Shropshire Safeguarding Community Partnership

Children's Safeguarding Partnership Annual Report 2024-2025

Foreword

As the Lead Safeguarding Partners of the Shropshire Safeguarding Children's Partnership, we are pleased to present the Annual Report for the period April 2024 to March 2025. This report is published in line with the statutory responsibilities under the requirements in Working Together to Safeguard Children 2023 (WT23).

As Lead Safeguarding Partners we are committed to leading the Partnership to continually improve outcomes for children and their families in Shropshire. We have taken this opportunity to reflect on our progress in delivering our priorities, assess our training activities and consider how agencies can best work together to safeguard children in Shropshire.

During 2024-2025 we commissioned an Independent Case Review Diagnostic, held a 'Turning the Curve' event and planning is well underway for a number of multi-agency 'Spotlight Sessions' in the next year. All of these areas of work were driven by what our data and other assurance activity tells us, and what we know from the families we work with. These opportunities have been invaluable to the partnership, not only have they gathered large numbers of multi-agency professionals in one place to discuss system changes, they have also garnered their support and enthusiasm and captured their ideas which will be used to inform the ongoing transformational work Shropshire needs to complete.

Lastly, we would like to thank the Partnership staff, for their continued support in the smooth functioning and promotion of the Partnership. We would also like to thank our Stakeholders from across the partnership and all the frontline practitioners and managers for their commitment, hard work, and effort in safeguarding children in Shropshire.

Tanya Miles
Interim Chief Executive
Shropshire Council

Simon Whitehouse
Chief Executive
Shropshire, Telford and Wrekin
Integrated Care Board

Richard Cooper
Chief Constable
West Mercia Police

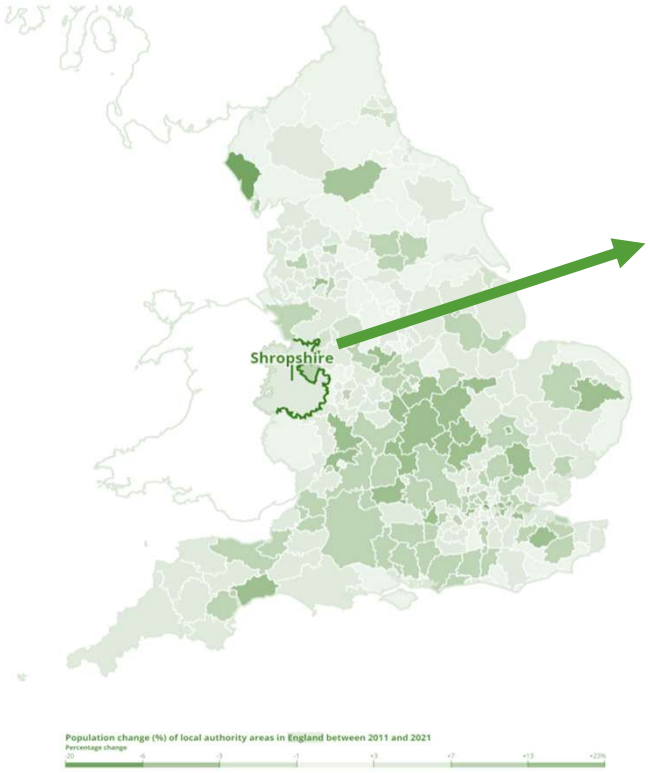
Contents

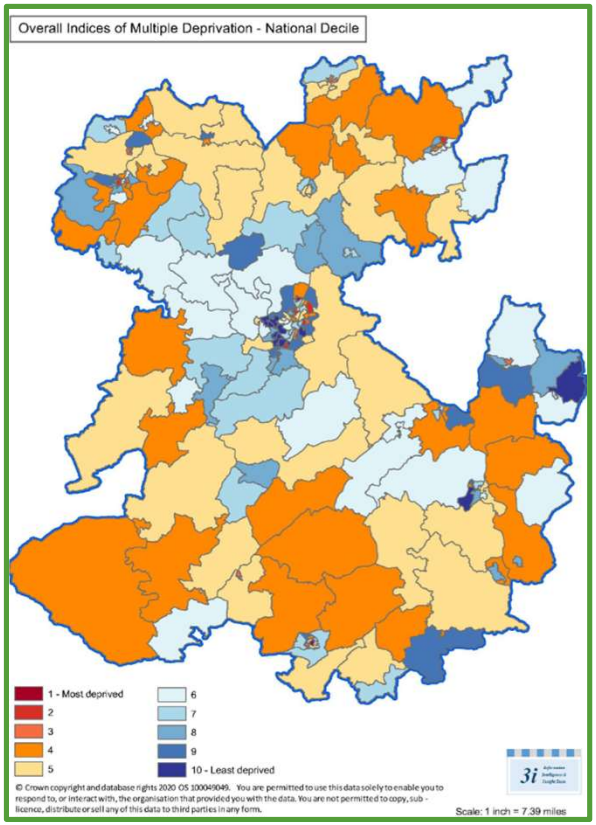
Life in Shropshire as at 11/2/2025

2nd largest Inland Council in England

1,235 square miles

Overall deprivation is low. Ludlow East and Harlescott fall within the 10% most deprived areas in England.





Population size of

329,260

(Mid-year estimate 2023)

Population Density

Shropshire: 1 person per hectare

England: 4.3 people per hectare

26.2% aged 65+ compared to 18.7% in England (2023 MYE)

59,393 aged 0-17 or 18.1%, England 20.8% (2023 MYE)

183 schools of which 13 are independent and 19 are special independent (Jan 2025)

37,289 pupils in state schools (Jan 2025)

Smallest state primary school – 18 pupils

Smallest state secondary school – 526 pupils

93.0% from white background, 94.4% with English as first language

19.1% of pupils eligible for free school meals, including nursery, 25.7% England (Jan 2025). 19.6% excluding nursery in Shropshire.

Employment rate of 78.6%, West Midlands 74.1% (Dec 2024)

13.9% self employment rate in Shropshire, 8.6% West Midlands (Dec 2024)

Life in Shropshire

Challenges of Rurality

Shropshire is a diverse, large, predominately rural inland county with a wide range of land use, economic activities, employment and social conditions. The population has been increasing at a slightly slower rate than England. Much of the growth has been due to people moving to Shropshire due to its rurality. Shropshire has a relatively high concentration of people in the older age groups.

Unlike many rural areas the population of Shropshire is distributed across the county making Shropshire one of the most deprived counties for access to services

6,100 pupils transported to school each day

Using 140 operators

At a cost of £18,000,000 per year

98% of land is rural

3,240 miles of road.

91% rural roads

57.2% live in rural areas

About the Shropshire Safeguarding Children Partnership

Our shared vision

We started 2024-2025 with a shared vision for the Shropshire Safeguarding Community Partnership (SSCP) under it's tri-partite arrangements which include the safeguarding of children, safeguarding adults and community safety.

The SSCP is committed to increasing the safety and resilience of people in Shropshire (including children and adults with care and support needs) and their communities; in order to reduce harm caused by abuse, neglect and other crime.

What we do

Shropshire Safeguarding Children's Partnership is a range of partners coming together to safeguard children from abuse and neglect in Shropshire

Providing the foundation for the partnership are:

- our children and young people and their families, and;
- staff and volunteers working across social care, health and the criminal justice system.

The Partnership acts to seek assurance, scrutinise, challenge and ensure agencies are enabled to work together to achieve its vision

Priorities

From April to February the Partnership had 3 strategic priority groups set up to oversee the work. They were identified as joint priorities across the Partnership due to the impact on children, adults with care and support needs and our communities. They were the:

- **Local Domestic Abuse Partnership Board** (reported on in the Community Safety Partnership Annual Report 2024-2025)
- **Tacking Drug and Alcohol Misuse Group** (reported on in the Community Safety Partnership Annual Report 2024-2025)
- **Tackling Exploitation Group**

These priorities were revised in February 2025 – more on this later in the report.

Leadership and Management Arrangements

Lead Safeguarding Partners (LSPs) and Delegated Safeguarding Partners (DSPs)

In implementing Working Together to Safeguard Children 2023 the Partnership is working closely with the Telford & Wrekin Safeguarding Partnership to embed the Lead Safeguarding Partner (LSP) arrangements. Our LSP meetings bring together the LSPs from both local authorities along with the LSPs in the Police and Health, who have a footprint across both geographical areas.

Our Delegated Safeguarding Partners (DSPs) meet as a Safeguarding Executive Group. Both the Lead Safeguarding Partners and the Delegated Safeguarding Partners meet twice yearly. Membership of both groups along with the membership of the Children's Safeguarding Partnership can be found at the end of this report.

Our Structure

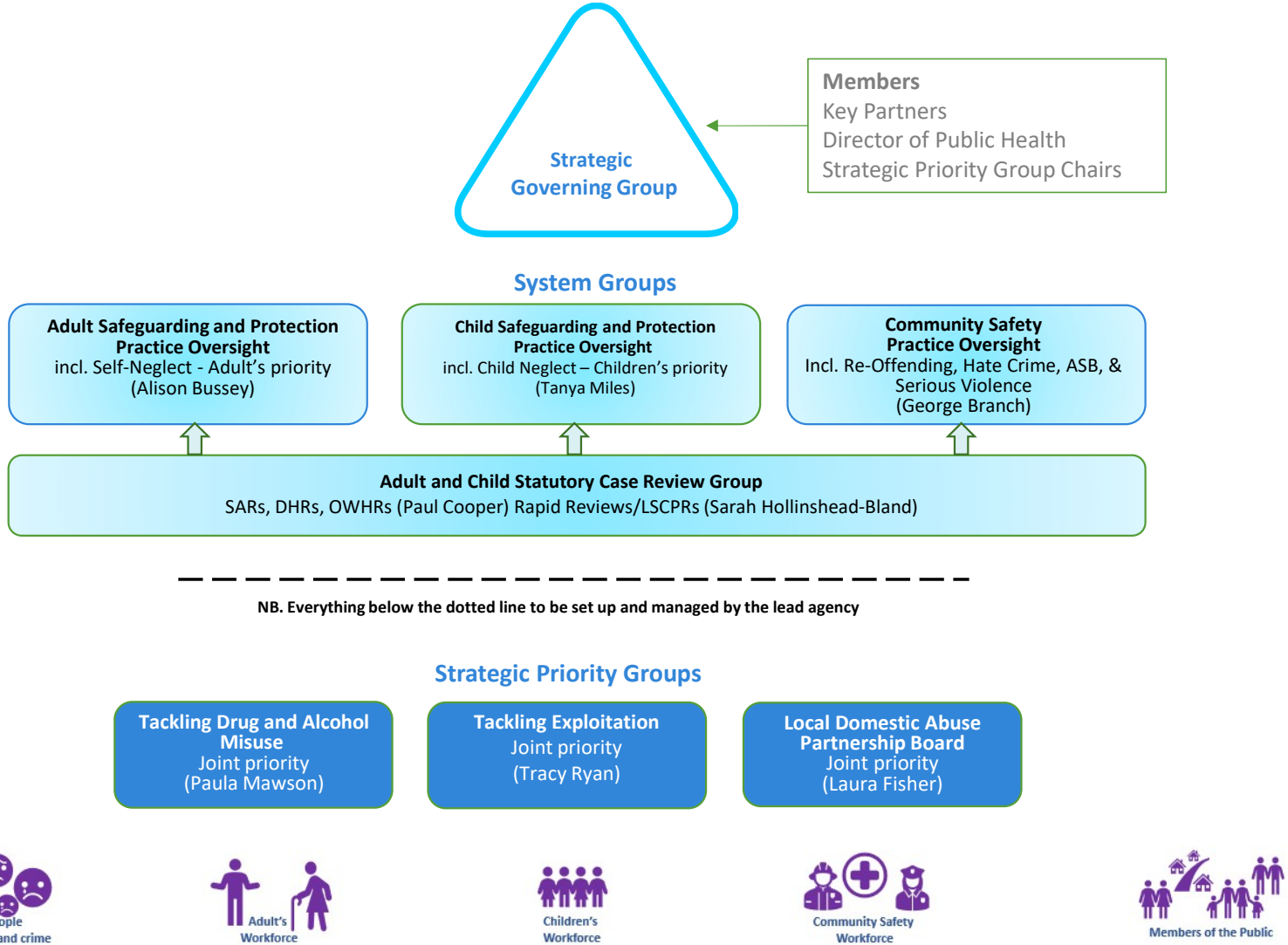
During 2024-2025 the Partnership reviewed its effectiveness and arrangements to enable a stronger focus on child safeguarding. A Children's Safeguarding Partnership began operating from July 2024 and replaced the previous SSCP Strategic Governing Group that oversaw the tri-partite arrangements. The Children's Safeguarding Partnership continues to work collaboratively with the Safeguarding Adults Board and Community Safety Partnership Board under the auspices of the SSCP. Our structure charts can be found on the next slide.

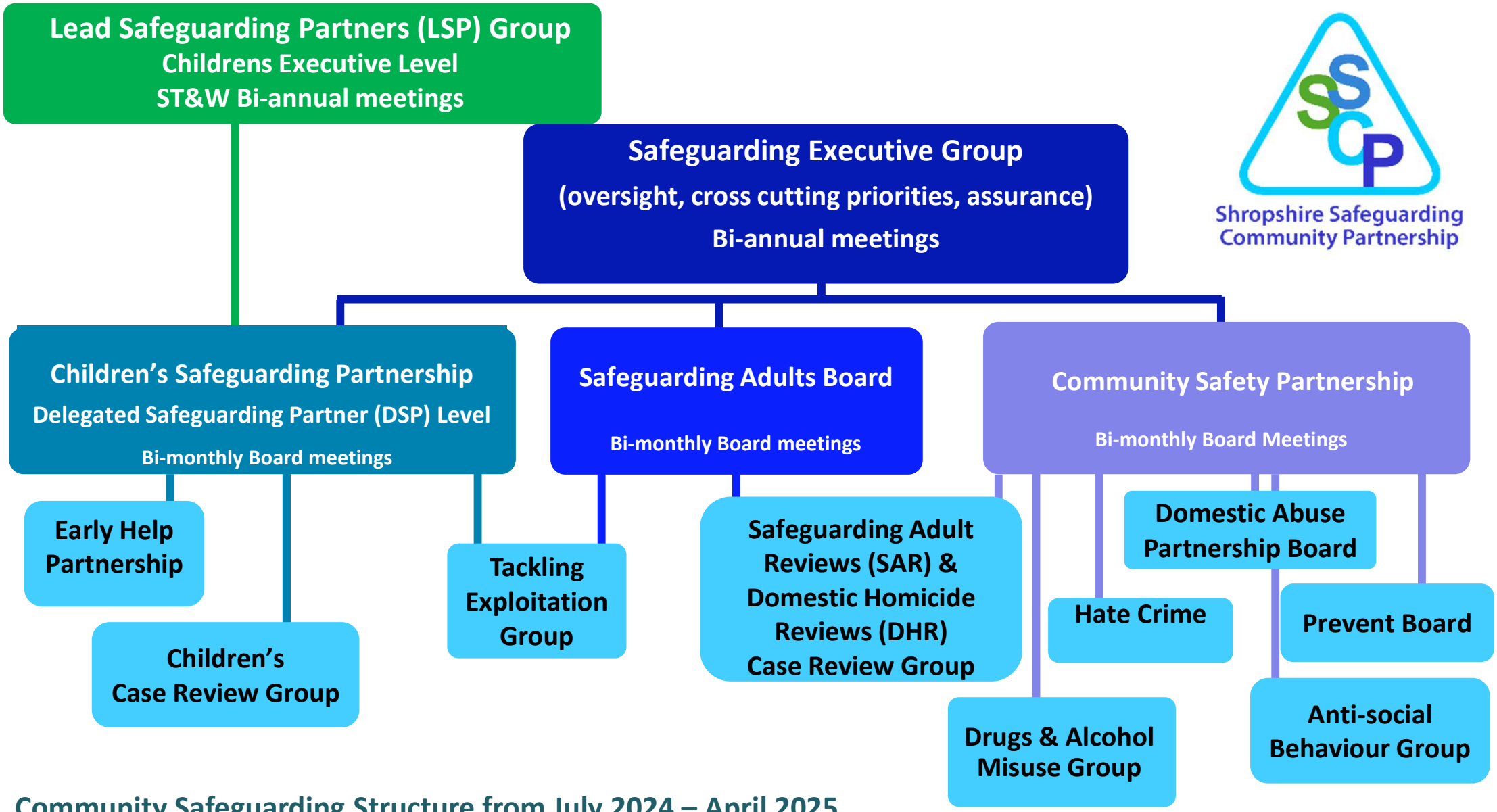
Business Unit

The Partnership is supported by a Business Unit which consists of:

- Business Manager
- 2 x Development Officers
- Learning and Development Co-Ordinator
- 3 x Administrative Support (2 x 0.6 FTE, 1 x 0.8 FTE)

Shropshire Safeguarding Community Partnership Structure
April 2024 – July 2024





Community Safeguarding Structure from July 2024 – April 2025

Funding for 2024/2025

Contributor	2024/25 % of expected income	2024/25
Shropshire Council	61.62%	£266,680
West Mercia Police	14.68%	£63,543
Integrated Care Board	22.28%	£96,420
West Mercia Youth Justice Board	0.51%	£2,190
Shropshire Fire and Rescue Service	0.71%	£3,070
Probation Service	0.20%	£869.33
TOTAL		£432, 772.33

The budget which funds the Children's Safeguarding Partnership is shared with the Adult Safeguarding Board and the Community Safety Partnership.

Other sources of income include contributions from local colleges and dedicated school grants, bringing in an additional £6,350.

Implementation of National Reforms

Governance

The partnership has undertaken the necessary work to develop a delivery plan and framework to implement Working Together to Safeguard Children 2023, including the necessary leadership through the identification of lead and designated safeguarding partners and the engagement with education representatives. We have reviewed and revised our governance structures to create a Children's Safeguarding Partnership and have moved back to meeting in person.

Strengthening role and representation of education and voluntary sector partners in safeguarding systems

There is growing recognition of importance of the educational sector involvement in our Partnership arrangements.

- The sector is now represented across all levels of the Partnership structure
- At a strategic level representatives sit on the Executive Group and have a voice in setting the direction and priorities of the Partnership
- There are strong links with the Education Partnership and specifically the Education Safeguarding Sub-group which enables Designated Safeguarding Leads to actively participate in partnership workstreams, contribute to practice and shape the safeguarding agenda
- The educational sector is also fully involved in the development and implementation of strategies, plans and priorities

The Partnership recognises the need to engage the voluntary sector in it's work and will work towards strengthening these arrangements in 2025-2026.

Enhancing scrutiny and accountability arrangements

The Independent Scrutineer role

- Evaluates and contributes to the revision of the multi-agency safeguarding arrangements and the annual report
- Provides oversight, challenge and assurance regarding the functioning of our arrangements
- Engages with a wide range of activities e.g. attends board meetings, observes sub-groups, review policies and procedures, scrutinises data and quality assurance processes, conducts deep dive investigations and provides recommendations for improvement
- Provides critical challenge to statutory partners and support
- Identifies areas for development and drives continuous improvement
- Supports the development of more robust data analysis and performance monitoring
- Encourages a culture of openness, challenge and reflection among safeguarding partners

Scrutiny arrangements form part of robust performance and quality assurance arrangements for the partnership. The partnership has developed a framework for the delivery of future independent scrutiny and is actively working on:

- Development of a Quality Assurance and Performance subgroup focussed on quality assurance, performance monitoring and the embedding of learning into practice
- A multi-agency case file audit framework
- Strengthening multi-agency data sharing and analysis
- S11 and S175 compliance audits
- Regulatory reports and inspections
- Independent scrutiny and accountability within single agency governance arrangements

Implementation of National Reforms

Shifting focus to early help, prevention and support for families

- In October 2024 a Health Workshop was held around Early Help which included the Local Authority and provider presentations.
- The Early Help transformation programme has worked at pace and delivered significant system change, without national funding or involvement in national change programmes.
- We are combining best practice in public health prevention in services to families to ensure that interventions are evidence based, and services are integrated.
- We are planning a Spotlight Session on Early Help and Prevention for 2025.

Updating policies, procedures, thresholds, practice standards and training to reflect new guidance

- We held a 'Turning the Curve' event in March 2025 focussing on practice and have delivered briefings for strategic leaders
- We have engaged with national facilitators and advisors to support the change process
- We have updated to procedures and training to reflect these changes
- We have developed comprehensive action plans
- We are currently undertaking a review of thresholds

The Effectiveness of Our Partnership Arrangements – Case Review Diagnostic

The Partnership commissioned an independent diagnostic review to conduct a deep-dive of a select number of statutory case reviews, aiming to identify broader patterns. The review sought to address the following key points:

- Investigate why recurring themes continue to emerge in case reviews;
- Determine, based on best practice evidence, local insights, and current measures, what changes are necessary to prevent these recurring issues in Shropshire, including additional actions required to fill existing gaps;
- Explore alternative approaches to effectively share and embed learning throughout the system;
- Identify the barriers to learning from statutory case reviews for practitioners and their managers

Case Review Diagnostic – Findings in Relation to LCSPRs

Findings	Action we have taken
Outstanding reviews: A significant number of reviews and action plans remain incomplete, some for a lengthy period of time, which impacts on the subjects of case reviews as well as professionals. Implementation of learning is hampered by these delays	We have commissioned 2 themed reviews for children's cases, rather than 8 individual CSPR's - neglect and sexual abuse; a 3rd review will be carried out by partners, looking at cross-border working. We had 17 action plans open, and we have since been able to close 5 of these.
Leadership and culture: Leadership within the partnership and individual partners including challenge, support and escalation, is not always effective. Resourcing limitations contribute to delays and issues re: application of learning.	We held a workshop for all review panel and subgroup members which gave agencies the opportunity to share their views of how the review processes and pathways could be improved, including how the partnership can scrutinise and be assured on an ongoing basis that the system is working as it should and take to remedial action as required and ensuring appropriate partner engagement. We have commenced the use of the child practice review log with a front sheet which gives an overview of the data, learning and headlines. The Partnership will reconsider an appropriate budget to conduct statutory reviews in 2025-2026.
The case review system: A core process for reviews is in place but needs development as it does not always work as effectively as it should. Some documentation, practice in reviews and decision making, and action plans needs to be improved. Opportunities for extracting learning at Rapid Reviews can be strengthened to avoid CSPRs where appropriate.	We have strengthened the process for decision-making and record keeping at the point of a serious incident notification. We have also revised the scoping form which agencies are asked to complete for Rapid Reviews, simplifying it and ensuring that the voice of the child and family is captured. A proposal to improve Rapid Reviews by statutory partners agreeing the themes to be discussed in the meeting has been considered and will be piloted in 2025-2026.

Case Review Diagnostic – Findings in Relation to LCSPRs

Findings	Action we have taken
Learning and development offer: There has been some strong learning events and materials produced. However, learning from reviews is impacted by the delay in conducting reviews, and systemic root causes or themes are not always identified. Application of learning is also hampered by some superficial actions in action plans, which the SSCP is aware of and is addressing.	We set up a multi-agency learning and development task and finish group to review aggregated themes and actions, map learning and development offers already in place across Shropshire. The group has planned learning and communications for the coming year, including different methods and resources for doing so. We have agreed how learning and development will include identifying need from case reviews and other evidence; and how we will evaluate impact. We have developed and delivered a series of webinars on learning from case reviews, and we continue to produce learning briefings.
Case reviews as a window on systemic approaches and themes and 'stem the tide' of reviews including earlier intervention and prevention: There are common themes from reviews that may suggest a systemic review of strategy and practice would be useful to improve practice and stop further referrals for statutory case reviews. For example: Think Family Neglect Information Sharing Thresholds Earlier intervention and consistency of effective safeguarding pre-social care. From the evidence and case reviews audited, the culture of safeguarding and prevention in some universal services appears to require greater attention so that issues are picked up earlier.	We have developed a learning log to capture learning and common themes from case reviews. This ensures that the right activities are in place where appropriate, to tackle any identified thematic learning from reviews, so that prevention and earlier intervention are more effective and consider all aspects of the systems framework (systems and processes; practice and practice knowledge; wide service context; leadership and culture). Planning is underway for a multi-agency Spotlight Session on Childhood Neglect for practitioners and managers. The Partnership thresholds document is currently under review.

The Effectiveness of Our Partnership Arrangements - Performance

We are continuing to develop our multi-agency dataset under our new arrangements with a focus on the following improvements:

- Inclusion of Health Visiting data
- Inclusion of number of referrals received from Adult Services into Children's Social Care
- The development of heat maps showing the geographical location of child safeguarding referrals to inform targeted interventions
- Assurance of the correct application of CSE and CSA markers
- The need to build a picture of the child's journey

Performance highlights:

What do we know	What have we done
We have seen a high number of children 0-5years coming into Children's Social Care	✓ Since the Children's Summit in 2024 which explored this issue with multi-agency professionals, we have seen an increase in health referrals, which has allowed for earlier support ✓ MACFA Children Looked After 0-5 years ✓ Transformation of Early Help Services and positive outcomes for children
For the first time since 2021 the number of children entering care is reducing and more children are being returned to their families	✓ This is positive and will be kept under review
Police referrals to Children's Social Care are still high which is concerning, and they spike during the school holiday periods	✓ Early Help Partnership to analyse two spikes in contacts from the police and do a dip sample audit for deeper examination. ✓ The Partnership to identify what youth provision is available in the community and what schools are doing effectively in term time, so that consideration can be given to replicating it in school holidays
Referrals resulting in No Further Action (NFA) are coming down, demonstrating a better understanding across the workforce of how to make an appropriate safeguarding referral and/or more appropriate use of Early Help services	✓ This is positive and will be kept under review
We have identified higher numbers of missing children. Lower numbers of Shropshire Children who are looked After go missing, however, a high number of residential children's homes are located in Shropshire and therefore other Local Authorities are responsible for children who go missing.	✓ The Partnership will continue to monitor missing children's data as we move into 2025 and will consider appropriate action

The Effectiveness of Our Partnership Arrangements

Quality Assurance and Performance Activity

The Partnership has carried out the following activity and will be convening a Quality Assurance & Performance Sub-group during 25/26, to review and assess multi agency safeguarding practice on the front and to support the embedding of local and national learning across the Partnership. The group will be key to further develop and support our continuous improvement journey.

Audit Activity

Section 11 Audits take place bi-annually so this year we have worked with the region to focus on planning for the 2025 audit.

We have undertaken 3 **Multi-Agency Case File Audits (MACFAs)** this year on:

- Children Looked After 0-5 years
- Pregnancy
- Children of Parents where Trigger Trio is Present

Child Safeguarding Practice Review Panel Reports

The Partnership has considered its response to each of the National Panel reports that have recently been published. Areas for improvement are actioned through the relevant sub-group with oversight of the Quality Assurance and Performance sub-group.

- Child Safeguarding Practice Review Panel Annual Report 2023-2024 - responses will inform future planning, including the Families First programme, and will be incorporated into the Partnership's single improvement plan.
- ''I wanted them all to notice'' - has led to planning for a MACFA on Child Sexual Abuse in 2025 to seek assurance that learning is embedded.
- Safeguarding Children in Elective Home Education – led to revisions of Shropshire's Elective Home Education Policy 2025

Multi-Agency Case File Audits (MACFAs) – CLA 0-5yrs

We saw a rise in children under 5 years coming into the care of the local authority, (Children Looked After - CLA), with no previous social care involvement. We wanted to identify if Early Help had been considered or offered to the families.

A dip sample audit was undertaken on 8 children and their families.

Good practice

- Some areas offered Early Help
- Joint visits between agencies took place
- Referrals completed appropriately
- Home visits from non-statutory agencies who were recognising concerns

Challenges identified

- Little evidence of early help support for parents when an unborn has a Child Protection Plan
- Agencies not recognising themselves as being part of Early Help
- Agencies not always recognising that a family may benefit from Early Help support
- Little exploration as to why families may not want to work with Early Help

Learning identified

- Ensure parents records are included in audit request; many agencies have little or no involvement with the baby
- Need to strengthen the audit template
- Audit did not appreciate wider agency involvement, (for example housing/probation)
- Unclear whether practitioners utilised the Threshold document

MACFA - Children of Parents where Trigger Trio is Present

A multi-agency case file audit was conducted on 10 children and their families where there were parental mental health needs, substance misuse and domestic abuse present (the Trigger Trio). All cases had reached the stage of pre-proceedings for a Care Order to be granted by the Court.

Learning identified

- Reminder that all agencies can refer to MARAC
- Rationale for down-grading Domestic Abuse Risk Assessments (DARA) by the Domestic Abuse Reduction Officer (DARO) was not clearly recorded
- Clinical supervision forms in MPFT amended to ask direct question about the men in a child's life
- Too much reliance on parental self-reporting and information not being triangulated
- How do we support women who have no choice but to go back to a relationship due to coercive control?
- How are people informed and supported to access the Domestic Violence Disclosure Scheme (DVDS), also known as Clare's Law?
- Conversations need to take place with fathers who are domestic abuse perpetrators, about their joint responsibility to safeguard the child, so not all the responsibility is placed on the victim, the non-abusing parent
- Chronologies are not used effectively to inform decision-making
- There is not a clear pathway for Education Welfare Officers to follow when a child becomes Looked After
- PITSTOP is not always aware of the mental health needs of families, as MPFT are not a member
- PITSTOP outcomes are not always recorded on agency records
- Escalation is not always timely

Good Practice

- Good use of announced and unannounced visits by both MPFT and EAS
- Good single-agency working to support parents
- Some parents working with With You were able to abstain from substances
- Good continuity of care in one case with only 2 MPFT Care Co-ordinators for father
- Agencies were able to identify single and multi-agency learning

Overall Grades:
All audits were rated **Good** with some areas of **Requires Improvement**

Multi-Agency Case File Audits (MACFAs) – Pregnancy Audit

We identified a potential risk of pregnant women not being referred to the appropriate services within a timely way, to ensure the right support is offered to mothers, fathers and unborn children.

4 women were identified and the details shared with agencies to identify their involvement, including when their current pregnancy was disclosed.

Good practice

- Local authority contacting the midwifery team within SaTh for information sharing
- Housing shared information to Children's Social Care when a pregnancy was disclosed
- Checks carried out with health teams
- Appropriate referrals for mother completed once referred to maternity services
- Father's records reviewed to confirm no disclosure made by him, when being seen by a professional

Challenges identified

- When pregnancy disclosed, no apparent professional curiosity or checks made to ascertain if this is correct.
- Unclear if background checks were made of unborn siblings to identify any concerns or risks
- When professional is aware of the pregnancy, did they review their records to ascertain any risks or vulnerabilities
- Lack of a whole family approach, therefore risks were not identified

Learning identified

- To ensure when a child/children are placed in the care of the local authority, that information is shared with the parents GP, so information can be added to their medical records.

A Focus on Early Help and Prevention

Why?

- An independent review of Early Help in 2023, indicated that significant change was needed in Early Help services to prevent children needing services.
- Rising numbers of children aged 0-4 years coming into the care of the Local Authority.

What?

- Full transformation of Early Help Services, with a new structure implemented June 2024.
- Creation of integrated Community and Family Hubs across the county with no additional national funding, developed collaboratively with public health.
- A new Early Help Strategy, launched in July 2024 developed with partners, both statutory and in the voluntary sector.
- A new 0-4 team and pathway developed with public health nursing services and midwifery – Focus on the first 1001 days.
- Focused 12-week intervention model in working with families.
- Embedding of EHAST (Early Help & Support Team) working with families to provide early advice and guidance reducing NFAs.
- Whole system multi-agency summit on 0-4 years, resulting in earlier referrals to Early Help and Children's Social Care
- 'Turning the Curve' workshops, with both system leaders and practitioners to create whole system change.

Outcomes

- Significant transformation of services.
- Reduction of demand into the front door diverting families away from a social work intervention. Only 4% of children open to Targeted Early Help (TEH) were escalated for a Social Work Assessment in Q4.
- 365% increase in families attending local Hubs in the last 12 months, from 249 families in April 2024, to 1159 families by end of March 2025.
- Early Help Contacts have significantly increased and have remained at over 100 children per quarter.
- EHAST have worked with 667 families of which 25 stepped up to TEH, which is only 3.75% of the cohort, with an average intervention of 9 days.
- Potential grant funding for the year 2024-2025, we exceeded the target of 456 and managed to achieve a total of 536, so an achievement of 118% of the funded target.
- Over 2000 young people replied to our Youth Survey and have been heard, with their views represented in our Youth Strategy

Future Planning

- Implementation of the Families First Programme, to ensure that all families have access to integrated services at the earliest opportunities, with seamless localised support.
- Phase 2 of the Community and Family Hubs, including outreach and alignment with neighbourhoods, is continuing with change the curve.

Community and Family Hubs

Working collaboratively with Public Health, we have increased the Early Help Offer, from Universal to Targeted through the Community and Family Hubs. A hub and spoke approach with co-located services, ensures that rural and isolated children, young people and families are supported.

Early Help Impact and outcomes

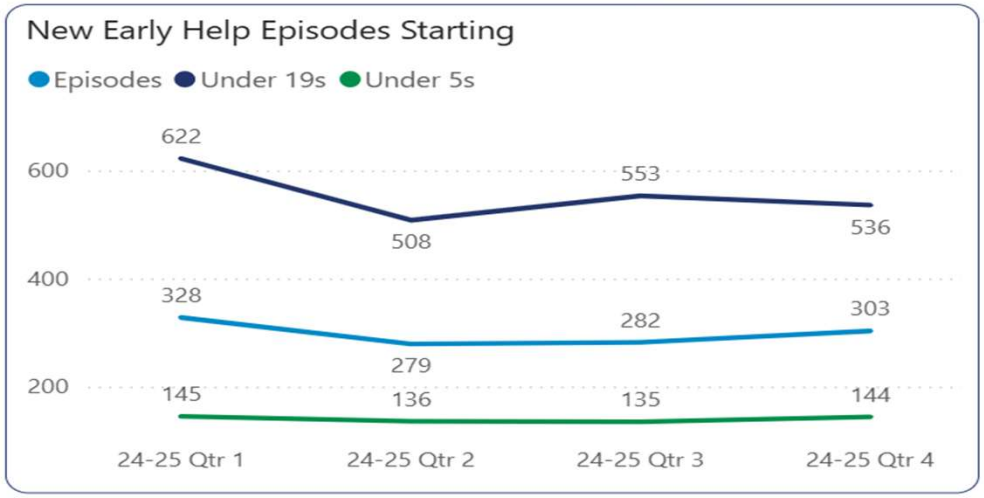
- The average length of Targeted Early Help interventions has reduced slightly, averaging out at 134 days per intervention over the year 2024-25.
- There has been a 31% increase in families worked within Targeted Early Help, compared to the previous years' increase of 83%. We believe this increase is due to process changes following transformation and we expect the figure to level out over the coming years.
- 81% of parents rate the services at 9 or 10 on a 10 scale, which is a big increase from the previous year's 73% in 2023/24 and 57% from 2022/23.

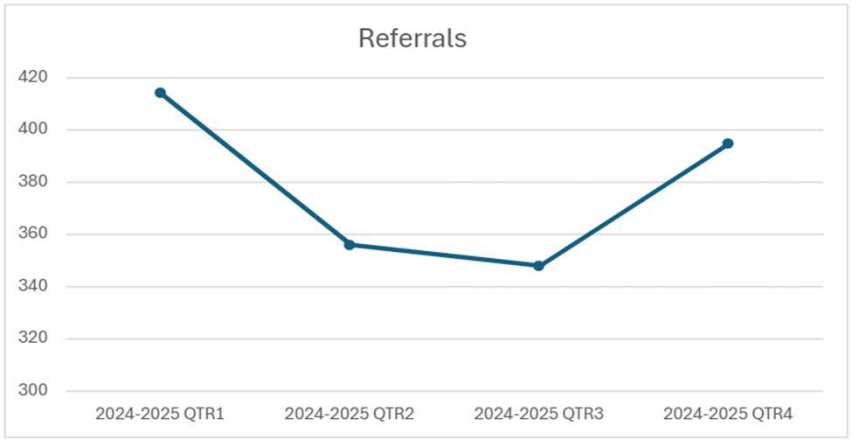
Benchmark for Success – Impact of Early Help

Following our investment in Early Help Transformation, we are seeing the impact for children and their families through trends in our data.

This includes:

- An increase in the number of Early Help interventions commencing.
- An overall reduction in the number of referrals into children's social care as early help services, universal services and the community become even more engaged in supporting families with the right service at the right time.

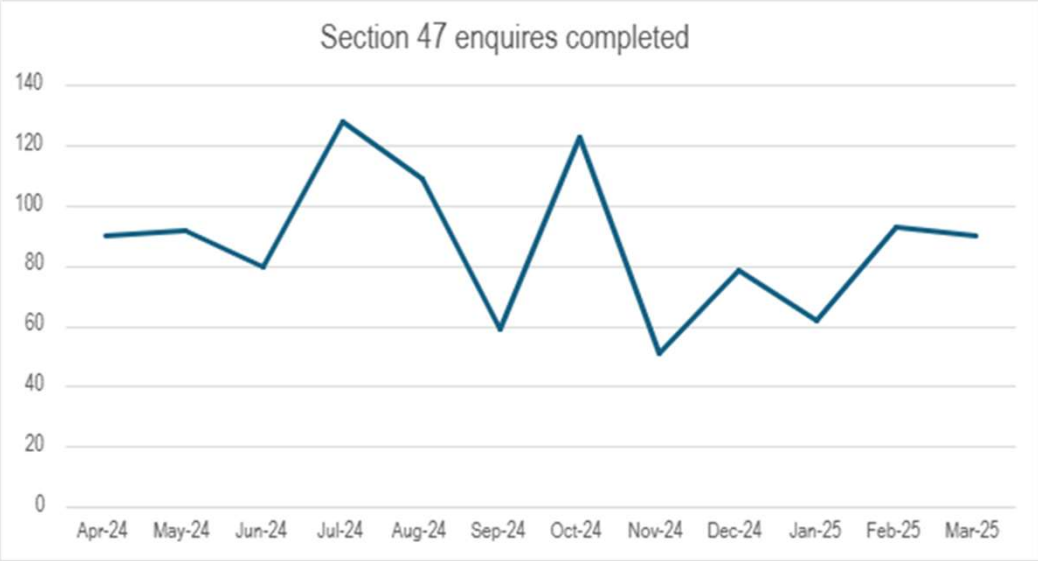




Section 47 Investigations

Section 47 Investigations take place following a Multi-agency Strategy discussion, where all relevant information about a child or young person that could be at risk of significant harm is considered.

The graph to the right shows that we continue to see variation in demand, with spikes often around the time of school holidays. This is an expected variation in demand nationally and evidences the importance of the relationship's children have in schools and how they act as a protective factor for them.



Children Looked After Overview 2024 – 2025

Demand

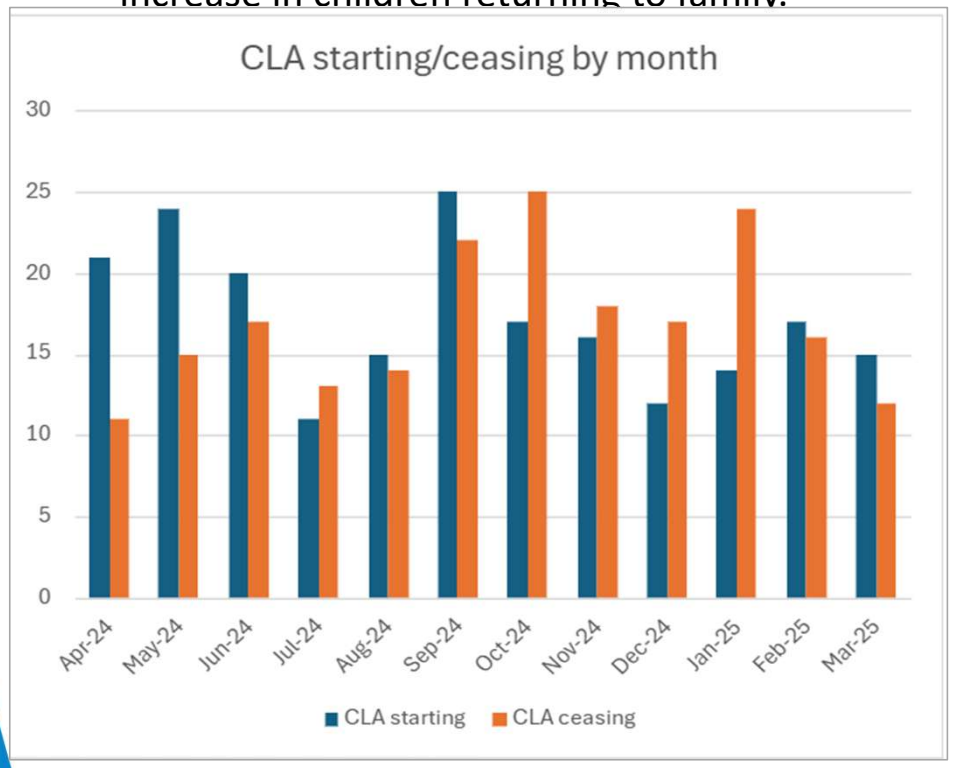
- Children looked after (CLA) numbers had been on an increased trajectory since 2017, with a notable increase at the start of the Covid-19 Pandemic coupled with unaccompanied asylum-seeking children under the National Transfer Scheme (NTS).
- "Last 50 CLA" audits are undertaken periodically throughout the year, to review decision making and assure ourselves that the 'right' children are becoming looked after. We are assured that all the children becoming looked after are doing so appropriately and, over 2024/25 our QA work has highlighted a reduction in incidents of drift and delay, prior to becoming CLA, with robust management decision making and effective escalation.

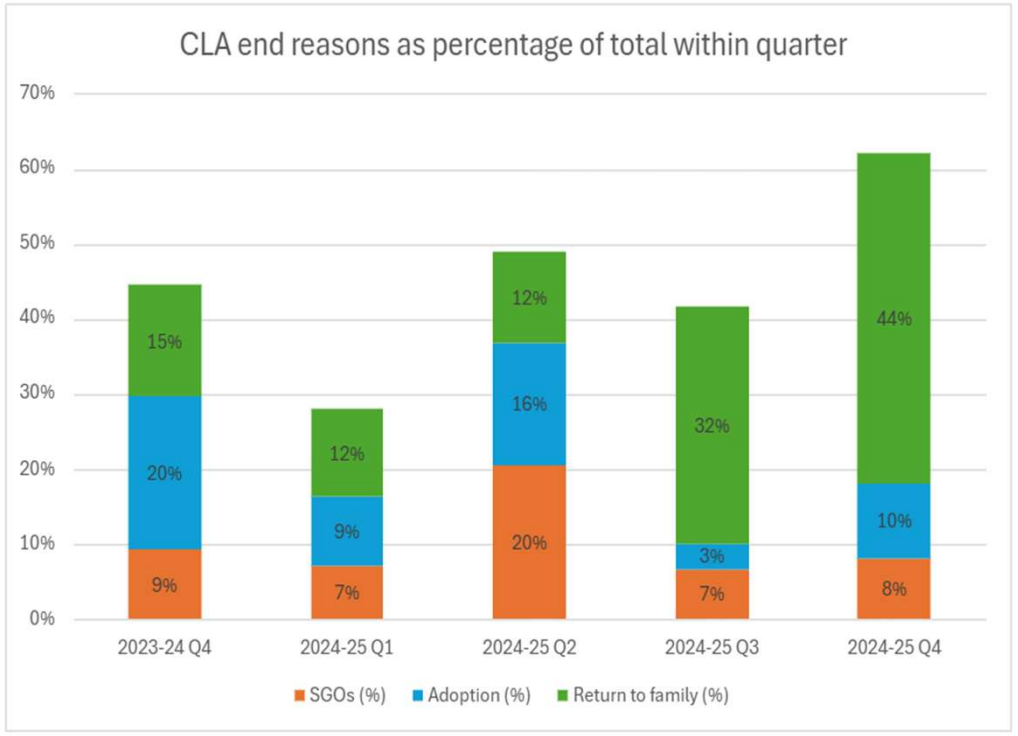
Families

- We will always look to maintain or reunify children with their birth families where this is safe to do so implementing the Stepping Stones and PATHS interventions that deliver direct work to support families being successful in these circumstances and securing children back with their families.
- We will always seek to reduce state intervention in family life whilst maintaining support for them. For example, revised Special Guardianship Order (SGO) offers.
- We work hard to keep siblings together and maintain lifelong links where this is not possible
- Always try to create a family environment wherever child is living and maintain links with family

Children Looked After outcomes

In the last 12 months, we have seen a gradual change in children and young people becoming looked after and those existing local authority care with a focus on positive outcomes, such as the increase in children returning to family.





Police Protection

What do we know

- Shropshire's rate of children being taken into Police Protection was higher than the West Midlands as a whole. West Mercia Police advised it was approximately 30% higher (as of January 2025).
- A joint audit (Police, CSC supported by the DfE) was undertaken in January 2025 to further understand the practice in this area.
- We dip sampled 6 children, scrutinising each agency record held on each child and viewed the police body cam footage, where available.

What are we doing to improve

- Developing a summary of key issues around using police protection for police notebooks. (West Mercia Police);
- Collaborating with police on warrants and ensure social work support is available;
- Ensuring police contact children social care before using police protection, especially during the day. (West Mercia Police);
- Updating the police protection protocol;
- Briefing Emergency Social Work Team (completed 31/03/25);
- Improving communication with police to ensure they understand that children are the responsibility of children social care, not the police. (West Mercia Police, Children Social Care)

How do we know it

The audit highlighted the following key learning:

✓The joint protocol was not being consistently applied;

✓The police station was being utilised inappropriately as a place of safety following the PP, for most children;

✓Missed opportunities to explore with parents/carers their wider family/friend's network, as an alternative to the PP;

✓Inconsistencies between CSC response of core hour teams and ESWT;

✓Lack of joint decision making between CSC and Police

Impact and Outcomes

Following the joint audit there has been a significant decrease in the use of PPO and we are now in line with the other West Mercia regions. Where PPO has been used, this has been appropriate.

West Mercia Police advise that the numbers continue to be in line with other policing areas, which shows the positive impact following the joint audit undertaken in January 2025.

We are demonstrating restorative practice with families and working in partnership with them – doing 'with' rather than 'to'.

We are keeping children within their families and/or family networks, where is it safe, appropriate and proportionate to do so.

The Effectiveness of Our Partnership Arrangements – Sub-Groups

Neglect

We have reconvened our Neglect sub-group who have implemented the following:

- ✓ Planning for the **Spotlight Session** in 2025 on Childhood Neglect
- ✓ Considered **multi-agency performance indicators for the dashboard**
- ✓ Established a task and finish group to **review the neglect guidance, screening tool and use of Graded Care Profile 2**
- ✓ **Sharing of good practice and case studies**
- ✓ Sharing of the **Educational Neglect guidance**

Impact summary – Case Study

Following concerns for a child's welfare a request for consultation was made to the Integration Consultation Panel (ICP), and the family were allocated a Targeted Early Help worker. The intervention has achieved positive outcomes for the child and family, and their feedback is detailed to the right.

The Effectiveness of Our Arrangements – Sub-Groups

Child Sexual Abuse

We convened a Child Sexual Abuse task and finish group who have implemented the following:

- ✓ Considered our response to the Child Safeguarding Practice Review's Report **"I wanted them all to notice"**
- ✓ Resolved operation issues with the **Child Sex Offender Disclosure Scheme**
- ✓ Raised awareness of the importance of **collaboration and information sharing** among professionals
- ✓ Contributed to the development of a regional **Child Sexual Abuse Response Pathway**, which will include recognition, response, and strategy elements around sexual abuse

The future of the Child Sexual Abuse task and finish group will be considered by the Partnership in 2025 following the roll out of the **Child Sexual Abuse Response Pathway**

The Effectiveness of Our Arrangements – Sub-Groups

Tackling Exploitation

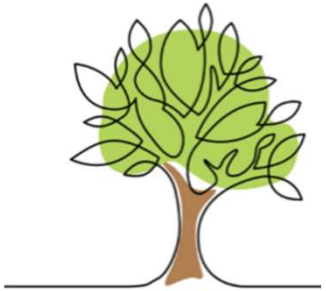
The sub-group has implemented the following in 2024-2025:

- ✓ Consideration of the **Independent Inquiry into Telford and Wrekin Child Sexual Exploitation (IITCSE)** to help inform areas of focus, as a bordering Partnership area and learning of national interest
- ✓ **West Mercia Police conducted a test purchasing operation** in Shropshire hotels as part of a national operation. National feedback is awaited on actions to be taken
- ✓ Consideration of establishing a task and finish group across Adult's and Children's Services to explore **transitional safeguarding**
- ✓ **Exploitation triage** continues to meet twice weekly to consider all Child Exploitation Risk Assessments and police intelligence regarding exploitation.
- ✓ **Child Exploitation Panel** is held once a month. Actions for the Partnership are identified, focusing on developing the work force and disrupting exploitation within Shropshire

Impact summary

The Trees Team (Together Reducing and Ending Exploitation in Shropshire) reports the following impact:

- ✓ Fewer children coming into care as police now have a shared understanding that removing children from their families does not decrease risks (it can often increase risks). We therefore, no longer have children subject to police powers of protection (unless this is used as a disruption to safeguard the child);
- ✓ Where children and families do need to relocate, we have excellent relationships with housing and through their support can put in place safeguards that are needed and move families quickly;
- ✓ We have prevented children from becoming permanently excluded from school/college, as we know this can increase risks to children and young people;
- ✓ We have kept children at home and avoided them having to come into local authority care, where often this would mean residential care, given the complexities around risk. We have worked with well over 100 children and less than 10% have needed alternative accommodation



Partnership Highlights – Turning the Curve

In November 2024 the Partnership Board considered the current system challenges facing Shropshire as a 'place' for children and families who require help and support to achieve good outcomes. It acknowledged the ever-increasing complexity of need, higher demand for services and critical resource challenges, facing the whole partnership. It was agreed that two initiatives would be rolled out:

A **'Turning the Curve'** event took place in March 2025, working with the DfE National Facilitators for Health and the Police, to work with us on sharing our ambition and vision for a truly integrated system for helping to safeguard and protect children. Senior, middle and operational managers from a wide cross section of agencies actively engaged in the event, sharing their views on what needs to be done, in an open and honest way. We shared real examples of practice that is outstanding and examples of what we know is getting in the way of this being the norm for all children and families.

Collectively we reaffirmed our shared ambition to:

- have a single integrated system
- support the well-being of and protect all children from significant harm inside and outside of the home
- have a system with children and families at the heart
- for our work to be influenced by children and families' voices, and
- for Shropshire to be the best place for children and families to live and grow.

Partnership Highlights – Turning the Curve

We agreed our transformed system will:

- deliver a child friendly Shropshire
- with consistent 'good and outstanding' outcomes for children and families
- receive positive HMI / Ofsted / CQC ratings
- see service responses influenced by accurate shared data and analysis
- see more children able to live with their families
- see more suitable family placements - foster or kinship care
- include a skills mix within multi-agency teams
- deliver effective Early Help with evidence-based practice and partnerships with families
- effectively deploy resources across the partnership, and
- embed a restorative, strengths-based practice model

An action plan from the 'Turning the Curve' event has been developed with some quick wins and longer-term strategic actions for the Partnership to consider and implement as part of the Children's reform work during 25/26.

Spotlight Sessions

The Partnership commissioned a safeguarding consultant to work with us to develop and implement four half day sessions for a range of relevant partners, including strategic leaders. These events, planned for 2025-2026, will focus on obtaining a better understanding and scrutiny of what the current provision is around key themes identified from the diagnostic review of statutory case reviews and will implement a plan of improvement.

The first event will be on **Childhood Neglect** with the purpose of:

- providing information about childhood neglect and Shropshire's evidence base
- gathering information from attendees about what they think is working well, could be better, and map interventions/services we have to tackle neglect and
- agreeing what needs to happen next to improve our leadership and practice in tackling neglect and to inform revisions to our Neglect Strategy.

The 3 further Spotlight sessions will focus on the following:

- **Hidden Harm**
- **Modern Day Risks**
- **Prevention and Early Intervention**

The outcome of these events will be reported in next years' annual report.

Learning from Child Safeguarding Practice Reviews (CSPR)

In 2024-2025 the Partnership received **5 Rapid Reviews referrals, involving 15 children.**

All 5 Rapid Reviews led to a decision to undertake a Local Child Safeguarding Practice Review.

LCSPR	LCSPR	LCSPR
Ivy Ivy is a 4-month-old baby. Whilst seeing her GP the doctor noticed a lump on the left side of her rib cage and noted that her mother smelt of alcohol. A Child Protection medical confirmed a number of non-accidental injuries.	**Family 1 (Formerly known as Powell)** The children's father/stepfather was arrested under the Obscene Publications Communications Act 2003. The Police found the family home in a poor state; overcrowded, dirty and cluttered. There were concerns the children weren't being appropriately educated at home. There were concerns that the children have been exposed to significant emotional harm, neglect and have suffered physical and sexual harm, over a prolonged period.	**A Shropshire School** Children's Social Care were contacted by the Designated Safeguarding Lead at the school who shared information regarding peer bullying and abuse.

These reviews are on-going and the learning will be published in next years' report.

Joint Family Reviews - combined CSPRs and Safeguarding Adult Reviews (SARs) commissioned due to the vulnerabilities of both adults and children in these families

Joint LCSPR and SARs
Family A (previously known as Family Pugh) This referral was received in December 2022, following the death of the children's mother. Concerns were raised about significant self-neglect by the mother and then the impact of this on her two children, who were caring for her.
Family B (previously known as Family Jones) Mid May 2023, West Mercia Police were contacted by a member of the public reporting a young boy running in the street naked. Police attended and located the child. He was identified as Mrs Jones's 11-year-old son. He was taken back to his home address. On arrival, officers discovered his mother had been taken seriously ill and she later died. Officers recorded that the property was in an abysmal state.

These reviews remain on-going and the learning will be published in next years' report.

Jasmine

A referral was received at the end of the financial year 2022 for a 16-year-old child who was looked after and at risk of exploitation.

Child U

A referral was received in August 2022, for a four-week-old baby with a head injury, which was suspected to be non-accidental. The statutory partners felt that all learning had been identified during the rapid review, however after discussion with the Child Safeguarding Review Panel, it was agreed that a LCSPR should be undertaken.

LCSPR Cross-Border Working Thematic

Darren

On collecting Darren from his father's home his mother noticed some bruising under his chin and bruising on both of his legs. During a Child protection medical the consultant paediatrician noted multiple, suspected non-accidental injuries.

This thematic review includes the 3 children outlined and remains on-going. The learning will be published in next year's report.

LCSPR
Neglect Thematic

Family 1 (previously known as The Powell children)
The children's father/stepfather was arrested under the Obscene Publications Communications Act 2003. The Police found the family home in a poor state; overcrowded, dirty and cluttered. There were concerns the children weren't being appropriately educated at home. There were concerns that the children have been exposed to significant emotional harm, neglect and have suffered physical and sexual harm, over a prolonged period.

Family 2
A referral for a Rapid Review was made in June 2024 for a 2-year-old with a burn to her foot. Her parents had not sought any medical attention.

Family 3 (previously known as Peter)
The Police made a referral for a Rapid Review, after a visit to his home following reports of shouting and screaming coming from the house. Police witnessed Peter's mother letting him out of a wardrobe; he had visible injuries. Peter was asked how he got the injuries, and he said he had fallen off his bike.

This thematic review includes the 3 families outlined and remains on-going. The learning will be published in next year's report.

1. What happened

The review explored agency involvement with siblings M and N. M was in Secondary School and N was in Primary School.

M, the older sibling, had learning difficulties and died from Septicaemia.

Following M's death it was found that conditions within the home identified neglect towards the children and N the younger sibling went to live with foster carers.

2. Consider historical information

When agencies hold historical information about circumstances or events that indicate a risk to a child the information should be:

- made available to professionals working with the family
- actively sought out by those involved
- considered if new information or concerns arise
- used to inform assessments including risk assessments

3. Listen to concerns from the public

When agencies receive information from **members of the public** about children who may be at risk of harm then this should be given **appropriate weight** of importance as information provided by professionals.

Information from members of the public should be **followed up** and **further information sought**. Information **gathering** is different to sharing information.

Support and signpost the public to other services that can help if needed.

8. Keeping contact during COVID 19

Neither child was considered to be a vulnerable child who needed to be in school during Lockdown according to their school's risk rating.
If a child is not in school due to COVID 19 restrictions schools should work with other involved agencies to agree their risk rating. The **rationale** for this rating must be clear and reviewed.
Ensure there is **direct contact with the child** and do not rely on pre-recorded information from parents. Use the Assessment Practice learning resource for good assessment practice guidance.

Shropshire Safeguarding Community Partnership

4. Safeguarding Lead Competence

The person who has the responsibility for overseeing Safeguarding within a team or agency should have the **appropriate knowledge and skills** to fulfil this role.

The Safeguarding Lead should also ensure their role is understood by the staff team.

Safeguarding Leads should receive regular management oversight to ensure they that they are **supervised and supported by the agency** and not working alone.

7. Use Neglect screening tool & GCP2

Practitioners should use the **Neglect Screening Tool** as soon as there are early indicators of Child Neglect.

The Graded Care Profile **(GCP2)** helps practitioners identify when poor parenting has become neglectful. It is a licensed tool so only those trained in using it can do so.

6. Use Education, Health and Care Plans

When a child has an Education, Health and Care Plan they must be **updated annually** with relevant information about the child's educational aspirations, their health and social care status including any concerns that are being investigated.

Plans should also show how agencies **will work together** to support a child to achieve their potential.
If a child regularly misses school then professional curiosity should be applied. The Plan should inform how absences will be addressed.

5. Ensure good safeguarding practice

All staff should have access to **up to date** safeguarding training, this will help to build confidence in raising concerns.

The **chronology guidance** should be followed.
All safeguarding concerns should be **made in writing** and information shared with the Safeguarding Lead.
Decisions about information sharing and taking action relating to safeguarding concerns should be **taken with Management oversight.** Decision making rationale and action should be **recorded** at each stage.

Children M & N

Local Child Safeguarding Practice Review
Practitioner's Learning Briefing

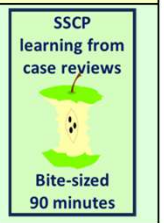
Multi-Agency Training

The SSCP Business Unit deliver multiagency learning from case reviews and have an overview of delivery of SSCP Raising Awareness in Safeguarding and Protecting Children training across Shropshire.

All multiagency learning includes local safeguarding arrangements and is informed by the findings of local and national reviews, emerging themes, trends and guidance, and workforce needs.

Delivery of the Learning from Case Reviews

Staff and volunteers who work with children, adults and community roles across our safeguarding and community safety system, attended the following learning events during this financial year.

Title of learning event	Webinars	Attendees	Length
Understanding Intrafamilial Abuse	3	153	
Domestic Abuse Homicide and Suicide	2	87	
Why don't men come forward	3	113	
Voice of the person	1	33	

SSCP Training Delivery

Title of learning event	MSTeams meeting Sept-Dec	Attendees	Length
Training pool meetings	8	160 (approx.)	1 hour
Raising Awareness	2	32	3 hours
Title of learning event	**In Person**	**Attendees**	**Length**
Train the Trainer	3	18	2 days
Training Pool meeting	1	22	1 day
Raising Awareness	2	15	3 hours

Training	Sessions	Attendees	Length
Raising Awareness in Safeguarding and Protecting Children	221	3243	2-4 hours

Learning from Case Reviews - Multi-agency Reflections

Remembering about professional curiosity always! Timely information sharing and not being scared to share information and act upon it. **Voice of the Person**	That we should never make assumptions, always speak appropriately to families and be mindful how easily people can lose trust in services **Voice of the Person**	the importance of checking in with other professionals and asking for advice and guidance from their knowledge and experience **Voice of the Person**
No matter which agency is involved, challenges and the want to make a positive influence remains the same theme **Voice of the Person**	That having conversations with families and victims can be difficult and that this is familiar to all professionals. **Understanding Intrafamilial Abuse**	There are various aspects to D.A that some survivors don't even recognise as abuse and a lot of barriers to reporting **Understanding Intrafamilial Abuse**
Professional curiosity perhaps isn't curious enough **Understanding Intrafamilial Abuse**	being aware and not being closed minded about my role. Being curious. and being knowledgeable. **Domestic Abuse – Homicide and Suicide**	Understanding our own bias. Importance of working together with other agencies **Domestic Abuse – Homicide and Suicide**
Professional curiosity around presentation, demeanour, mental health and or substance misuse **Why don't men come forward**	To challenge unconscious bias and not to make assumptions **Why don't men come forward**	To be more aware of and delve deeper (invisible) men and their lived experience **Why don't men come forward**

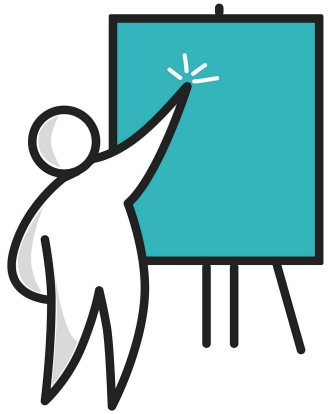
SSCP Multi-Agency Training Pool

SSCP Training Pool members are Designated Safeguarding Leads and experienced safeguarding trainers from a wide range of agencies throughout Shropshire. There are currently 76 trainers within 46 organisations, representing diverse agencies from statutory, voluntary and independent organisations throughout Shropshire.

The SSCP Learning and Development Co-ordinator plans a programme of Training Pool meetings to ensure that regular safeguarding updates are received. All trainers receive training resources to deliver within their agencies including Raising Awareness in Safeguarding and Protecting Children presentation, lesson plan, certificate, evaluation template, and information about local safeguarding arrangements to share with each learner.

The impact and reach of the Partnership to raise awareness about Safeguarding and Child Protection Training across Shropshire is only possible because of the dedication and enthusiasm of the professionals who make up the Training Pool.

33 trainers delivered training in 2024-2025. 133 sessions were delivered face-to-face, and 88 training sessions were delivered either face-to-face or virtually.



Impact Summary

Attendees consistently feedback to both training delivered by training pool members, and the Learning and Development Coordinator, that they appreciate the knowledge of trainers and the interactive methods used to engage them with the content. Resources that include local safeguarding arrangements are well received.

Leaders can be assured that safeguarding messages through training and learning events are consistent across Shropshire, highlighting local issues and supporting staff in responding effectively to children and their families.

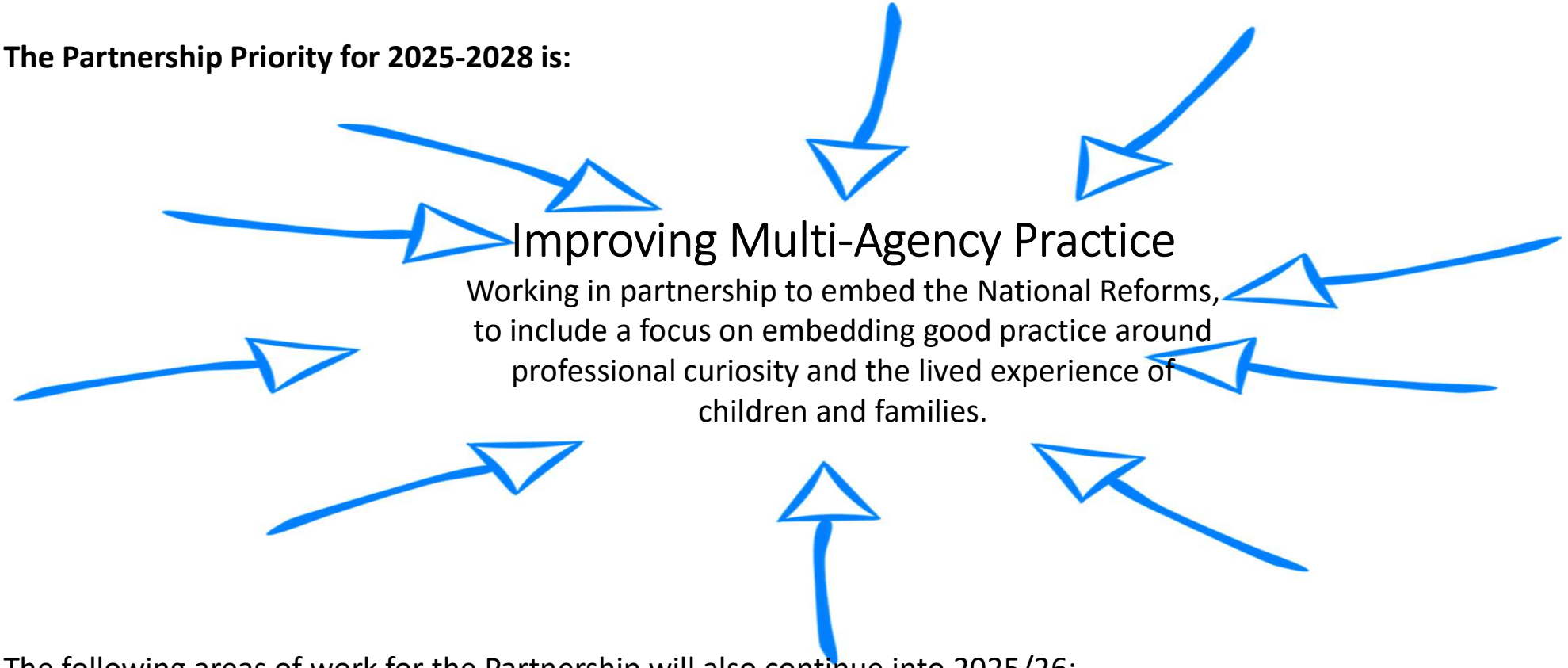
Reflections from Multi-Agency Learners

What to look for when working with young people. How to report concerns.	*Enhanced awareness of the different categories of abuse and how best to identify them.*	*Specifically wanted training related to our local area and the information given was exactly what was needed.*	*Padlet was really useful I am going to go away and read the handouts and make notes. Thank you for the knowledge and insights provided*	*I will now know how to respond when a child discloses something of concern. I will be on the alert for possible signs of abuse*	*Found the training useful. Especially the updates to County lines and how it can impact a family and the signs to look out for*
Made it relevant to me as a professional and as a parent/grandparent	*Videos were informative although hard to watch but gave real context to it all*	*Have more of a critical 'it could happen here' approach to safeguarding.*	*With colleagues we looked up the urban dictionary and it made us really think about the language we used*	*Approach my work with more of a questioning mind when coming into contact with the young people I see*	*Clear on threshold doc, that Safeguarding is everyone's responsibility, how to record a disclosure and helped raise awareness with regards affluent neglect*
Really good informative, engaging and strangely enjoyable	*Listening to real life stories so that topics were extremely relatable*	*Thinking of ways to rework our own safeguarding policy to be more robust.*			
The course leader allowed us to discuss issues which were relevant to our particular setting. These were interesting because we had examples of practical application of the knowledge and learning	*I will now know who to contact if I have concerns about a child. This is so important when working with children. I was shocked that so many children are receiving help in Shropshire because of neglect*	*The concept of disguised compliance was new to me. I have found it extraordinary the variety of forms of abuse and signs to watch out for. I will be more vigilant as a result*	*Refreshed knowledge and updated info for Shropshire specifically*	*Terminology and local statistics, information that I was not aware of*	*The different types of neglect a child can experience and how they can all relate*
			All of this was an eye opener as I'm new to working with children	*AI was a strong discussion topic*	*Excellently delivered concise detailed and engrossing*

Priority Setting

The Partnership held a Priority Setting Workshop in February 2025 to agree the strategic plan for the next 3 years.

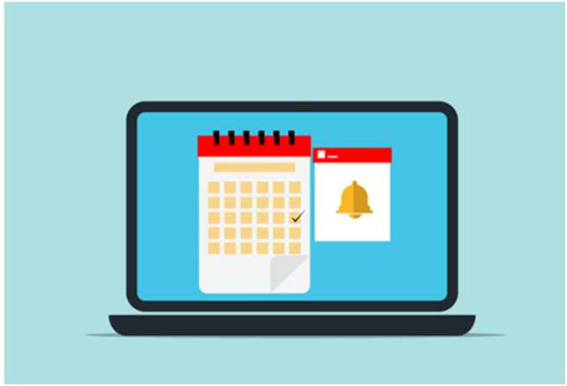
The Partnership Priority for 2025-2028 is:



The following areas of work for the Partnership will also continue into 2025/26:

- Child Sexual Abuse
- Neglect
- Exploitation

Partnership Focus for 2025-2026



As we move into 2025-2026 the Partnership will keep the momentum going around its transformation work under its new priority of **Improving Multi-Agency Practice.**

Learning and challenges outlined in this report will shape our plans for the coming year. We will continue to embed learning from the Independent Case Review Diagnostic and our other assurance activity.

We look forward to bringing multi-agency partners together at the planned Spotlight Sessions in 2025 and know that there will be further development areas from these events to improve outcomes for children and their families.

Our focus will remain on our priority area of improving multi-agency practice throughout the implementation of National Reforms and the Families First Programme, with children and their families at the centre of all we do.

Partnership Membership 2024-2025

Lead Safeguarding Partners	
Agency	**Job Title**
Shropshire Council	Chief Executive
Shropshire, Telford & Wrekin Integrated Care Board	Chief Executive
West Mercia Police	Chief Constable

Delegated Safeguarding Partners	
Agency	**Job Title**
Shropshire Council	Director Children's Services
Shropshire, Telford & Wrekin Integrated Care Board	Chief Nursing Officer
West Mercia Police	Shropshire Local Commander

Partnership Membership 2024-2025

Children's Safeguarding Partnership Membership	
Agency	**Job Title**
Shropshire Local Authority Departments	
Shropshire Council – Public Health	Operational Lead Health Protection
Shropshire Council – Children's Services	Service Manager Early Help
Shropshire Council – Children's Services	Assistant Director Children's Services
Shropshire Council - Education	Head of the Virtual School and Access to Education
Shropshire Council – Education	Head of Education Quality and Safeguarding
Shropshire Council – Education	Assistant Director – Education and Achievement
Shropshire Council – Housing	Head of Service - Housing, Resettlement & Independent Living
Shropshire Council	Performance Analyst
Shropshire NHS Trusts and Services	
Shropshire, Telford & Wrekin ICB	Designated Nurse for Safeguarding Children
Robert Jones and Agnes Hunt Orthopaedic Hospital Trust	Named Nurse for Safeguarding Children
Midlands Partnership NHS University Foundation Trust	Head of Operational Safeguarding
Shropshire Recovery Partnership	Team Manager
Shropshire Community Health Trust	Head of Children's Safeguarding
Shrewsbury, Telford & Wrekin Hospital Trust	Safeguarding Lead for Children
Shrewsbury, Telford & Wrekin Hospital Trust	Lead Safeguarding Midwife

Partnership Membership 2024-2025

Children's Safeguarding Partnership Membership contd.	
Agency	**Job Title**
West Mercia Police and Youth Justice	
West Mercia Police	Detective Superintendent
West Mercia Youth Justice Service	Head of Service
Probation Service	
National Probation Service	Head of Service
Other Services	
Shropshire Fire & Rescue Service	Temporary Area Manager
Independent Scrutiny	
Shropshire Council Cabinet Member	Portfolio Holder
	Independent Scrutineer

In Summary

2024/25 has been a year of changes across the partnership, including revisions to governance, implementation of revised national guidance and changes across our workforce.

Despite this, the partnership has strengthened its resolve and activity to work together to safeguarding children and young people through a range of innovative approaches.

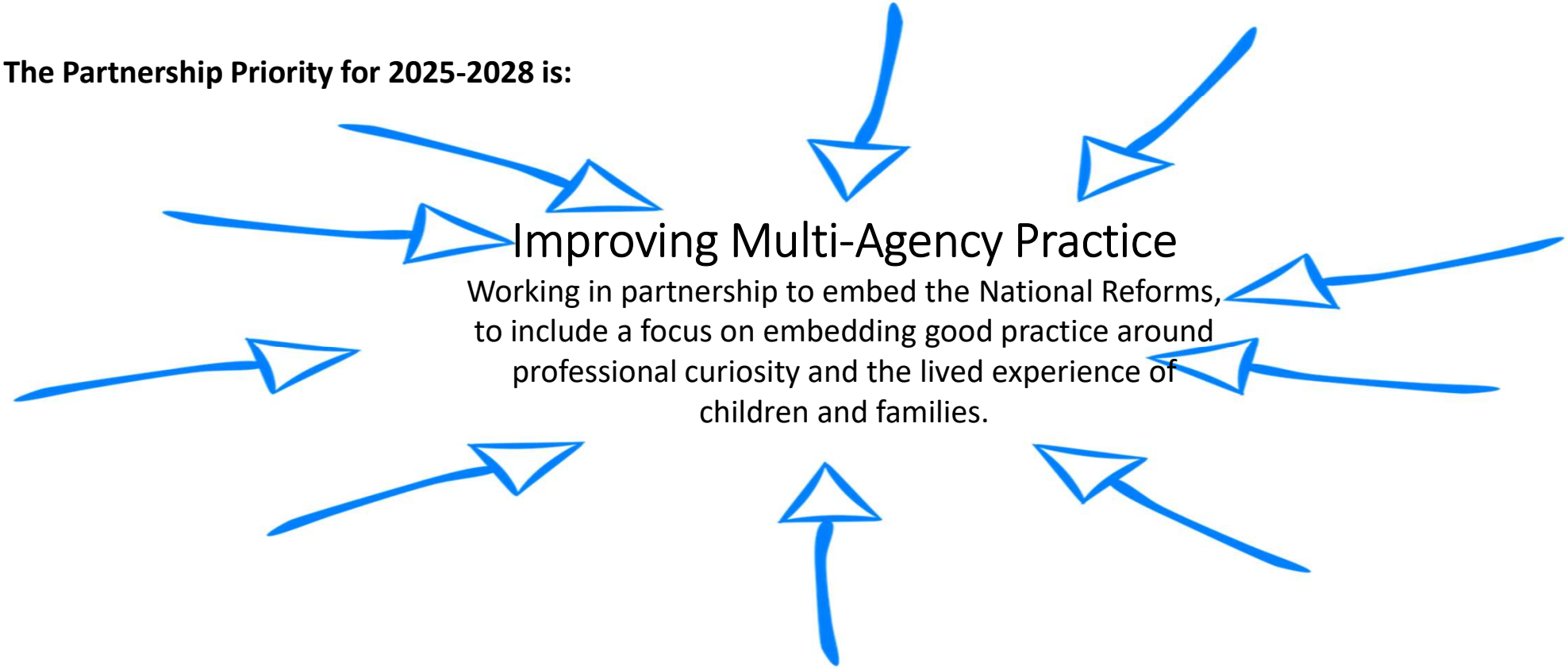
This activity has laid a firm foundation to build upon during 2025/26 as we look forward to engaging in our planned 'Spotlight' sessions across the partnership and prepare for our collective focus to improve multi-agency practice in preparation for the national Families First Partnership (FFP) reforms.

We would like to thank all partners for their collective energy, focus and dedication to safeguarding children and young people in Shropshire.

Our Priorities for 2025/26 onwards

The Partnership held a Priority Setting Workshop in February 2025 to agree the strategic plan for the next 3 years.

The Partnership Priority for 2025-2028 is:



The following areas of work for the Partnership will also continue into 2025/26:

- Child Sexual Abuse
- Neglect
- Exploitation

If you have concerns or need help

First Point of Contact
0345 678 9021
To report safeguarding concerns for adult and children

Emergency Social Work Team
0345 678 9040
For out of hours safeguarding concerns

Action Counters Terrorism (ACT)
0800 011 3764
For concerns about someone being drawn into radicalisation

Public Protection Unit (West Mercia Police):
0300 333 3000

NSPCC:
0800 800 5000

Childline:
0800 1111