Solihull Local Safeguarding Children Board

Statutory Annual Report

1st April 2016 until 31st March 2017

The effectiveness of partners' work to safeguard and promote the welfare of children in Solihull.

About this report

Every year, the LSCB (Local Safeguarding Children Board) publishes a report accounting for its effectiveness. This is the account for 2016-2017.

In this report we aim to provide a rigorous and transparent assessment of performance and effectiveness of local services to safeguarding children. We aim to describe the challenges we have identified and their causes. We set out what we are doing about them and what we have learned from our reviews of practice across all our participating agencies.

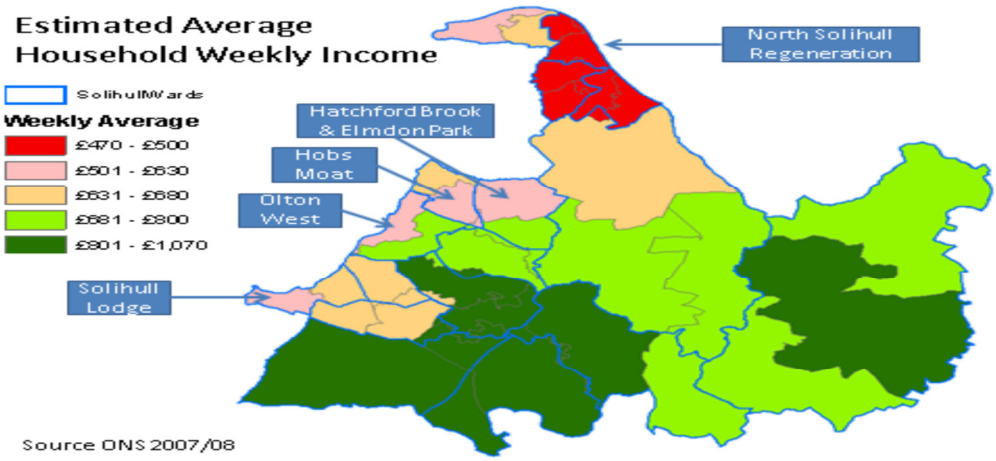
The report begins by analysing our progress in relation to the priorities and areas for development set in 2015-2016. We show how our learning has led to improvements, informing our decision to have a sustained focus on the same priorities with a shift in emphasis in the coming year 2017-2018.

An analysis of key child protection performance indicators for the year 2016-2017 is also provided, followed by our overall analysis of the current LSCB effectiveness and future challenges.

The improvement plan is the core working document for the LSCB and ensures the business is clear, priorities are robustly monitored and that we make a difference to children and young people as we create impact from local and national learning.

Contents

1. Facts about Solihull



1.1 Solihull is a broadly affluent borough characterised by above-average levels of income and home ownership. A high proportion of residents (50%) are classified as belonging to the Prosperous Suburbs socio-demographic classification. 22 of the Borough's 133 Lower Super Output Areas (LSOAs) are in the most 20% deprived areas in the country and just 2 are in the bottom 5%.

1.2 Solihull has significant geographic and infrastructure advantages, lying at the heart of the West Midlands motorway network, with excellent public transport connections with the Birmingham city conurbation and linked to European and global markets by Birmingham International Airport. Economically, this supports a strong service sector economy with a thriving Solihull town centre and key regional strategic assets, for example the NEC complex, Land Rover and the Birmingham & Blythe Valley Business Parks.

1.3 Solihull is challenged by a prosperity gap, with performance indicators in the Regeneration Area, framed by the wards of Chelmsley Wood, Kingshurst & Fordbridge and Smith's Wood to north of Birmingham International Airport, significantly lagging the rest of the Borough. The Regeneration Area contains the 20 most deprived LSOA neighbourhoods in Solihull, with 24 of the areas 29 LSOAs in the bottom 25% nationally. The impact of is felt across a broad range of outcomes including educational attainment, employment, crime and health. We therefore take care in the Board to understand the postcode variations. Solihull is in the midst of dynamic and rapid socio-demographic change. The Black and Asian Minority Ethnic (BAME) population has more than doubled since the 2001 Census and now represents nearly 11% of the total population. Yet the Borough is less diverse than England as a whole and significantly less so than neighbouring Birmingham, but with BAME groups representing a relatively higher proportion of young people in Solihull (over 15% of those aged 15 and under) this representation is set to increase. Whilst Solihull's population is ageing, the age profile of the North Solihull regeneration wards is significantly younger than the rest of the Borough. 29% of the population in north Solihull are aged 19 years and under and 20% aged 20-34 years, compared to 23% and 15% respectively in the rest of the Borough. At the other end of the spectrum just 14% of the North Solihull population is aged 65 and over and 1.4% is aged 85+, compared to 20% and 3% in the South. This difference in age profile is important in our deliberations about the development of services. Particularly as they relate to the development of early help support to families.

2. LSCB Effectiveness: An account of progress made on priorities set for 2015/2017

The LSCB agreed on 3 key priorities for 2015-2017:

- To safeguarding children from sexual exploitation.
- To safeguard children living with neglect.
- To support the delivery of Early help services.

Progress made by the LSCB in each priority area is described below:

2.1. LSCB priority: Safeguarding children from sexual exploitation (CSE):

Achievements

2.1.1. There is sustained collective ambition among partners and leaders making a difference to children in Solihull as the arrangements develop and the appetite for continual improvement and training continues. Solihull continues to lead and innovate in the West Midlands region in **identifying** and helping children at risk of sexual exploitation as seen in the creation and implementation of a bespoke CSE screening tool for children aged under 12 years, now applied region wide. Children have been helped by the local arrangements with demonstrable reduction in risks to them seen during the course of our work with them.

2.1.2. Across the West Midlands region, Solihull's Chief Executive (CEO) provides the CEO lead and Solihull's Director of Children's Services (DCS) provides the DCS lead on CSE. This ensures sound local direction and accountability with regional synergy. The Council's portfolio holder for Children's Services is an active member of the CSE steering group and has led on ensuring members are informed of CSE developments.

2.1.3. The CSE steering group, a sub group of the LSCB, is chaired by the Detective Chief Inspector for Coventry and Solihull, who is the Child Abuse Lead in the Police Public Protection Unit. He moved to another police department at the end of this reporting period, handing over to a new chair, also a DCI with similar responsibilities. The make up of the steering group has changed to now include high level leads to enable more speedy impact on operations. This group will review the CSE strategy and performance framework The Police have identified a range of civil and criminal avenues to disrupt potentially offending behaviours and prevent sexual exploitation and the new steering group will explore how best to improve tactical and operational level information sharing to ensure that case level work informs tactical and strategic actions.

2.1.4. Multi-agency Sexual Exploitation (MASE) meetings are a part of our routine response to children at risk. Their effectiveness is seen through the reduction of risks to individual children as a result of partnership effort and specialist support and this is monitored by the CSE steering group.

2.1.5. The Local Authority's CSE team provides a clear offer to children and young people working in collaboration with partners.

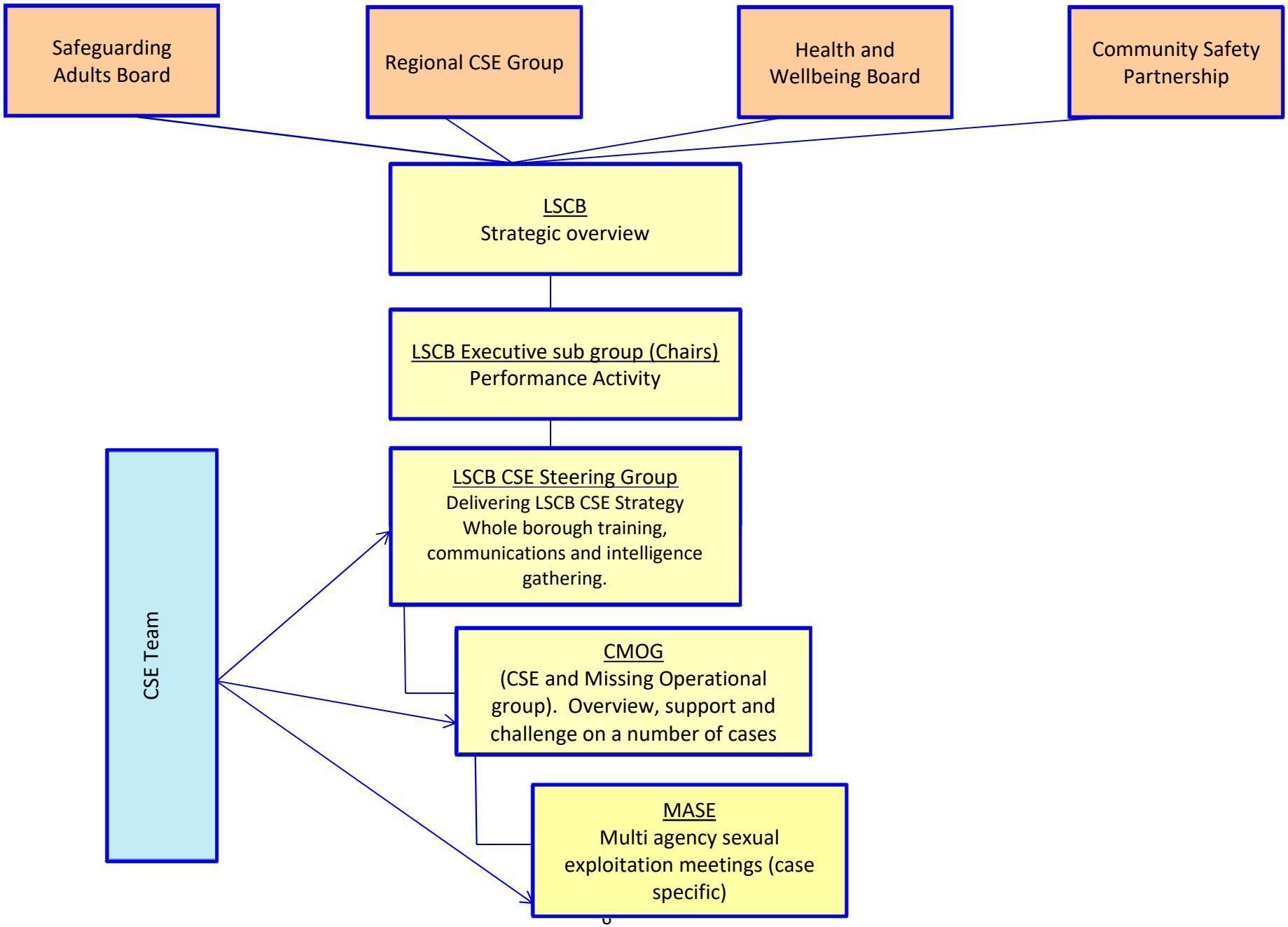
2.1.6. The CSE performance framework has been revised to better reflect the CSE strategy objectives. A drive to raise awareness among taxi drivers has been very successful with 1556 taxi drivers plus 12 private hire companies trained in this time.

2.1.7. The majority of our schools have “safe and healthy relationships” as part of the PHSE curriculum and training for governors regularly features in schools safeguarding programmes.

2.1.8. CSE training continues to be directly influenced by the experience of young people working with local young people and using national research to understand their perspective. The 2 multi-agency CSE modules are honed to ensure practitioners can connect to the experience of the child and gain the essential awareness and skills needed to work with them.

2.1.9. As a result, the CSE training has been successful, and at the time of writing, a total of 108 professionals from a wide variety of agencies, including the voluntary sector, have received high quality awareness-raising and skills acquisition training around CSE.

TABLE 1


Safeguarding Adults Board
Regional CSE Group
Health and Wellbeing Board
Community Safety Partnership
LSCB
Strategic overview
LSCB Executive sub group (Chairs)
Performance Activity
LSCB CSE Steering Group
Delivering LSCB CSE Strategy
Whole borough training, communications and intelligence gathering.
CSE Team
CMOG
(CSE and Missing Operational group). Overview, support and challenge on a number of cases
MASE
Multi agency sexual exploitation meetings (case specific)

CSE: Areas for improvement

2.1.10. Improvements in arrangements for children missing from home or care have been made following a LSCB workshop to create an action plan to ensure delivery. Two strategic leads for delivering this action plan, the Head of Service for the Child Protection and Review Unit in the Local Authority and the Detective Chief Inspector in the Public Protection Unit in the Police work together to ensure improvements are made, prioritising the sharing of intelligence from return interviews so that this information can be used to identify and act to prevent exploitation. The logistics, systems and processes have been created to make this happen. The CSE steering group will monitor this work to ensure it is embedded and sustained.

2.1.11. Young people at risk of CSE maturing into adulthood were prioritised by the group in 2016-2017and the business manager from the Safeguarding Adult Board is now a regular member. A new group, referred to as the ”4 boards safeguarding” group and made up of representatives from the Health and Wellbeing board, the Safeguarding Adult Board, Safer Solihull and led by the LSCB has begun gathering evidence to support the need to establish new commissioning arrangements to deliver services to young adults at risk of CSE. This is supported by the chairs of each of the relevant boards and the Children’s Services portfolio holder.

2.1.12. The newly formed CSE steering group will work to ensure connectivity with the front line and will consider more creative ways to deliver on complex operations.

2.2. LSCB Priority: Neglect

Achievements

2.2.1. A serious case review relating to neglect was published in October 2016 and the action plan has been incorporated into the LSCB improvement plan. The new Ofsted Joint Targeted Area Inspection Framework has provided, in the evaluation criteria, standards for practitioners to work to and the guidance has provided a framework for LSCB development on this priority area. Individual partners have carried out a stocktaking exercise, to measure their performance against these standards and this will be brought together early in 2017-2018 to provide a collective LSCB self evaluation. This work will be used to inform the new neglect strategy which has also involved the views of children and young people and practitioners. This will be delivered in 2017-2018.

2.2.2. The importance of supervision is now understood across the partnership and the LSCB safeguarding children in education settings sub-group has developed a supervision policy for practitioners working in education settings.

2.2.3. Neglect, domestic violence, parental mental health and substance misuse are key features of all LSCB training, providing practitioners with the skills and confidence to challenge in practice. The training strategy places an emphasis on these areas. Module 6 is exclusively about neglect and these features. This module and the new additional modules on coercion and control and the “graded care profile” combine to enable highly challenging practice dilemmas to be explored through group activity, helping practitioners to identify and manage non-compliance and

disguised compliance. The training also provides practitioners with the competencies to navigate the complexities of working with highly challenging families through effective partnership working. This year saw an increase in numbers attending Module 6 (Neglect). (114 professionals attended this training in 2016/17).

2.2.4. The LSCB is part of a national pilot on delivering the "Graded Care Profile" tool, which helps practitioners, children and parents articulate and understand what they are seeing in terms of neglect. A multi-agency implementation group, made up of practitioners using the tool was formed to test the tool and advise on training. This training is an additional module to Module 6 on neglect.

2.2.5. A case study involving the same family runs through all modules and in particular modules 2 & 6 look specifically at neglect and the complex factors impacting on the family case study. This helps ensure that the learning from local serious case reviews is embedded in the training. Practitioners learn to navigate the thresholds together. The LSCB has worked with Women's Aid, SMBC Domestic Abuse Co-ordinator and the Safeguarding Adults Board to continually improve the curriculum and learning methodologies.

2.2.6. The LSCB communications strategy involved briefings to practitioners throughout Autumn 2016 and Spring 2017 on the various LSCB approved tools. A practitioner's toolkit provides all the tools and links to guidance in one place. The briefings placed emphasis on the need for widespread understanding of neglect and the application of the threshold document and the importance of making good quality referrals. Partners regularly use the LSCB website to access a range of professional materials and tools and up to date information on safeguarding from both national and local perspectives.

2.2.7. The LSCB has selected 2 key performance indicators to monitor drift and delay in practice. These are the duration a child has a child protection plan and the rate of children with repeat plans. These are regularly scrutinised by the LSCB executive sub-group. Further analysis of these is provided on page 14. In summary, performance is at acceptable levels and careful scrutiny of these indicators will continue and the Local Authority has put in place plans to carry out specific audits to help understand key practice issues.

2.2.8. Multi-agency case audits show that the threshold guidance is now largely understood by most practitioners and there is a need for continued and repeated communications to sustain this position. New threshold guidance has been published and posters and leaflets distributed to raise awareness. The audits also demonstrated a need to continue the improvements around core group working and the importance of a sustained focus on the prevention of drift and delay.

LSCB priority Neglect: Next steps

2.2.9. The evidence gathered from individual agency stocktakes will inform a new neglect strategy.

2.2.10. The strategy will be promoted by all agencies to ensure an awareness of the standards we aspire to when we are worried about neglect.

2.2.11. A new set of policies will be devised to support practitioners working with children when they have concerns about neglect that do not meet the criteria for formal statutory intervention to ensure they are supported to work together effectively.

2.2.12. Training on the graded care profile tool will be targeted at staff who regularly make home visits as part of their normal duties or those who supervise staff who do this.

2.3. LSCB Priority: Early Help

2.3.1. At the time of writing, the Early Help programme board is revising the early help strategy. This currently embraces a range of primary, secondary and tertiary preventative activities impacting on long term morbidity and mortality outcomes as well as those around safeguarding children and young people. The new strategy will clarify targeted preventative services.

2.3.2. The troubled families programme has been located in the Local Authority engage service and has seen considerable success. The team is delivering and exceeding targets for engaging individuals and families with the Troubled families programme and is having success in “turning families around”.

2.3.3. There is a consensus on the need to provide a new structure to communicate concerns and referrals, and the notion of using signs of safety as a model for this is being developed at the time of writing.

2.3.4. Five Syrian families arrived in Solihull during this time and a team of highly skilled practitioners worked with them ensuring they were appropriately housed, the children found schools and income opportunities were identified with each family. In addition, work with the local community to ensure their arrival was accepted and understood, led to a safe and comfortable transition for them.

2.3.5. Local collaboratives share information and intelligence, provide support and challenge and co-ordinate prevention activities locally. The children’s needs assessment provides the evidence base for targeted activities and supports strategic planning.

2.3.6. The LSCB carried out a review of “Front door” services, including MASH and the Engage duty team. Positive developments were seen by this review in the co-location of the duty team with the MASH service, enabling conversations about step-up and step down cases to take place. Currently the team is staffed by rotation. A permanent manager has been appointed and plans are well developed to appoint permanent duty desk staff. This will create stability and will enable the development of the skills needed to support partners to work together as well as those needed to negotiate and challenge.

2.3.7. An IT (Information Technology) system has been designed and the procurement process is advancing. This will provide software to facilitate efficient assessments as well as data collection to inform incidence and quality assurance functions. In the meantime, arrangements are underway to ensure Engage staff in the Local Authority can use the existing social care case management system, “Carefirst”.

2.3.8. In 2015-2017 there were 3,473 requests for support to the Local Authoruty Engage duty team and at the time of writing there are 802 cases open to that

service. Most referrals come from schools, and many come from police, health and women's aid. Some come from the MASH unit.

2.3.9. A recent audit has established that plans were in place with some variation in the quality of assessments.

2.3.10. Appropriate staff are supported to attend the Graded Care Profile training.

2.3.11. The MASH routinely make enquiries to establish if Engage has been involved with cases referred to them.

2.3.12. All neglect cases are flagged and tracked and the LSCB evaluation tool is used to carry out Deep Dive audits.

2.3.13. All staff in the Local Authority Engage team receive monthly supervision and in neglect cases, the standards described in the LSCB neglect strategy are used to help evaluate progress.

2.3.14. Over 550 parents received PACE training and schools are becoming increasingly involved. There has been very positive feedback from this training, with parents indicating increased awareness.

2.3.15. Work with a local large motor manufacturer to raise awareness among men about understanding mental health problems is proving very popular and is highly valued by male workers.

2.3.16. The "five ways" café involves working with SOLAR, a local mental health provider to raise awareness about mental health with adolescents. This has been provided and an informal evaluation is showing promising results.

2.3.17. Work with housing and the local credit unit has targeted areas of social deprivation to raise awareness among young people about the dangers of using money lenders, using video and music to deliver the message to local young people.

2.3.18. In October 2016, OVOS (Our Voice Our Service) , the Children in Care Council, in partnership with Engage celebrated young peoples successes at a fabulous award event , " Dream and Achieve". The Circus themed event was hugely successful and enjoyed by the 38 young people receiving the awards and their families and carers.

Local Authority Engage: Next steps

2.3.19. A training needs analysis will be carried out to produce a workforce strategy endorsing appropriate staff achieve the competencies from the graded care profile training and mental health first aid training. It will also identify gaps in knowledge and understanding.

2.3.20. The early help and parenting strategies will clarify the Local Authority engage offer within the context of partners' services.

2.3.21. The audit process will be embedded.

2.3.22. An IT system will be procured.

2.3.23. The LSCB will evaluate early help training.

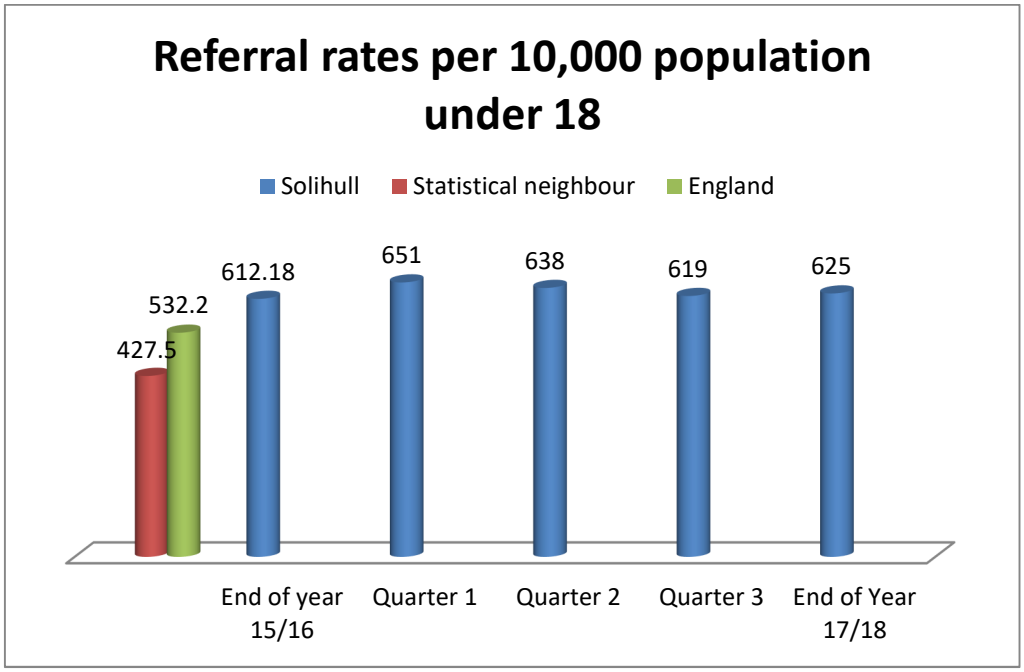
2.3.24. A new set of multi-agency policies will be devised to support practitioners working with children when they have concerns about neglect that do not meet the criteria for formal statutory intervention, to ensure they are supported to work together effectively.

Performance analysis: Progress on areas for development identified in the annual report 2015-2016		
Action identified on annual report 2015-2016	**Update**	**Next steps**
Increasingly engage young people by delivering a campaign on “sexting” using methods determined by them.	Young people in schools created their own sexting campaign led and delivered by young people	Continue to consult with looked after children about neglect.
Accelerate and scrutinise the work on missing children to improve intelligence sharing	Workshop produced an action plan which provided focus for delivery. Logistics for information sharing in place.	CSE steering group will continue to monitor to ensure impact.
Work with the Safeguarding Adults Board to explore the best way to ensure that children at risk of sexual exploitation get the help and protection they need when they mature in to adulthood	A group known as the “four boards safeguarding” group has formed and identified that young people transitioning to adulthood and at risk of CSE are common business to all four boards. A mandate from each of the four chairs supports the production of evidence to inform new ways of commissioning. This group also produced a learning resource based on lessons learned from Serious case reviews, Domestic Homicide Reviews and Safeguarding adult reviews.	Produce the evidence and influence commissioning plans.
Deliver tangible products from the protocol with the safer Solihull Partnership, the Health and Well Being Board and the Safeguarding Adults board.		Promote the learning resource among practitioners.
Revise and promote the thresholds document.	Threshold document reviewed by the policy sub-group and widely disseminated.	Refreshed posters and leaflets to be distributed.
Roll out the graded care profile training	Implementation group influenced training design. See training report.	Continue roll out and monitor the application of the tool in practice.
Ensure practitioners are aware of the implications of the Signs of Safety methodology	Briefings provided by the LSCB. Model used in child protection conferences and well received by partners and families.	Use as a framework for practice, including communications, referrals and information sharing.
Closely scrutinise the DV triage, early help duty desk arrangements	The LSCB carried out a thorough review of MASH and the engage duty desk and made recommendations for improvement.	LSCB executive group to monitor delivery of action plan.
Influence the MASH review process.		
Roll out the remaining modules of the LSCB safeguarding training strategy.	All modules now delivered with positive feedback is good. (see training paraxx)	Delivery the training (adjusted following evaluation)

3. Performance analysis: Child protection data.

3.1 Referral rates

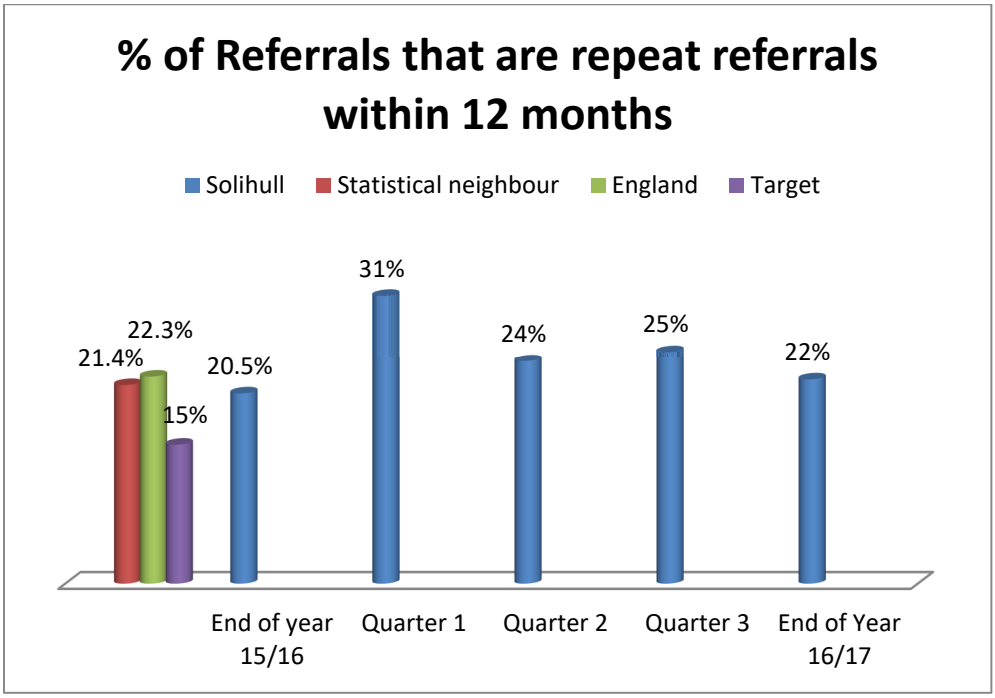
3.2 Referral rates per 10,000 (625) are higher than statistical neighbours (427.5) and England average (532.2) and are higher than the period 2016-2017 (612.18). Caution needs to be taken when drawing conclusions about this. These figures are slightly inflated by definitial issues which fluctuated in this period but will stabilise in 17/18. They are also inflated by 32% by re-referral rates and this is addressed below



3.3 Repeat referral rates

3.4 There will always be children who need to be referred on more than one occasion, but any rise in re-referral rates suggests that we look into whether initial referrals may have been dealt with. Repeat referral rates are slightly higher than last year, 22% compared to 20.5% in 2015-2016 a slight reversal of the trend over the last 3 years. While these rates compare favourably to statistical neighbours (21.4%) and England averages (22.3%) careful monitoring in 2017/2018 is needed to ensure this is not a recurring pattern.

The LSCB carried out a review of MASH and Engage Services and made recommendations to refine decision making at MASH screening level and changes are already underway to deliver on this. The impact of this will be realised in 2017-2018.



3.5 **Proportion proceeding to S47 or Single assessment**

3.6 In 2016-2017 the proportion of referrals proceeding to an assessment or a section 47 enquiry has increased from 67% in 15/16 to 81% in 17/18. This is in line with the England (85.9%) and statistical neighbour (85.2%) averages. This indicates that the threshold guidance is understood and applied as referrals are more appropriate. The LSCB MASH review highlighted that the quality of referrals is in need of improvement. Briefings provided in the Autumn 2016 and the Spring of 2017 included guidance on making effective referrals. Consultation with practitioners and managers has led to agreement on a re-design of the referral form and, at the time of writing, the LA is leading on using a "Signs of Safety" model to structure referrals. Consultation on this is underway with a view to delivery in the Autumn of 2017.

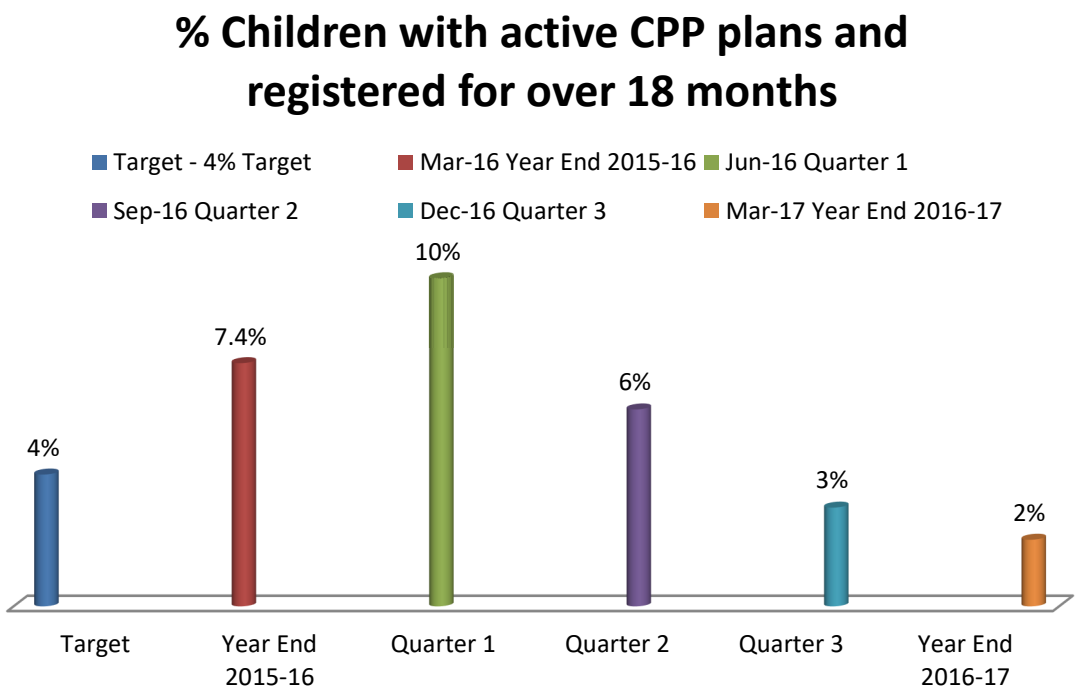
3.7 **Drift and delay**

3.8 Serious case reviews and national learning emphasise the importance of preventing drift and delay in decision making, particularly in the area of neglect. Multi-agency case audits indicate that drift and delay is largely identified in practice and action is taken to address it. The LSCB has selected just one key performance indicator to indicate the timeliness of decision making to prevent drift and delay in delivering child protection plans, measuring the duration of plans.

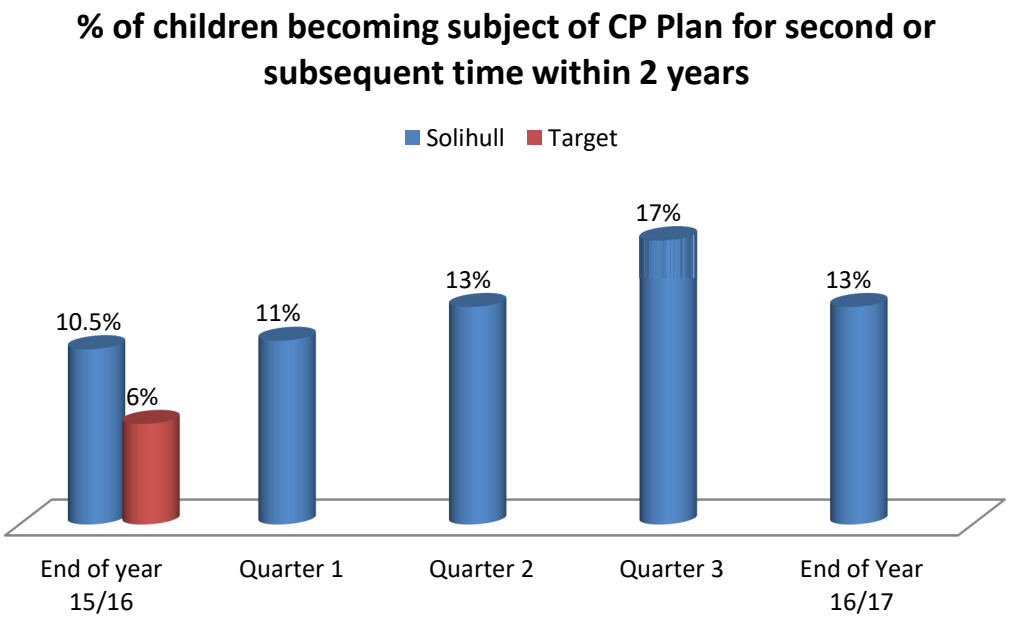
3.9 **The proportion of children with child protection plans for 18 months**

The Local Authority have embedded scrutiny arrangements to reduce the risk of drift and delay providing challenge when a plan reaches 12 months. Solihull's rate in 2016-2017 (2%) is less than 2015-2016 (7.4%). An acceptable level is considered to be between 0% and 4%. While the end of year data shows that 3% of child protection plans lasted 2 years or more, at the time of writing, there are no plans that lasted this long.

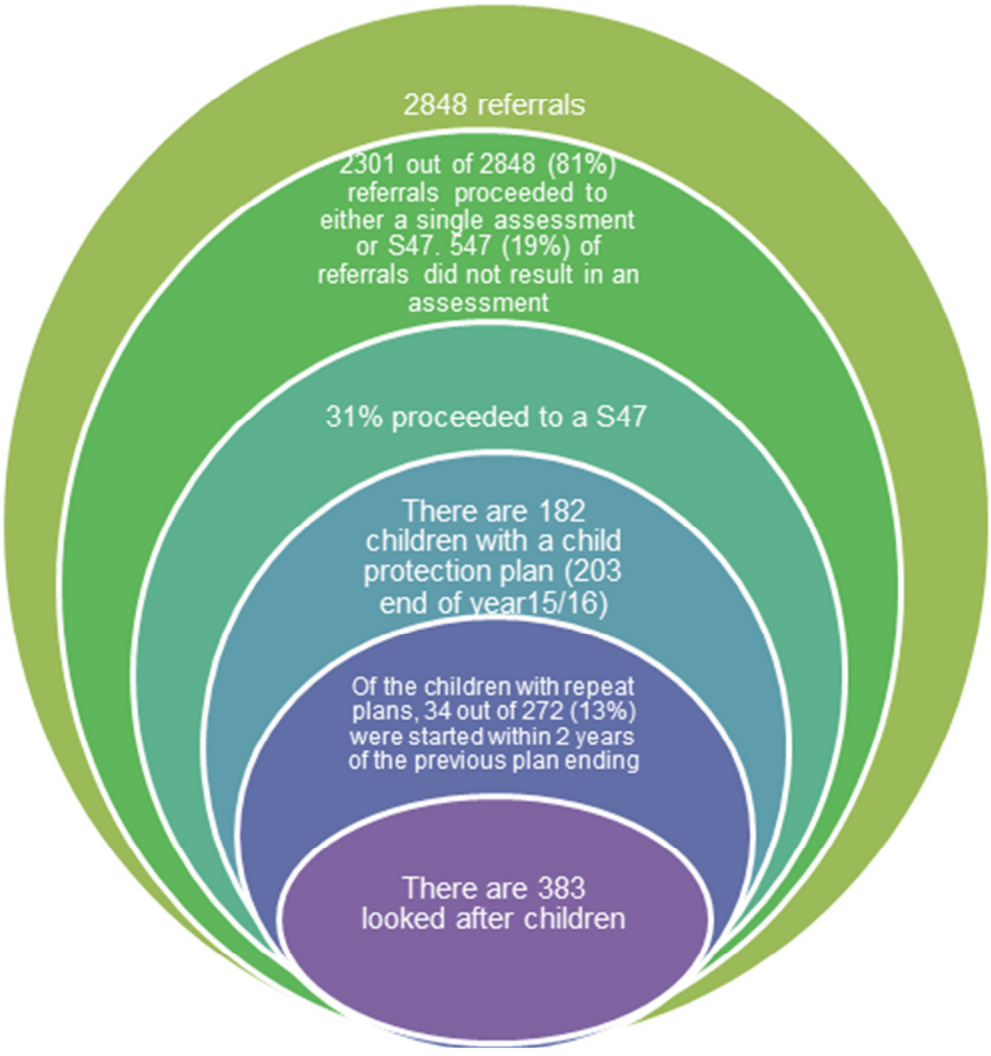
3.10 This indicates that children do not have child protection plans for long periods, decisions are made swiftly and robustly to ensure movement into the next stage, whether that be to early help or legal proceedings.



3.11 The proportion of children who started a plan in this period who have repeat child protection plans within 2 years, is slightly higher (13%) than in 2015/16 (10.5%). As numbers are low there is possible distortion as one large family could be an inflationary factor. However a small increase over the last 3 years is seen and this proportion exceeds the set target of 6%. This number is inflated by two families with large sibling groups, but this needs careful monitoring through 2017-2018 to ensure initial decision making is sound. At the time of writing, the local authority is preparing to audit children in need, child protection and looked after cases where negect was the main feature to ascertain retrospectively the quality of initial decision making.



3.12 2016/17 workflow:



3.13 **Performance summary**

3.14 Overall performance indicates timely decision making and children are moving through the system in good time. There is a small increase in re-referral rates and repeat child protection plans and this is subject to careful analysis by the Local Authority working with the LSCB. In 2017-2018 Independent Reviewing Officers (IRO's) chairing initial conferences which are as a result of a repeat referrals, will meet with the IRO who chaired the initial process to establish any learning. Work is also underway to improve the quality of referrals. The MASH review, carried out by the LSCB, found that this is an area requiring improvement. New processes are being designed to enable practitioners to articulate their concerns and the Signs of Safety model will provide structure for this. The form will also be available as a word document to help practitioners prepare their referral. Consultation workshops are planned in the Summer and Autumn of 2017 on this. The Local Authority will also carry out specific audits of children re-referred for neglect, those with child protection plans for neglect and those looked after due to neglect, to establish if there are areas for improvement around decision making.

3.15 **Performance next steps**

- Improve the quality of referrals, revised referral processes
- Carry out audits to learn about decision making about neglect in relation to children in need, children with child protection plans and children looked after where there are concerns about neglect.
- Conference chairs to establish learning in relation to children with repeat plans.

4. Regulation 5: LSCB Functions

4.1 Regulation 5 of the Local Safeguarding Children Boards regulations 2006 sets out the functions of the LSCB in relation to its objectives under Section 14 of the Children Act 2004. This is an account of those functions.

4.2 *Policy development* (*Regulation 5 1(a))*

4.3 The LSCB entered into discussions with regional colleagues to consider the benefits of joining a regional procedures group. At the time of writing a new LSCB independent chair has recently been appointed and will guide the LSCB on next steps.

4.4 A consultant was appointed to review all of the child protection procedures and provided advice on editorial issues to ensure the current procedures were sound.

4.5 The following policies were approved by the policy sub-group in this reporting period

- Dispute Resolution procedure
- Threshold guidance
- Neglect strategy

4.6 In 2017-2018 the group will work on the following local procedures.

- Children missing from home or care
- CSE strategy
- Review of dispute resolution procedure
- Procedures for multi-agency working with children where there are concerns about neglect that do not meet the criteria for formal statutory child protection procedures.

4.7 It will also consider regional developments and take steps to work effectively with partners with the new LSCB independent chair.

4.8 *Thresholds (Regulation 5 1(a) (i))*

4.9 Multi-agency case audits show a need for sustained communications to ensure practitioners are aware of the threshold guidance and know how to apply it. The document was revised and promoted. The LSCB communications and training strategies incorporate and prioritise this document to ensure awareness and case audits establish practitioner application of the tool. New leaflets and posters have been produced and will be distributed in the Summer of 2017.

4.10 Training *(Regulation 5 1(a) (ii))*

4.11 This is an account of the LSCB multi-agency training developments in the period March 2016-March 2017. The LSCB training strategy covers the period from April 2015-March 2017 and training is provided in 9 connecting modules.

4.12 In January 2015 Solihull LSCB commissioned a review of its approach to multi-agency learning and development to produce an evidenced informed rationale for a safeguarding learning curriculum for 2015-2017. The review also identified the resources needed to deliver the training made up of nine modules aimed to develop specific competencies largely derived from serious case reviews, domestic homicide reviews and safeguarding adult reviews. These competencies are designed to enhance the workforce ability to share information, communicate, negotiate and challenge in a multi-agency environment. It complements, but does not replace in-house training. All modules offered are in high demand as the strategy allows practitioners and organisations to choose the competencies they need to enhance at individual and organisation level resulting in high participation and positive evaluations. The e-enabled booking system has streamlined booking arrangements, producing efficiencies and clear guidelines and pre-reading for each course. Training is in nine modules and is targeted at all levels. Module 4 is specifically designed for leaders and managers. In this reporting period, new add-ons to module 6 (neglect) were provided around coercion and control and the Graded Care Profile. An account of the evaluation of the Graded Care Profile training is provided here. For evaluation of all the courses, click here.

4.13 **LSCB Multi-Agency Training Pool**

4.14 We would like to express thanks to the dedicated contribution of colleagues in the multi-agency training pool who make the delivery of the full range of Modules possible**:**

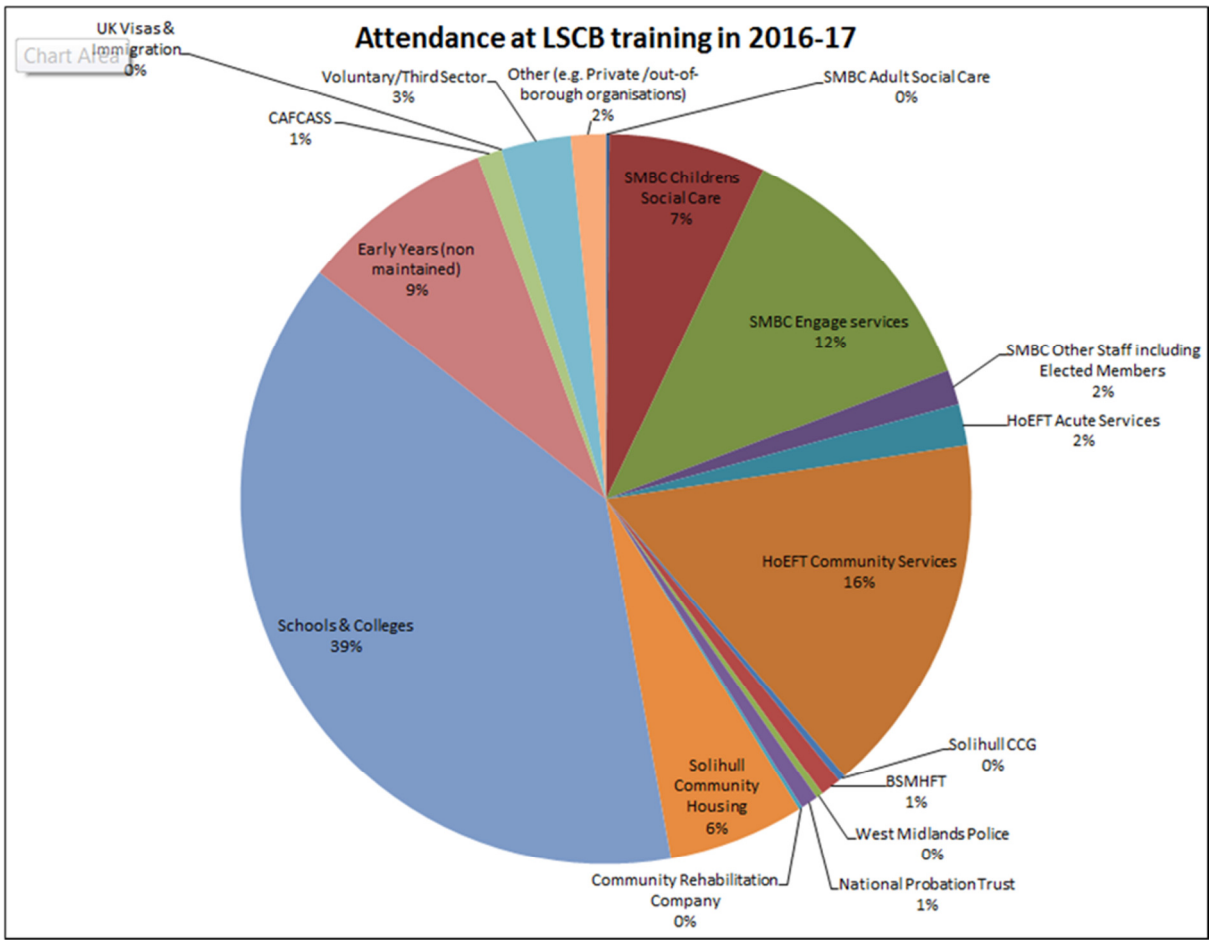
Adam Birchall	(Children's Social Care)
Dr Alan Stanton	(CCG- Designated Doctor& HEFT- Consultant community Paediatrician)
Ann Jones	(West Midlands Police)
Bec Baylis	(Women's Aid)
Ceri-Lisa Murland	(Probation)
Deborah Adams	(Children's Social Care)
Deborah Hadwin	(SMBC Work Force Development)
Gina Godwin	(Early Years- Wise Owls Nursery)
Nicki Thomas	(HoEFT)
Phillipa Brookes	(Education- Smiths Wood Sports College)
Toni Clifton	(Children's Social Care)

4.15 **Learning Faculty**

4.16 The LSCB training strategy involves the active engagement of practitioners in training design. The purpose of the faculty is to provide an open consultative forum to enable multi-agency practitioners and managers who access LSCB/SSAB (Solihull Safeguarding Adult Board) training programmes to review previous training, monitor existing training and engage in the planning and design of future training provision. This ensures that training meets front-line needs and is informed by national and local drivers including legislation, policy and practice development. The faculty is an opportunity for practitioners to influence training. It is not a committee. Practitioners from diverse settings in children and adults services take an active part in the faculty. Three meetings take place every academic year, one meeting per academic term. Information is available on the LSCB website and practitioners are encouraged to submit thoughts and information related to topics of discussion, even if they are unable to attend the meetings.

4.17 **Attendance on LSCB multi-agency training**

A total of 649 people participated in the LSCB multi-agency training between April 2016 and March 2017. The following chart demonstrates the agencies represented in the delegates that attended.



Evaluation of LSCB training

4.18 In September 2016 the LSCB launched a new online booking system which requires each person registering for a module to complete a pre training evaluation to rate their skills, knowledge and confidence in the subject out of 10. A manual post training evaluation is then completed immediately after the training to capture thoughts, feelings and recommendations about the course, and a post training evaluation is generated through the online system 3 months after the learner has completed the course. This evaluation is sent to the person who attended and their manager to help demonstrate and capture the impact the learning is having back in the work place. The introduction of this system means at the time of this report being produced, we can currently provide evaluation comparisons for pre-and 3 month post training from September – December 2016 and these are included for each module below. On going consultation on the curriculum and methodology is also provided through the LSCB learning faculty, made of up practitioners and managers from all partner agencies. The new add-ons to module 6 (Neglect) around coercion and control and the Graded Care profile received very positive evaluations. As the Graded Care Profile training is core to the new neglect strategy this is reported below. To see the full evaluation report, click here.

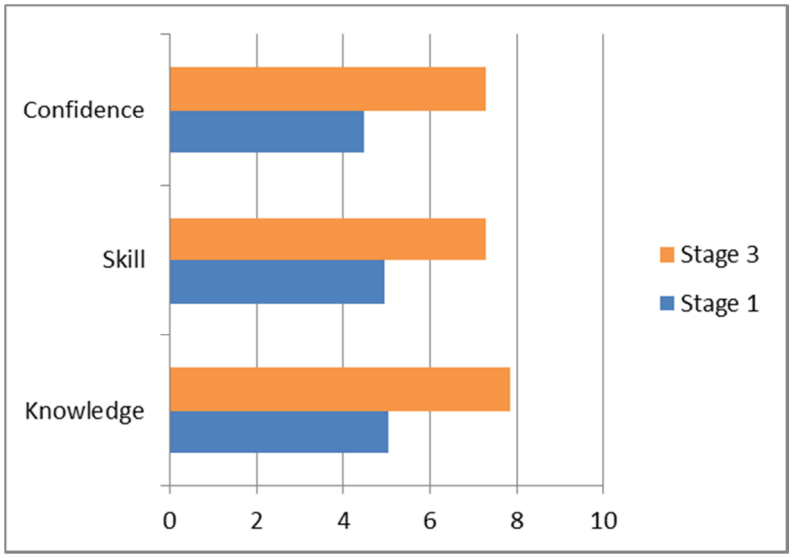
Graded Care Profile Training

4.19 A small group of 11 multi-agency practitioners volunteered to be part of an initial implementation group and were trained to use the Graded Care Profile 2 (GCP2)

tool in June. Their experience then informed a wider multi-agency role out from November 2016.

4.20 38 people have now been trained in 4 courses, plus the 11 members of the implementation group.

4.21 The chart below shows the average positive variance demonstrated between stage 1 pre-evaluation and stage 3 evaluations completed 3 months after the completion of module 6c.



4.22 Examples of practitioner responses to the following question 3 months after the courses were completed:

What difference do you think this training has made to your practice and work with children, young people and their families?
"I have used the graded care profile training as a table top exercise prior to making a referral to Childrens Services. It was very good at facilitating analysis of concerns. It has made me feel more confident at evidencing neglect and working with families where neglect is an issue."
"Another tool to use with Young people and families; valuable that it can be used in differing ways".

4.23 Examples of manager's responses to the following question asked 3 months after the courses were completed:

What difference do you think this training has made to the delegate's practice and work with children, young people and their families?
"Enables the practitioner to consider neglect in more detail as the situation arises; able to use information to help with referral".

4.24 Every practitioner who has been trained is contacted quarterly to complete a data return which is submitted to the NSPCC as part of the pilot agreement. From October 2016 – March 2017 Solihull had completed 16 Graded Care Profiles, (12 as table top exercises). These have been completed by Children's Social Care 6, Engage 3, Schools and Colleges 4, Early Years 1, HoEFT 1, and Vol Sector 1.

4.25 Agencies appear keen to support their staff to attend training, so extra dates have been added to the calendar aimed at specific target groups as the training is for people who regularly carry out home visits as part of their normal duties.

Training: Next steps

4.26 The full range of modules is now being delivered and the evidence included with each module is showing how both practitioners and managers feel the training is having a positive impact in the work place. A revised strategy will be created for 2017-2019 based on learning from the detailed evaluations. The LSCB multi-agency case audit process tests awareness of threshold and sensitivity to drift and delay and shows improvements over the last 2 years of the audit cycle.

4.27 **Local Authority Designated Officer (LADO) report *(Regulation 5 1(a) (iii) and (IV))***

4.28 Statutory guidance requires the Local Authority Designated Officer (LADO) dealing with allegations against adults that work with children to report to the LSCB on an annual basis about the work undertaken. The following is a summary of that report.

4.29 In Solihull the LADO is the Head of Safeguards and Quality Assurance within the children's social work service. The LADO is supported by officers of the Child Protection and Review Unit, managing referrals, chairing Position of Trust (POT) meetings, and providing advice and support This arrangement is in line with the statutory guidance within Working Together to Safeguard Children 2015. The work undertaken is quality assured by the LADO.

LADO threshold

4.30 The threshold for LADO cases is described in Working Together 2015 as:

An allegation may relate to a person who works with children who has:

- behaved in a way that has harmed a child, or may have harmed a child;
- possibly committed a criminal offence against or related to a child; or
- behaved towards a child or children in a way that indicates they may pose a risk of harm to children.

4.31 The guidance requires Local Authorities to have a Local Authority Designated Officer (LADO) to be involved in the management and oversight of individual cases. The LADO should provide advice and guidance to employers and voluntary organisations, liaising with the police and other agencies and monitoring the progress of cases to ensure that they are dealt with as quickly as possible, consistent with a thorough and fair process.

Analysis of data

4.32 Total number of referrals received over the last 3 years

Table 1 - Total number of allegations referred to the LADO			
Year	**2014**	**2015**	**2016/17** 01 Apr – 31 Mar 2017
Number of allegations	43	61	**75**

4.33 The number of contacts leading to formal referrals during the reporting year 2016/17 represents an increase of 21% against the previously reported full 12 month period (2015 calendar year). NB: the number of referrals recorded for 2015/16 was 57. The 2016/17 figure represents an increase of 30% against this. This is a positive picture as it reflects greater awareness within the agencies working in the borough of the 'managing allegations' process.

4.34 In terms of activity, there were an additional number of contacts (59) from agencies considering the need to refer to the LADO (or 'checking out' their views and intended actions in relation to particular circumstances) where, after initial consultation, it was agreed that the threshold for LADO involvement was not met. Quality assurance activity was undertaken by the LADO on 28 of these issues – confirming that the correct view was reached. These contacts are actively encouraged by the LADO. This type of contact is included in the relevant procedures, is emphasised during the 'managing allegations' training programme, and, is also emphasised by the LADO when visiting particular groups of relevant staff (eg Early Years colleagues, head teachers etc).

4.35 During the year, allegations relating to non-recent abuse of young people by ***football coaches*** emerged nationally. This has led directly to one referral being received in relation to a coach in the Solihull area – although other allegations relating concerns of recent abuse by football coaches have been received. As a result Solihull LADO has further developed its links with the Football Association (FA) and subsequently confirmed a single point of contact for liaison regarding any future referrals relating to FA affiliated coaches (regardless of whether non-recent or recent abuse). Liaison is also being planned with Sport England alongside other West Midlands region LADO services.

4.36 Number of referrals by category of abuse:

Physical		**Emotional**		**Sexual**		**Neglect**	
2015 (2014)	**2016/17**	**2015** (2014)	**2016/ 17**	**2015** (2014)	**2016/ 17**	**2015** (2014)	**2016/ 17**
1 (1)	**1**	1 (1)	**1**	- (-)	**1**	- (-)	**1**
3 (-)	-	- (1)	-	1 (-)	**1**	- (-)	-
13 (11)	**22**	6 (4)	**7**	3 (3)	**5**	6 (1)	**6**
- (-)	**1**	- (-)	-	1 (-)	**1**	- (-)	-
- (-)	-	- (-)	-	- (-)	-	- (-)	-
- (-)	-	- (-)	-	- (-)	-	- (-)	-
- (-)	-	- (-)	-	- (-)	-	- (-)	-
- (-)	-	- (-)	-	- (-)	-	- (-)	-
- (-)	-	- (-)	-	- (-)	-	- (-)	-
- (-)	**1**	- (-)	-	2 (1)	**1**	- (-)	**1**
- (-)	-	- (1)	-	2 (-)	-	- (-)	-
- (-)	-	- (-)	-	- (-)	-	- (-)	-
- (-)	-	- (-)	-	- (-)	-	- (-)	-
3 (3)	**3**	1 (2)	**2**	- (-)	**3**	3 (-)	-
- (1)	-	- (1)	-	1 (2)	-	- (-)	-
3 (3)	**6**	2 (-)	**1**	2 (-)	**1**	1 (1)	**1**
2 (3)	**2**	2 (2)	-	1 (-)	**4**	1 (1)	**2**
25 (22)	**36**	12 (12)	**11**	13 (6)	**17**	11 (3)	**11**

4.37 There has been a further increase in the frequency of Physical and Sexual abuse category cases. The proportion of Physical abuse category cases has risen from 41% in 2015 to 49% in 2016/17.

4.38 Number and percentage of cases resolved within the year and associated timeliness of resolution.

Table 5. Of those cases concluded during the year 2016/17, the number that were resolved within the relevant timeframes (comparison with 2015)

Time period in months	Actual number		Percentage of the total completed		Rolling Percentage of total completed	
	2015	**2016/17**	2015	**2016/17**	2015	**2016/17**
Within 1 month	42	**36**	51%	**41%**	51%	**41%**
Within 3 months	36	**38**	43%	**44%**	94%	**85%**
Within 12 months	5	**11**	6%	**13%**	100%	**98%**
More than 12 months	0	**2**	0%	**2%**	100%	**100%**
Total completed	83	**87**				

4.39 The standard set is for 90% of cases to be completed within three months.

4.40 The rate of completion of cases within one month in 2016/17 fell from 51% to 41%. In terms of completing cases with the three month timescale – the rate of completion also fell from 94% to 85%. The number of cases completed in these timescales was not dissimilar to the previous year.

4.41 There has been some impact on timeliness of progressing enquiries as a result of an increase in other aspects of workload for the IROs involved in managing LADO referrals via the 'duty' system. This is being addressed by the provision of funding to secure two additional IROs (and a further senior IRO post for whom half of the remit will solely be progressing LADO matters). Currently one additional IRO has been successfully recruited - with activity underway to interview other prospective candidates in July 2017. The senior IRO/LADO post is awaiting the job description being evaluated before it can be advertised.

4.42 There were significantly more cases taking longer than 3 months to complete (13 cases in 2016/17 as opposed to 5 in 2015). See Table 6 below.

Managing allegations training

4.43 During 2016/17 The LADO provided 3 multi agency training sessions on behalf of the LSCB on the 'managing allegations' process. One session was delivered in the

evening to facilitate the attendance of early years providers (especially child-minders).The LADO has been supported in delivering these training sessions by staff from the Local Authority's Human Resources team. These training sessions have been well attended and the evaluations were very positive.

4.44 The LADO has responded to requests from Education colleagues to support better understanding of the LADO role and agency responsibility in relation to the managing allegations against staff process. Additional bespoke briefings were offered to Head Teachers (and Governors). Feedback about this was also positive.

Lessons Learned from cases

4.45 There has been learning for agencies/settings arising from specific cases. This has included ensuring that responsibilities re managing allegations are understood and acted upon to ensure referral to the LADO (and Children Social Care if needed) in good time.

4.46 There was learning for Solihull LADO in respect of holding review Position of Trust Meetings to track progress where there are protracted on-going Police and/or internal disciplinary investigations. There has also been learning relating to offering clarity to personnel agencies about expectations of them in progressing risk assessments in specific cases.

4.47 Specific learning for settings has also resulted in a number of independent agencies reviewing their safeguarding procedures and governance arrangements, agencies recognising the need to update staff training programmes to raise awareness of CSE risk, agencies reviewing guidance re use of mobile phones and electronic equipment.

4.48 Where appropriate, setting specific learning has been reflected upon and disseminated more widely (eg additional training/briefings to education settings in Solihull clarifying responsibilities arising from private law court orders in respect of children and parental contact arrangements).

4.49 The LADO has endeavoured to support broader learning for settings. Where concerns have been raised relating to a setting (for example via Ofsted) but the threshold for formal LADO involvement has not been evidenced, the information has been passed to relevant officers (for example Early Years Service or Schools Improvement Service) to inform their involvement and support of these settings going forward.

Conclusions

4.50 Analysis strongly suggests an improving picture in respect of awareness/understanding of the 'managing allegations' process in the borough and in respect of drawing through learning for settings to help improve their safeguarding arrangements where this has been identified.

4.51 The timeliness of progressing referrals has not been as strong during the period – although the completion rate within 3 months is not dissimilar to the target. Actions are in place to ensure focus on timeliness and to increase capacity within the service to support this.

4.52 The responsibility for the LADO function remains with the same post holder who is also the Head of Safeguards and Quality Assurance. He is supported on a day to day basis by the Independent Reviewing Officers (IROs) within the Child Protection and Review Unit.

4.53 The LADO provides a detailed annual report to the LSCB and routinely promotes referral pathways.

4.54 **Private fostering (*Regulation 5 1(a) (v))***

4.55 In 2016-2017 there were 7 children known to the local authority in private fostering arrangements in Solihull, 4 of them received a visit within 7 days of the Local Authority being informed and 5 of them received visits every 6 weeks. Private fostering is managed through one of the senior social workers in the fostering service.

4.56 Publicity materials on private fostering are on the Council website and promoted to schools via Designated Safeguarding Leads training. The Local Authority continues to promote awareness about private fostering in the community and an awareness raising campaing is planned for July durig private fostering week.

4.57 **The LSCB communications function *(Regulation 5 1(b))***

4.58 The LSCB's role is to communicate to persons and bodies in the area of the authority, the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so. Key highlights for work carried out in 2016/2017are set out below.

4.59 A LSCB website is now the key communication tool and is regularly used by practitioners. A toolkit icon has been created to support the provision of a series of briefings by the LSCB and partners in the Autumn and Spring of the reporting period. The toolkit is very popular as it is the one central point where practitioners can find a range of tools they need in practice.

4.60 The LSCB business unit responded to practitioners concerns and produced posters and leaflets to promote awareness of the threshold document.

4.61 **Communications: Next steps**

4.62 Communications plans for the Autumn and Spring of 2017/2018 will be agreed by the LSCB in July. It is likely to reflect the findings from multi-agency case audits, serious case reviews and the LSCB MASH review emphasising the importance of understanding consent around information sharing, ensuring clarity about processes in place around a child and the status of those processes, e.g. Child in Need, Child Protection or early help, as well as the challenges practitioners face when working with children with complex needs when they are concerned about neglect.

4.63 Consultation with practitioners will take place to improve referrals and communications with MASH and the Local Authority Engage duty desk.

4.64 Consultation will take place on how to bring about processes and procedures to support multi-agency collaboration to help children when practitioners are worried about neglect and cases have not yet reached the threshold for social work intervention.

4.65 **The LSCB is a learning organisation *(Regulation 5, 1 (c))***

4.66 The Learning and Improvement framework (available on request) has provided a clear understanding of how the LSCB improves practice from learning and provides the evidence rationale for members' decisions and priority setting.

4.67 The quality assurance framework is linked closely to the objectives in the Early Help, CSE and neglect strategies. This ensures effective use of available data and provides succinctness. The ***innovate multi-agency case audit programme,*** praised by inspectors is now embedded in LSCB business with an annual cycle enabling partners to manage this complex task. The full report provided to the March 2017 board is available. The LSCB also carried out a review of the MASH and engage duty desk services and Domestic Abuse triage arrangements and made recommendations for improvement through 2017-2018.

4.68 The improvement plan is therefore continually updated with learning from case audits, performance analysis national learning and serious case reviews. This is monitored by the LSCB executive group.

4.69 **LSCB participating in planning of services for children *(Regulation 5 (d))***

4.70 The protocol between the LSCB, the Safeguarding Adults Board, the Safer Solihull Partnership and the Health and Well being formed has been translated into viable products as a group made up of representatives from each board formed to consider areas of common business. Those products are:

- A *learning resource* using lessons learned from serious case reviews, domestic homicide reviews and safeguarding adults reviews has been created and will be posted on the website's of each board and used as a foundation for joint training.

- At the time of writing, the chairs of each board and the CSE steering group provided a mandate to this group to provide the evidence to support new ways of commissioning services for young adults at risk of sexual exploitation as transitions was identified as a priority by all four boards.

4.71 **Serious case reviews *(Regulation 5,1(e))***

4.72 A serious case review was published in October 2016 and the recommendations included in the LSCB improvement plan. Learning from this serious case review has influenced the work of the LSCB including the neglect strategy, training and quality assurance arrangements.

4.73 A further 2 serious case reviews have been commissioned by the LSCB independent chair and are due to be published in the next reporting period.

4.74 **Child Death Overview Panel (CDOP) *(Regulation 5, (2))***

4.75 The panel provides an annual report to the LSCB which can be found here.

4.76 **Children Missing Education**

4.77 Schools rigorously monitor children who are not regularly in school with particular reference to the child's safety. This includes children who are persistently absent, children whose attendance has dropped below the national average figures and continues to slip, and children who are not attending but have not been removed from school roll. Schools are also supported to use a Behaviour and Attendance tool to promote good attendance. This applies to all vulnerable groups, including those in need of safeguarding, at risk of CSE or in need of early help. A specialist Children Missing Education Team supports schools in working to ensure children missing education are safe and that procedures are followed. School Improvement Advisors discuss and challenge attendance/persistent absence termly and during their annual safeguarding visit.

5. Statutory Partners accounts of their safeguarding responsibilities

5.01 Partners provided presentations to account for their individual performance through 2016-2017 and this proved very helpful in understanding members' contributions to the priorities. However, there was insufficient time in the year to arrange for all partners to do this. The new LSCB independent chair will propose a new performance panel to deliver on this in 2017/2018.

5.02 Section 11 of the Children Act 2004 spells out the responsibilities of each statutory partner member of the LSCB in relation to safeguarding children. The most recent audit of compliance with this section of the act was reported to the LSCB in March 2016. Overall, the findings indicate compliance by most agencies with most of the requirements with areas for development including improvements in supervision arrangements. All agencies have also carried out an audit of compliance with regional standards and are largely compliant. Below is a summary of statutory partners contributions to safeguarding children in 2016-2017.

5.1 Voluntary and Community Sector Refereing Group (VCSRG)

5.1.1 VCSRG has been a committed member of the LSCB since 2011. The voluntary sector plays an important role within a framework of multi-agency activity to safeguard and promote the welfare of children in Solihull and operates in line with statutory policies and procedures.

5.1.2 Our direct work with children and families is underpinned by safeguarding and makes us well placed to advocate and represent the voices of children and identify potential safeguarding issues. The sector is key to delivering the early help framework. Our work prevents referrals and enables quicker transition in and out of the MASH team and enables the statutory sector to undertake its duties and thus target scarce resources more efficiently. Our wider work with families and whole life circumstances helps reduce repeat referrals to children's services.

5.1.3 A VCSRG member regularly attends and feeds back from the LSCB meetings. We contribute to Case Audits and engage with the 3 priorities by applying the

tools, training and assessment frameworks that result from LSCB work, such as the Graded Care Profile, CSE Screening tools and thresholds to support.

5.1.4 The voluntary sector have a platform (Sustain) where they can access reports delivered by LSCB representative on areas of safeguarding children that is relevant to them. Members of the VCSRG sit on other boards that link to LSCB work including Solihull Partnership, adult Safeguarding and Solihull Together.

5.1.5 Case audits (2016) found that the voluntary sector were doing substantial work around the 'voice of the child'. Designated members of staff for safeguarding children were assigned and agencies recognised the importance of embedding safeguarding in supervision, routine training and policies and procedures. Organisations had access to various sources of training including the LSCB modules. The Engage led Solihull Community Champions programme has been adopted by the sector – which audits 'safe' services for children.

5.1.6 Timescales are generally met well in the voluntary sector and access to trained, experienced volunteers maximises opportunities to reach many more vulnerable children. Transition work sits commonly in the sector.

5.1.7 The voluntary sector also brings in substantial income to Solihull that support LSCB responsibilities in the early help area, including major grant trust funds that offer additional services such as training for children and families and direct work with schools. The sector is commonly recognising the increase in level of need and complexity of cases for children, including MH in children and young people. We are working closely with children at risk and experiencing Neglect and CSE and carry out substantial work within the Early Help framework to overcome this.

5.2 West Midlands Police (WMP) Neighbourhood Policing update:

5.2.1. All our staff are trained and understand the referral mechanism into Safeguarding and MASH. Solihull Partnerships Team have provided training to all of our frontline staff. We have attended the local authority training days to provide inputs to the School DSL's (Designated Safeguarding Leads), focussing on clearer lines of communications and named point of contact support from NPU staff.

5.2.2. Whilst officers understand the need and referral processes into MASH, much of the NPU work is targeted towards Intervention and Prevention at Early Help stage. Below are some key areas where our work is to identify and work with young people to prevent them from needing child protection services.

5.2.3. **Vulnerability Referral Portal**

The vulnerability referral portal is utilised by officers on a daily basis, recognising that individuals can receive assistance from voluntary and third sector organisations. Partnership support from Age UK (who offer a triage service and appropriate referral to approx. 250 support pathways) and Early Help /Engage ensure early support is provided to young people and families. This partnership has continued to develop with increasing opportunity to offer positive diversion for some that might otherwise enter into criminality.

5.2.4. **Schools Panels**

The development of Solihull's two schools panels (North and South) allows for positive data sharing to allow preventative interventions to take place. Data sharing occurs on a weekly basis with all secondary schools. The panels are held each school term. All CSE victims are brought to the attention of the schools panels and interventions put in place which also gives the DSL's opportunity to be part of CMOG on a case by case basis.

5.2.5. **Early Help / LPS Meetings**

Local Problem Solving (LPS) meetings are held regularly at Neighbourhood Level across the 5 Local Policing Ward areas. LPS invite partnership contribution to solve problems and case manage individuals – the Local Authority Engage services play a key role in decision making with young people brought to their attention during these meetings. LPS's ensure that issues are dealt with at local level with a multi-agency influence with support and governance provided from Partnership (Borough Wide) Tasking.

5.2.6. **NEET Intervention work.**

The partnerships team, working together with SMBC Childrens Services identified a list of 194 young people who are classified as NEET (Not in Education Employment or Training). Police systems have been searched and this list has been reduced to 96 of interest which have been sub divided (Level 1 being those actively offending, Level 2 some historic Police contact, Level 3 Not active with indirect Police contact). Multi-agency meetings have taken place to triage and refer these individuals to relevant organisations e.g. SOVA, Princes Trust, BITA Pathways or LOMU. Consideration has also been given to those not engaging in positive pathways with unsupportive parents to directly refer to DWP for investigation as to removing their child benefit**.**

5.2.7. **TIPT Packages and interventions at Neighbourhood level**

Neighbourhood teams are allocated TIPT (Targeted Intervention and Prevention Tool) packages which identify individuals who live on their respective wards who are at risk of offending and/ or are vulnerable. Officers put in place interventions and prevention plans and refer individuals to other support agencies as appropriate with a view to prevent offending or escalation into child protection or offending.

5.2.8. **Police Protection Unit**

There is continued commitment to the MASH process and the LSCB MASH and Engage duty desk review and findings. As part of the review DV triage was looked at and seen to be a robust process with the issue of consent being highlighted. We have sought to bring the joint DV screening in which carries out the consent triage and therefore gives partners greater confidence in sharing information and ensuring the right outcome for victims.

5.2.9. West Midlands Police have a neglect strategy which informs front line work. The WMP highlights neglect cases through the MASH process and are committed to investigating these crimes**.**

5.2.10. The MAET that has come into Eastern to respond at pace to the initial joint visits which was an issue highlighted in Ofsted report and we have seen an increase in early disposals of low level offending with the appropriate outcomes.

5.2.11. We have continued to support all LSCB groups and a number of audits and are present on every SCR panel, where we already adapt to any learning points prior to the final publication. We also attend all initial case conference in a timely manner through the case conference attenders**.**

5.2.12. Police representation at multi-agency training is much improved.

Areas for focus 2017-2018

5.2.13. The police will work with partners to consider the application of the signs of safety model in practice and will promote the application of the graded care profile tool, including a commitment to attend multi-agency training.

5.2.14. In terms of single agency training our officers continue to complete all relevant training and attend on-going CPD events to ensure they maximise their knowledge and experience.

5.2.15. We will finalise the work on pre-screening information shared with DA triage and continue to lead on multi-agency developments around CSE.

5.3 NHS Solihull Clinical Commissioning Group (NHS CCG)

Achievements

5.3.1. Our safeguarding vision is to continue to commission services that promote and protect individual human rights, independence and well-being and secure assurances that the child or adult thought to be at risk, stays safe. Some of our key achievements for 2016/17 are shown below:

- We have established internal systems and processes and influenced across partnerships at national, regional and local levels to enable implementation and system cultural changes which will secure improved outcomes.
- Our designated doctor has taken a major role in the development of local services for the investigation of female genital mutilation (FGM), the updating of Chaperone policies for children in the light of the Myles Bradbury report and the updating of Local Safeguarding Children's Board procedures on self-harm and the 'neglect strategy.'
- Our head of safeguarding/ designated nurse has been actively engaged in the fight against modern day slavery. Regionally, and during 2016 we have been supporting the implementation of both international and national law and guidance through the West Midlands Anti-Slavery Network.

- Solihull CCG was audited by the CW Audit (internal NHS auditors) during May 2016. We have maintained the status of having 'significant controls' in place for safeguarding and public protection.

Challenges in Solihull

5.3.2. CCGs are not the sole commissioner for services provided to Solihull or neighbouring authorities' citizens and this can be confusing. We have therefore provided support to families via the Care Navigators based in Solihull Member Practices which can help people find their way around the system**.**

5.3.3. The 2016/17 and 2017/18 Sustainability and Transformation Plans (STPs) and the Birmingham and Solihull Health Commissioning Board work streams should strengthen assurances for local population and across the West Midlands Partnerships and for Birmingham and Solihull CCGs.

Solihull CCG Going Forward

5.3.4. **2017-18 key priorities for Solihull CCG and safeguarding team currently remain to:**

- Get better at protecting people from harm to include: early and/or preventive help for those at risk of abuse, including the local priorities given to child sexual exploitation, domestic abuse and neglect.
- Give every child the best start in life, this includes children with disabilities, looked after children, children and families meeting the local authority thresholds of intervention and those subject to child protection plans.
- Work in partnership to embed and implement the Care Act 2014, Making Safeguarding Personal, the Mental Capacity Act and support for children with care and support needs moving into adult services.
- Continue to support and strengthen system wide safeguarding quality assurance, including monitoring visits; assisting with evidencing best practice and improvements and making a difference to improving the safety and welfare of our most vulnerable residents.
- Continue to support greater system-wide learning, review and actions and evaluate outcomes of all domestic homicide reviews, serious case reviews action plans and Significant Incident Learning Process of both single and inter-agency action to receive assurance that plans have been implemented and in turn improves outcomes for children and adults with care and support needs in Solihull.
- Maintain systems for safeguarding training and competencies, ensuring learning and development positively impacts on practices and in turn improves outcomes for children, adults with care needs and their careers.
- Prepare to support system wide change as the Children and Social Work Act 2017 comes into force and the Mental Capacity Bill receives Royal Assent.

5.4 Birmingham and Solihull Mental Health Foundation Trust

5.4.1 During 2016/17 BSMHFT has continued to strengthen and increase the Safeguarding Team presence in operational services within Solihull in order to improve the effectiveness of safeguarding children and young people.

5.4.2 The Safeguarding Team have reviewed their quality assurance framework and are in the process of introducing a new model which will be implemented incrementally to improve the quality of clinical safeguarding practice across the Trust. The framework will include the introduction of practice guidelines.

5.4.3 The Safeguarding Team have prioritised providing support to Solar which provides Child and Adolescent Mental Health Care. A new management structure is being introduced and the Safeguarding Team have contributed to writing an improved operational framework and action plan.

5.4.4 With regard to partnership working, BSMHFT's Executive Director of Nursing is a Board Member and the Safeguarding Team attend the Child Sexual Exploitation and Missing Operational Group (CMOG), the CSE Steering Group and have worked to improve communication pathways with MASH and Engage. They have also contributed to the local Serious Case Review Process with panel membership and provision of reports.

5.4.5 **Training:**

In March 2017 The Safeguarding Team hosted a conference "Keeping the Family in Mind", which was to improve staff understanding of SCIE 30 Guidance and their role in Early Help intervention. This was supported by Engage who contributed to the programme.

5.4.6 Safeguarding training continues to be provided as per intercollegiate Levels 1, 2 and 3 and is mandatory. Solar staff will be expected to attend annual safeguarding training. This will be introduced during the 2017-18 financial year. We also provide training on Domestic Abuse, Female Genital Mutilation and Child Sexual Exploitation.

5.4.7 A whole Trust Training Needs Analysis (TNA) was produced for 2016/17. There is an additional TNA in progress specifically for Solar Staff.

5.4.8 **Training Compliance at end of Quarter 4 2016/17:**

Safeguarding Children	Training % Compliance
Level 1	96.4%
Level 2	91.6%
Level 3	91.6%

5.4.9 **Audit:**

We operate an "Assurance Visit" programme and have an audit cycle. We use "Patient Stories" to improve safeguarding quality. The Safeguarding Team have

collaborated with MASH to audit the quality of child safeguarding referrals sent from Solar into MASH and a plan is in place to improve quality and completeness of such referrals.

5.4.10 **Supervision:**

The Safeguarding Team provide monthly safeguarding supervision to operational staff.

5.4.11 **Areas for improvement for 2017/18:**

- Safeguarding practice needs to be supported by effective operational leadership and thorough clinical understanding of safeguarding. We are introducing a Quality Assurance Framework to support and improve this with associated guidelines and standards.
- Staffs understanding of Early Help needs to be improved and we need to evidence our participation in early help provision more effectively and accurately.
- Child Sexual Exploitation continues to be a national and local priority. BSMHFT are piloting CSE routine enquiry and screening of 16-18 year olds attending with mental health crisis in Emergency Departments in order to improve identification and follow through.

5.5 Heart of England NHS Foundation Trust

5.5.1. The Trust is committed to ensuring the safety of children and to equipping staff with the appropriate training, advice, support and supervision to identify and respond proportionately to the needs of children and families.

5.5.2. **During 2016-17 the Trust has:**

- Continued to develop and refine partnership working in the Multi-agency Safeguarding Hubs in Birmingham and Solihull, improving the timeliness of information sharing and increasing capacity for joint decision making for children.
- Expanded the scope and scale of safeguarding supervision and access to advice and support within the organisation helping to support staff and enhance their decision making.
- Continued to scope the safeguarding educational needs of the whole workforce and develop various online learning resources hosted on Moodle.
- Maintained safeguarding children training levels at over 95% for Level 1 and 2 and over 90% for Level 3.
- Enhanced the safeguarding assessment skills used in the NNU and Community settings with the rollout of specific training.

- Continued to deliver training to support the identification and response to child sexual exploitation and PREVENT (compliance rates now over 80% for both).

- The Trust a Safeguarding Conference which was extremely well attended and evaluated.

- Implemented the recommendations from the Lamphard Review (2015).

- Continued to lead a well-established safeguarding audit programme which focuses on transition points or areas of identified risk.

- Monitored patterns of safeguarding activity and demonstrated substantial improvements in the quality of information provided in safeguarding referrals throughout the organisation through targeted interventions in key areas.

- Increased mechanisms to provide service user feedback in relation to safeguarding within the organisation.

- Enhanced links with complaints and incidents which enhances intelligence about user experience and safeguarding.

- The Trust is able to provide examples of specific cases where children or adults were identified as vulnerable/ at risk of abuse or neglect and due to sharing of information effective multi-agency responses were put in place to safeguard.

- The Trust has enhanced the domestic abuse advice available in the Trust, increased access for patients to specialist advice through partnerships with Women's Aid and increased in house educational opportunities in relation to dome Raining to support the identification and response to domestic abuse.

5.5.3. **Moving Forward**

The Trust will continue to review its compliance with all statutory requirements from the Care Act 2014 and the Children Act 2004 and 1989, reporting quarterly internally and to relevant external partners.

5.5.4. In addition the Trust is working to:

- Enhance the learning and development opportunities in relation to PREVENT and CSE.

- Increasing audit activity and reviewing all audit findings to ensure the most critical issues are subject to scrutiny.

- Enhancing the provision of early help to families.

- Continue to seek to enhance user/ patient feedback in relation to safeguarding.

5.6 Cafcass

5.6.1 Cafcass (the Children and Family Court Advisory and Support Service) is a non-departmental public body sponsored by the Ministry of Justice. Cafcass represents children in family court cases, ensuring that children's voices are heard and decisions are taken in their best interests.

5.6.2 The demand on Cafcass services grew once again in 2016/17, by around 13% in public law (involving the local authority) and 9% in private law (involving arrangements for children following parental separation). Demand is now approximately 30% higher in public law, and 20% higher in private law, than it was three years ago, putting the family justice system under considerable pressure. Nonetheless, each of Cafcass' Key Performance Indicators has been met.

5.6.3 Cafcass' main priorities in 2016/17 were to continue to improve the quality of our work, and to support family justice reform. These are a few examples of how we have done this:

- Production of the Domestic Abuse Practice Pathway which provides a structured framework for assessing cases where domestic abuse is a feature, and ten new evidence-based assessment tools.

- A revised Quality Assurance and Impact Framework, together with mechanisms to establish, and raise, the quality of our work including thematic audits, Area Quality Reviews, and the work of the National Improvement Service.

- Provision of continuous Learning and Development opportunities for staff including: e-learning; Research in Practice resources, the Cafcass library and the dissemination of internal research.

- Contributions to innovations and family justice reform, designed to improve children's outcomes and make family justice more efficient. These are formed in private law by projects trialling pre-court or out-of-court ways of resolving disputes; and in public law projects aimed at helping local authorities and parents to 'find common ground', thus diverting cases from or expediting cases within, care proceedings.

- Support to our child exploitation and diversity ambassadors/champions who collate learning from inside and outside the organisation on these subjects and promote it to colleagues.

- The Cafcass research programme which supports the work of external researchers, such as the ground-breaking work of Professor Karen Broadhurst and her team into repeat removals from mothers in care proceedings; and undertakes four small-scale internal research projects each year. This year we have undertaken, for example, studies into: domestic abuse in spend-time-with (contact) applications (this has been in collaboration with Women's Aid); trafficking and radicalisation cases known to us; and high conflict (rule 16.4) cases.

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5.7 Solihull Community Housing

5.7.1. Solihull Community Housing (SCH) is an Arm's Length Management Organisation (ALMO), which provides landlord and other housing services on behalf of Solihull MBC.

5.7.2. SCH is governed by a Board of 12 members, a third of whom are Council nominees, one third tenants and one-third independent representatives, chosen for their specialist skills and experience. A Scrutiny Committee made up of tenants and leaseholders assists in reviewing performance across all areas of our business.

5.7.3. In addition to providing traditional landlord services for Council tenants, SCH delivers a cross tenure anti-social behaviour service, housing options and homelessness services, together with home adaptation and support services to help those with mobility problems or other support needs, to continue to live safely and comfortably in their own homes. This includes, for example, adaptations for the benefit of children with physical disabilities.

5.7.4. SCH has been a member of the Local Safeguarding Children Board since 2006. We continue to be committed to safeguarding, recognising the important role that housing can play within a framework of effective multi-agency activity to safeguard and promote the welfare of children**.**

5.7.5. We have an internal Safeguarding Champions Group, and safeguarding updates and newsletters are disseminated via a combination of Business Bulletins, e-mail and postings on SCH's safeguarding intranet pages.

5.7.6. SCH's Delivery Plan sets out our key delivery objectives for the coming year. 2017/18 will be the first year of SCH's new Future Strategic Vision (2017- 2022): to Provide Homes, Improve Wellbeing and Strengthen Communities. A key theme within the strategy, and reflected in the Delivery Plan, is to work productively with partners and to support the Council to achieve its priority objectives.

5.7.7. From April 2017, a new Youth Hub service, delivered by St Basil's, will provide housing advice and assistance to all young people aged between 16 and 24. This arrangement is being piloted for a two year period and is anticipated to increase homelessness preventions for this age group. Any statutory housing duties that arise will continue to be delivered by SCH on behalf of the Council.

5.7.8. SCH frontline staff have many contacts with customers who have children, both in their homes and in our offices. Early identification of issues and appropriate referrals for support or intervention, together with continued engagement with multi-agency working including case audits, the Domestic Abuse Triage, MASH and CSE groups, all contribute to the LSCB's priorities**.**

5.8 Solihull Early Years

5.8.1. Solihull Early Years and Education Improvement Service (SEYEIS)

- Safeguarding continues to be a high priority in Solihull early years and childcare provision.

- Childminder, private, voluntary, independent (PVI), and maintained early years provision continues to improve across the borough. Currently 94.7% of providers are judged to be good or better by Ofsted. Less than 1% of settings are judged to be inadequate and less than 1% of settings have had safeguarding identified as an area for improvement during an inspection.

- The Early Years team within SEYEIS continue to provide a Setting Improvement Strategy (SIS) visit for all PVI providers. Early Years provision within schools is visited as part of the school improvement visit in the autumn term. Safeguarding practice is monitored and evaluated part of the discussion held during the visit; this includes exploration of practitioner knowledge and understanding of issues such as abuse and neglect, Prevent, and CSE, and checking out that they are using the Thresholds to support referrals to the right service at the right time.

5.8.2. Early years Training

- Safeguarding Awareness training is offered to all providers. The training explores key aspects of safeguarding including abuse and neglect, Prevent, CSE and FGM. Reference is also made to Early Help.

- We have combined the awareness and refresher training sessions to accommodate the needs of practitioners as a result of feedback. This year we have doubled the number of training sessions offered in response to demand from providers.

- Safeguarding is included within the Childminding Induction programme.

- The agenda at Leaders and Managers termly meetings always includes a section on Safeguarding to ensure it remains at the forefront of practitioners' minds.

- This year we have introduced a Designated Safeguarding Lead (DSL) course aimed primarily at the registered provider or committee and the setting's DSL.

- We now have a dedicated early years website www.solgrid.org.uk/eyc on which is posted information and links relating to safeguarding.

April 2016 – Mar 2017 training attendance	**Safeguarding Awareness (13)**	**DSL (2)**	**Safer Recruitment (2)**	**LSCB Modular training (Varied)**
PVI providers	268	57	20	55

5.8.3. **Ofsted and Local authority meetings**

- As of March 2017, there are no Early Years Regional HMIs due to a restructuring within Ofsted. At this stage it is not clear whether the termly meetings will continue between the Early Years team and Ofsted to discuss provision within the borough.

5.8.4. **Safeguarding in Education Provision 10 Safeguarding in Education Provision**

5.8.5. There is 100% compliance to the 157/175 audit process. All 93 education providers in Solihull engaged in the process in Summer 2016. This included Local Authority maintained schools, academies, independent schools and Post 16 provision.

5.8.6. Governance of safeguarding is strong in education. School leaders are reflective of their practice and seek to continually improve. Designated Safeguarding Leads (DSLs) attend training regularly to keep up to date. Safeguarding governors attend safeguarding training around their statutory duties provided by the local authority.

5.8.7. Education providers are clear on the importance of safer recruitment processes. Education leads (Head teachers, governor, bursar or admin) attend training, which focuses on safer recruitment and selection, which focuses on maintaining a culture of vigilance, provided by the local authority. Health and safety audits and fire assessments are in place and up to date.

5.8.8. All education providers in Solihull have clear oversight of pupil numbers where there are child protection concerns and the level of risk. Education providers are increasingly well skilled at identifying pupils at risk of harm using the Solihull multi-agency thresholds. They are also becoming increasingly skilled in knowing the thresholds of early help for pupils in need of additional help**.** This is as a result of the work promoting educations providers' understanding of early help and safeguarding being everyone's business, and the rigorous application of Solihull's multi-agency thresholds criteria in identifying pupils at risk and providing an appropriate level of support**.**

5.8.9. All education providers understand the requirements of the Prevent Duty. The Preventing Radicalisation and Extremism pathway in the DSL Handbook supports staff in ensuring staff are trained, the PSHE curriculum includes teaching pupils about radicalisation and extremism, and how to act in the event of a concern. This is regularly reviewed, and updated**.**

5.8.10. Education leads on the prevention of CSE. There is on-going training in this area (both multi-agency through the LSCB and sector specific through SEIS) and this strengthens their work. The new under 12s screening school has been well received by education providers. The over 12's CSE screening tool is now well embedded and supports decision making around safeguarding pupils considered to be at risk of or being subject to CSE**.**

5.8.11. Education engagement in the early help domestic abuse triage process is positive. Education providers liaise well with the education MASH representative, providing prompt responses about school attendance, presentation, concerns and parental engagement. The DVRIM and DASH tools continue to be a focus to ensure that all education providers use these to inform decision making and referrals, sending them with any referral. This continues to be a priority, linked to current LSCB priorities and being mindful of the impact on parenting capacity of the toxic trio, poverty, and disability in the family**.**

5.8.12. Education providers are aware of their duty to report known FGM . DSL's have received awareness training. A new FGM screening tool is currently in its draft format, and has been shared with education providers for their comments. A FGM pathway in the DSL handbook and child protection policy is a clear point of reference of education staff.

5.8.13. Education providers continue to be increasingly skilled in identifying neglect and communicating the level of concern, using the Solihull Multi-agency Thresholds criteria. The Neglect strategy has been shared across the sector. Education staff receive multi-agency training on neglect (LSCB) and sector specific training (SEIS). A neglect pathway has been produced for education providers to support them in their work which is included in the DSL Handbook.

5.8.14. LSCB education sub-group has representation from across each collaborative as well as post 16 and independent schools. This group provides a mechanism for dissemination of key information from the LSCB board and a forum for raising any queries and issues around safeguarding and ensuring an appropriate level of response**.**

5.8.15. The PSHE work in education has been strengthened through the embedding of healthy safe relationships work and the DSL Handbook which focuses on specific safeguarding issues and how pupils can be taught about these in the curriculum and make safe choices/know how to act in the event of a concern about a peer or sibling. The peer on peer abuse section has been revised and stronger links made to the anti-bullying pathway and the sexually inappropriate behaviours pathway.

5.8.16. Attendance (children missing from education) was a key focus of the summer 2016 safeguarding visits, ensuring correct attendance codes are being used and registers are being recorded appropriately; and checking that pupils are where they should be. Attendance of disadvantaged pupils, particularly FSM pupils remains a priority moving forward.

5.9 Community Rehabilitation Company (CRC)

5.9.1. This has been a year of transition for Solihull Community Rehabilitation Company (CRC). A restructure has been underway for the past year putting into place "Our Plan to Change Lives", Staffordshire and West Midlands (SWM) CRC's new operating model. Our Plan can be accessed here**:**
http://dlnrcrc.co.uk/dec2015/Our_Plan_to_Change_Lives_Magazine_%28Low%20Res%29.pdf

5.9.2. It is predicated on an approach to reducing re-offending that can be summarised as "Whole Person, Whole Journey, Whole System". In order to make Our Plan a reality, the organisation's staffing is being restructured. In addition, Solihull probation will move into new offices as well as onto a new IT platform**.**

5.9.3. Against this background of considerable change, Solihull CRC has continued to deliver services to its service users, some of whom have care and support needs, particularly with their mental and emotional health. Solihull CRC works in partnership to ensure that vulnerable service users are supported towards reducing their reoffending however for those who do not engage as required by their court order or prison release conditions, breach or recall to custody is the end result.

5.9.4. Solihull CRC proactively seeks service user engagement and achieves this through its links with User Voice, a service user led organisation commissioned by SWM CRC to improve our service by creating service user councils through which feedback from service users is gathered and fed back to SWM CRC's Executive Team. Nathan Emanuel, User Voice Midlands Programme Manager, said in Our Plan to Change Lives:

"I think one of the biggest changes for the CRC in the last 12 months is the value of co-production between Service Users and the CRC. The Service User is being valued by the new business and is giving them a real opportunity. More people will be switched on by the willingness of probation to assist in their change and give them a platform to transform their lives."

5.9.5. Establishing Our Plan to Change Lives has been the main priority for the organisation however this has not compromised our stance on frontline officers contributing to the child safeguarding system in the Borough. This is a position that the CRC will not compromise on owing to the fact that many on our caseload are adults with vulnerable children. In the same vein we continue to contribute to the Multi-Agency Risk Assessment Conference (MARAC) as well as to the Domestic Violence triage systems in Solihull. These, together with our domestic violence programmes, partnership working and routine use of home visits, also contribute to identifying and addressing safeguarding issues.

5.9.6. In the coming year, we will be focussing on the implementation of Our Plan to Change Lives and this will continue our focus on Solihull CRC's contribution to safeguarding children in the Borough.

5.10 National Probation Service

5.10.1. The National Probation Service (NPS) works with high risk of harm sexual and violent offenders and all sexual and violent offenders qualifying for management under the MAPPA (Multi Agency Public Protection Panel Arrangements). It is also responsible for all public interest decisions in relation to offender assessments and management, such as court reports, parole reports and the breach of cases supervised by Community Rehabilitation Companies, (CRCs).

5.10.2. The NPS team in Solihull is responsible for:

- Assessing the risk of serious harm posed to children by offenders due to their actual offending, including targeting children or the impact it has on them, for example domestic abuse.

- Highlighting concerns in relation to potential harm e.g. substance misusing parents /carers, challenging environments.

- Identifying children at increased risk of exposure to victimisation including CSE, Honour Based Violence, Female Genital Mutilation, Organised Crime and Serious Group Offending as either victims or perpetrators.

- Identifying children at risk of anti-social behaviour and other negative behaviour due to the behaviour of parents and others.

- Taking account of the impact of caring responsibilities on the parents/carers ability to comply with the proposed sentence of the Court.

- Considering the impact imprisonment will have on the child/ren's welfare when custody is a stated option of the Court.

- Supporting families to access services to support rehabilitation for parents/carers and positive outcomes for children and families.

- Sharing information to support the safeguarding, protection and welfare of children at both strategic and operational levels.

- Responding to requests for Serious Case Reviews, including archived cases, and reviewing involvement in the management of the cases including court process and allocation.

- Liaising directly with CRC colleagues to complete risk escalation processes and support the completion of Serious Case Reviews to include court process and allocation.

5.10.3. During 2016 -17 the NPS in Solihull has prioritised establishing core operational practices in the new organisation. These have included:

- 'Baselining' core child safeguarding training to ensure that all NPS employed staff have received the new customised NPS core training.

- Engaging with LSCB to establish business prioritises.

- Ensuring that the office systems for child safeguarding are in place and taking action to ensure staff are following the systems.

- Monitoring the checking and referral tracking system and supporting offender managers in chasing responses and when necessary escalating the referral to a manager in Children Services.

- Assuring that each member of staff has read the Working Together Guidance 2015 along with other key NPS documents developed to support public protection.

- Providing staff with the opportunity during their line management meeting or as part of routine consultation, to discuss concerns they have for the children of the people they supervise, and supporting them in clarifying what actions are required to manage the risks posed.

- Reviewing all the relevant safeguarding children cases being managed by their team with any case with a named child at high risk being highlighted to the Senior Probation Officer with regular updates.

- Contributing to the development and engagement with multi agency arrangements including MAPPA, MARAC, Children Protection Conferences, Multi-Agency Safeguarding Hubs and Youth Offender Services.

- Setting up arrangements for transfers of young adults cases, to include an up to date risk assessments and if possible, three way meetings.

- Liaising with CRC colleagues to set up and maintain arrangements for the purpose of risk escalation.

5.11 Youth Offending Services

5.11.1. Solihull Youth Offending Service (SYOS) is a multi-agency service which consists of the Local Authority, West Midlands Police, Probation and Health. Solihull YOS is a specialist service based within the Childrens, Young People and Families department of the Local Authority. The primary aim of the service is to prevent and reduce youth crime across Solihull, delivered through the following objectives:

- preventing and reducing offending
- reducing reoffending
- increasing victim and public confidence
- ensuring the safe and effective use of custody

5.11.2. The safety and wellbeing of young people is integral to the assessment, planning and delivery of interventions to safeguard public protection and community safety. During 2016-2017 the main objective was to stabilise the service following the departure from Solihull's Engage service. In light of this the YOS Management Board agreed the YOS would deliver against a two year youth justice plan as opposed to a one year plan.

5.11.3. The YOS continues to see low numbers of young people entering the youth justice system. This is not only supported by the vision of prevention and early intervention from both SMBC's Early Help and the Police's Thrive Plus strategy. Collaborative efforts have seen first time entrants reduce by a half compared to previous years. Unfortunately however this is against a back drop of an increased number of young people reoffending and committing more offences.

5.11.4. **YOS Performance**

The throughput of total number of offences committed within the 2016-2017 period increased but only slightly by 9%, the equivalent of 9 more offences being committed in the cohort. Almost 50% of the client group that YOS provided a service to were from prevention referrals directly sourced from the Police or MASH/Engage duty desk.

5.11.5. **First Time Entrants (FTE's) to the Criminal Justice System:** The data set for first time entrants outlines a reduction of 52%, from 81 in the previous year to 42 in the comparative cohort for 2016. Solihull has remained well below the local and national average for FTE's. The success of this reduction are collaborative efforts of agencies delivering robust prevention and early intervention services including prevention support from within the youth offending service, support from the Engage Service and the delivery of the Police's thrive Plus model, all of which focus on intervening at the earliest opportunity to reduce the risk of vulnerability and risk of reoffending. The YOS in particular have reinvested in the prevention as part of the early help offer through:

- Promotion of the YOS's early help offer of prevention (formally YISP) and intensive one to one support which includes a robust assessment of need using ASSET Plus.

- Developing the pre court offer with the Youth Crime Officer. An increase in police contribution by the Police has supported the development of an offer for young people in receipt of Acceptable Behaviour Agreements, Anti-Social Behaviour and on the verge of entering the criminal justice system through. This is delivered by the additional Youth Crime Officer that has been in post since November 2016.

- The development and delivery of youth crime prevention programmes within the Pupil Referral Unit.

- Better links with the step cross process with Engage and MASH.

- The local offer to support and reduce the number of looked after children entering the criminal justice system

5.11.6. **Reoffending rates:** The rate of reoffending has seen a slight increase from the previous year's data (2013/2014). The increase is as a result of the lower number of offenders in this cohort committing fewer offences, compared with more offenders committing the same numbers of offences. There was a slight increase in the frequency of reoffending but the baseline was significantly lower for Solihull in comparison to others and remains well under the national average.

5.11.7. From July 2016 the YOS began collating using the live reoffending tool. The 6 month data highlighted above shows a very encouraging downward projection of reoffending within the 6 month period in comparison to the annual data collated between June 2014 – June 2015. In order to make a robust analysis of the reoffending rate it is important to revisit this following a full year of data collection.

5.11.8. **Use of Custody following Sentence:** There has been a further reduction of the number of young people entering custody, from an already low baseline. This in line with national and regional trends.

5.11.9. In June 2017, the Crown Prosecution Services launched revised guidelines for sentencing young people. As a result, the YOS have therefore seen an increase in requests for Pre Sentence Reports which is followed by an assessment of the young person and the offence to assist the magistrate in sentencing to the most suitable order.

5.11.10. **YOS Performance against LSCB Priorities:** Young people entering the Youth Justice System lead complex and troubled lives. Therefore the YOS will continue to operate across thresholds and will work in partnership with key agencies to support vulnerable young people. The YOS will offer preventative and statutory support to young people who have Children in Need Plans, young people known to CSE services, and will continue to support young people at risk of offending to support both the Youth Justice and the Early Help agenda through prevention services.

5.11.11. The table below reflects young people open to the YOS during 2016-2017 and also children's services specialist teams. Increases in young people requiring YOS support are noted from the LAC team and the CSE Team. This may be a direct result of the Children In care and YOS protocol, with Social Workers referring the right young person for support.

Specialist Childrens Services Teams	Number of young people open to YOS and specialist teams April 2015- March 2016	Percentage of overall YOS cohort April 2015 – March 2016	Number of young people open to YOS and specialist teams April 2016-March 2017	Percentage of overall YOS cohort April 2016 – March 2017
CIN	23	16%	17	21%
LAC	4	2%	10	12%
CSE	3	2%	6	7%

5.11.12. In addition to the above, the YOS also supported 5 young people referred for Sexual Harmful Behaviours intervention.

5.11.13. **YOS Priorities 2017-2018**

The YOS will continue to deliver against key national indicators including reduction in first time entrants, reduction in reoffending and reduction in custody. Locally it has also been agreed that there will be a focus on reducing the number of looked after young people entering the criminal justice system, and securing better outcomes for young people who enter the youth justice system who have

special educational needs. The delivery against the Solihull Action Plan will be monitored quarterly at the YOS Management Board.

5.12 Solihull Local Authority Childrens Social Work Services

5.12.1 The appointment of a new Assistant Director, Children, Young People and Families this year is providing new impetus and energy for social work practice. There is a relentless focus on practice improvements, active involvement of management in providing support, challenge and oversight of social work practice and a visible presence in the field. This provides opportunities for conversations, challenge and dialogue and the creation of a culture for professional growth and development.

5.12.2 At the centre of this whole-systems change is the growing understanding, awareness and application of the Signs of Safety model of social care provision. The approach provides a simple structure for child protection processes and has gained widespread support from partners and family members, clearly demonstrated in an evaluation report carried out by the Principal Social Worker. Children's Services have begun to apply the model more broadly to help children at child in need and early help levels of the threshold framework. They have used it in revising referral templates for MASH and Engage duty. In 2017-18 they will build on the positive progress already made by ensuring core groups and other key meetings use the Signs of Safety effectively. The Ofsted report (Ofsted July 2016) noted that MASH is working well. A further review of MASH was carried out by the LSCB in March 2017 and validated those findings with recommendations for further development on quality assurance, governance and decision-making. The Local Authority has implemented the recommendations of individual management reviews for a serious case review published in October 2016 and will continue to contribute to the LSCB improvement plan to deliver on lessons learned.

5.12.3 Regular audit by an external consultant provides consistent and sound management oversight and challenge. There is a continuing focus on providing high quality and timely assessments with appropriate meaningful analysis and a determined effort by management to oversee improvements. Regular events for social workers place an emphasis on key areas of practice and learning is reinforced by managers.

5.12.4 Management oversight enables a clear view of thresholds and decision making throughout the child's journey. For example, child protection plans at 18 months are scrutinised and challenged appropriately by management to support sound decision making and prevent drift and delay. Children's Services have also introduced a mechanism for testing and learning from decisions to end a child protection plan when a further plan is required within 18 months. Although it is too soon to take aggregate learning from this, there has already been child-level learning.

5.12.5 The number of unaccompanied asylum seeking children has stabilised but remains at a much higher rate than local and regional averages. We anticipate that the number will reduce in 2017-18 because of the newly implemented National Transfer Scheme. However, progress regionally and nationally is slow and so far there has been no impact on our figures.

5.12.6 The workforce strategy, including recruitment and retention has seen an increase in permanent staff, in particular at team manager level. We have also increased the number of assistant team manager posts to improve management oversight. This is beginning to show improvements. There is greater stability at the front lineSocial worker caseloads average 18 children but there are still peaks and troughs and further work is needed in 2017-18 to ensure that they remain manageable.

5.12.7 We aim that Solihull becomes the employer of choice for social workers. Recently appointed social workers tell us they have made a positive decision to apply to us because of our reputation for manageable caseloads, good supervision and management stability and support. The local authority is working with the LSCB to implement the Graded Care Profile tool in practice. Already well underway, training will be completed for social workers and early help practitioners in 2017-18 and will enable comprehensive use to support assessment and decision-making and so reduce the harm caused to children by neglectful parenting.

5.12.8 The Children, Young People and Family senior management team (SMT) and Children's Services directorate leadership team (DLT) both scrutinise performance date monthly, providing detailed oversight and challenge and directing remedial action where necessary. Each head of service also regularly scrutinises performance data and works with their teams on continuous improvement.

5.12.9 The rate per 10,000 of children looked after is higher than statistical neighbours and the England average. Individual decisions to bring children into care appear safe and sound. There are robust pre-proceedings arrangements in place and a continual focus on ensuring that the full range of alternatives available are regularly considered for children when seeking permanent placement options for them. There is a dedicated resource in the Local Authority legal department with a remit to provide legal advice. Legal planning panels are held and are timely and consistently structured to ensure all available options in terms of family placements are considered. In 2017-18 the Council will launch an edge of care team aimed at intervening earlier to prevent the need for children to become looked after. The local authority children's social work and early help services: next steps for reducing the number of children who need to become looked after.

- Improving social work assessments so that they are succinct, analytical, reflect an understanding of the child's history and clearly shape plans and interventions.

- Improving core group processes and quality, including revised templates, so that they drive practice for children on child protection plans.

- Ensuring all social workers understand and apply the new data protection legislation.

- Procuring a new electronic case management provider to enable efficient and user friendly recording. (This work is being led corporately).

- Ensuring statutory visits are always done and recorded on time.

6. LSCB effectiveness: Summary Analysis

6.1 Combined and individual efforts to safeguard children are supported by a sharp focus on the LSCB priorities and an associated succinct performance framework. The LSCB infra-structure provides visibility and transparency, enabling challenge by partners and the independent chair. Progress is being made on all 3 priorities and the regulation 5 duties of the LSCB continue as normal business. The voice of the child is increasingly evident in the work of the board. Young people are consulted directly and regularly around training and the LSCB's developments.

6.2 Learning from case audit, the learning faculty, the serious case reviews, the MASH and engage duty desk and DA triage review and performance analysis is incorporated into the improvement plan. The new training strategy is well received. Practitioners and managers in partner agencies are beginning to gain confidence through the new competencies they acquire in training. Analysis of performance data shows overall continued improvement in performance. Regular monitoring will ensure this is sustained.

6.3 A summary of areas for development: In 2017/2018.

Source	Area for improvement	Lead
CSE	Sharing intelligence about children missing form home or care and using it for tactical and strategic disruptive activities.	Jo Floyd, Chair CSE steering group.
	Young people reaching adulthood who are at risk of sexual exploitation	
	Increased connectivity between strategic and front line activity.	
Neglect early help	Revise neglect strategy	Simon Rushall, Chair LSCB policy sub-group
	Create processes to promote collaboration to support children where there are concerns about neglect that do not meet the threshold for statutory child protection procedures.	
	Provide Graded Care profile training	LSCB trainer, Denise Lewis
Early Help	Revise early help strategy	Ian Mather, Public Health and chair of Early Help Programme board.
	LSCB to evaluate early help training	Denise Lewis, LSCB trainer
Analysis of performance data	Improve the quality of referrals	Simon Stubbs, Local Authority in consultation with partners.
	Receive LA audits of children with CIN, CPP and CLA where neglect is a concern.	
	Receive reports on the work carried out by conference chairs on repeat CP plans.	
Individual agency accounts	Propose a performance panel.	Betty Lynch, LSCB manager.

7. LSCB BUDGET AND SPENDING 2016/17

Contributions made	2016-2017
	£
Solihull MBC – including Schools forum	132,090
Solihull Clinical Commissioning Group	67,000
West Midlands Police	12,500
Heart of England Foundation NHS Trust	12,400
Solihull Community Housing	10,000
Community Rehabilitation Company and National Probation Service	1,977
CAFCASS	550
External Income	16,450
Carry Forward from 2015/16	4,806
Deficit funded by Solihull MBC	14,710
TOTAL INCOME	**272,483**

Spending Summary	2016-2017
	£
Pay, Overheads and Training	201,746
Independent Chair	24,116
Grants, Subscriptions, ICT etc	17,619
CDOP	13,000
Serious Case Review authors and independent consultants.	8,193
Room Hire	4,781
General Office Expenses	3,028
TOTAL EXPENDITURE	**272,483**

8. LSCB Attendance at Board Meetings 2016/17

Attendance at LSCB meetings 2016/17 (1st April 2016 – 31st March 2017)	Agency attendance
Birmingham & Solihull Mental Health NHS Foundation Trust	75%
CAFCASS	50%
Clinical Commissioning Group	100%
Community Rehabilitation Company	50%
School Representatives	100%
Heart of England NHS Foundation Trust	75%
National Probation Service	50%
NHS England	0%
Solihull Metropolitan Borough Council	100%
Solihull Community Housing	75%
Third Sector	75%
UK Visa and Immigration	25%
West Midlands Police	100%
Also the Lead member for children and young people is a participant observer and attended 100% of meetings in 2015/16	

9. Apendices: Performance data

Solihull Local Safeguarding Children Board: Monitoring effectiveness 2016- 2017			
LSCB Priority: Neglect; (Impact of the neglect strategy 2014-2017) This data informs the LSCB about the impact of the neglect strategy using high level key performance indicators. Data on the impact of communications and training is provided. The majority of children with child protection plans will be living with domestic violence, substance misuse and/or parental mental health problems violence. Data on children with child protection plans for 18 months or more provides insight into actions taken to prevent drift and delay.			
LSCB objective	Data Owner	Key Performance indicator	2016/17 End of year.
To promote the neglect strategy through training and communications	Denise Lewis	Nos of professionals reached through LSCB briefings	84
		Nos of professionals attending all LSCB training.	649
Ensure high quality training on neglect including. See training report for impact of training.	Denise Lewis	Nos of professionals receiving neglect training Nos receiving coercion and control training. Nos receiving graded care profile training.	114 5 38
Challenging drift and delay.	Simon Stubbs	Case audit. See case audit report. In most cases seen, drift and delay was recognised and challenged.	
		Percentage of children with child protection plans for 18 months or more.	2% (7.4% at year end 15/16)

CSE performance data: Delivering the CSE strategy 2015-2017 data for 16/17

PREVENT

CSE Strategic Objective 1: Raise awareness among children and young people about safe and healthy relationships, including online safety

Action	Data Owner	Progress Against Objective
Raise awareness among children and young people about safe and healthy relationships, including online safety	Bev Petch	No. of primary schools (key stage 2) where happy and safe relationships is embedded in the PHSE curriculum: **40** (out of 53, cumulative - 75%) NB. All of these schools are working on embedding this learning. The figure will be 100% by the end of 2017 when all will be using 'Jigsaw' resource that has safe and happy relationships learning explicitly threaded throughout.

CSE Strategic Objective 2; Increase community awareness about CSE

Action	Data Owner	Progress Against Objective	
Raise awareness in business establishments	Anne Bettison	No. of taxi drivers reached:	No. of taxi drivers who have received CSE training: **1556 - Plus 12 private hire operators**
Raise awareness among parents and carers	Sally Green	No. of parents who have received CSE PACE training: **550**	

Under 12's Screening Tool
Data Owner: Bev Petch

No. of under 12's screening tool carried out: **6 (cumulative)**	No. of these screening tools that have led to MASH referrals:**- 5 (cumulative)**	No. of schools/ education providers where at least one staff member has been training on the tool: **93/100% (cumulative) + 2 LA services providing education.**

PROTECT

CSE Strategic Objective 3: Children who are sexually exploited are protected

Action	Data Owner	Progress Against Objective		
Target children at risk of CSE using regional problem profile and intelligence	Angela James	No. at risk of CSE: 120 By age: **1 a**ged 9 years, **0** aged 10 years, **0** aged 11 years, **5** aged 12 years, **19** aged 13 years, **21** aged 14 years, **29** aged 15 years, **28** aged 16 years, **13** aged 17 years, **3** aged 18 years, **1** aged over 18 years, **0** not stated		
		Gender: **Male – 20, Female – 100**	Ethnicity: White UK **94**, White Other **1**, Dual Heritage **10**, Black Caribbean **1**, **,** Indian **2**, Pakistani **1**, Unknown **3**	
Assess quality of help to these children by ensuring the risks are reduced (CMOG)	Jim Edmonds	Total Nos. **101**	Level 1: **65** Level 2:**9** Level 3:**2** Pending: **14**	CIN: **113** CP: **8** LAC: **20**
Ensure we understand the experience of children missing from home or care by analysing return interview data	Children's social care (Karen Norton)	Missing from home no; **67** Episodes: **88** Missing from care no; **63** Episodes: **147** Number WRIs completed - **114** (**16** WRI refused)		

PURSUE

CSE Strategic Objective 4: Perpetrators are disrupted and/or held to account using appropriate criminal and or criminal interventions

Action	Data Owner	Progress Against Objective				
Use available criminal and civil interventions to disrupt local perpetrator activities	Jim Edmonds	No of harbouring notices: **10**	No on remand: 1	Other civil interventions: 0	No. of arrests:**10**	No. of criminal investigations/ prosecutions: **3 (1 Perpetrator currently charged and remanded. 1 x Perpetrator charged and bailed.)**