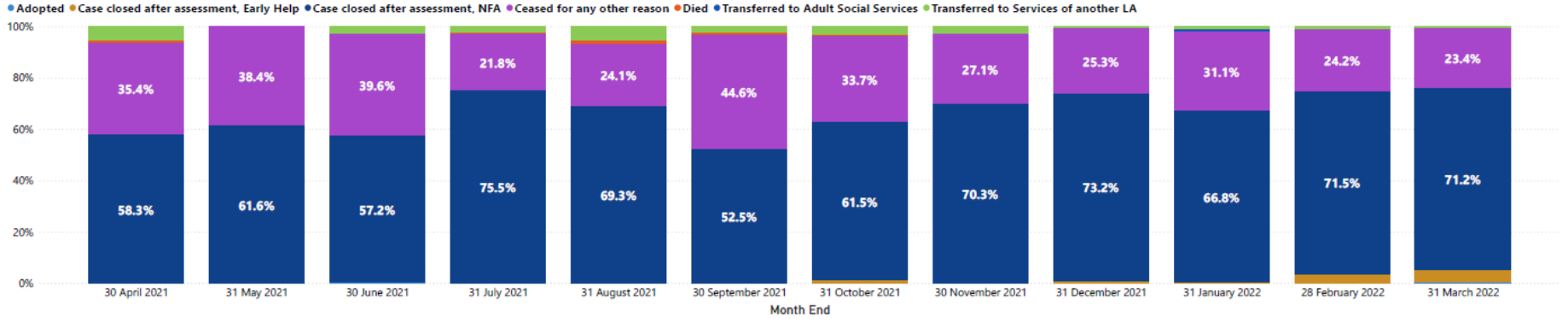
Sefton Council

Referral Outcome Overview (Between 1st Apr '21 - 31st March '22)

Count of Referral End Reasons by Month End

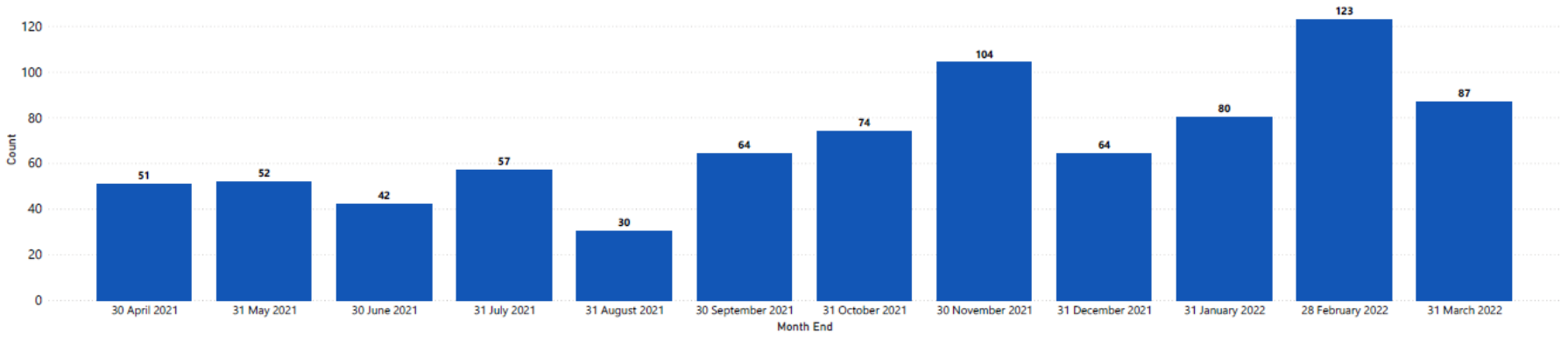


Percentage of Referral End Reasons by Month End



Repeat Referrals (Between 1st Apr '21 - 31st March '22)

Repeat Referrals in Month



Percentage of Repeat Referrals in Month