Solihull Local Safeguarding Children Board

Statutory Annual Report

1st April 2018 until 31st March 2019

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

About this report

Every year, the Local Safeguarding Children Board (LSCB) publishes a report accounting for its effectiveness. This is the account for 2018-2019.

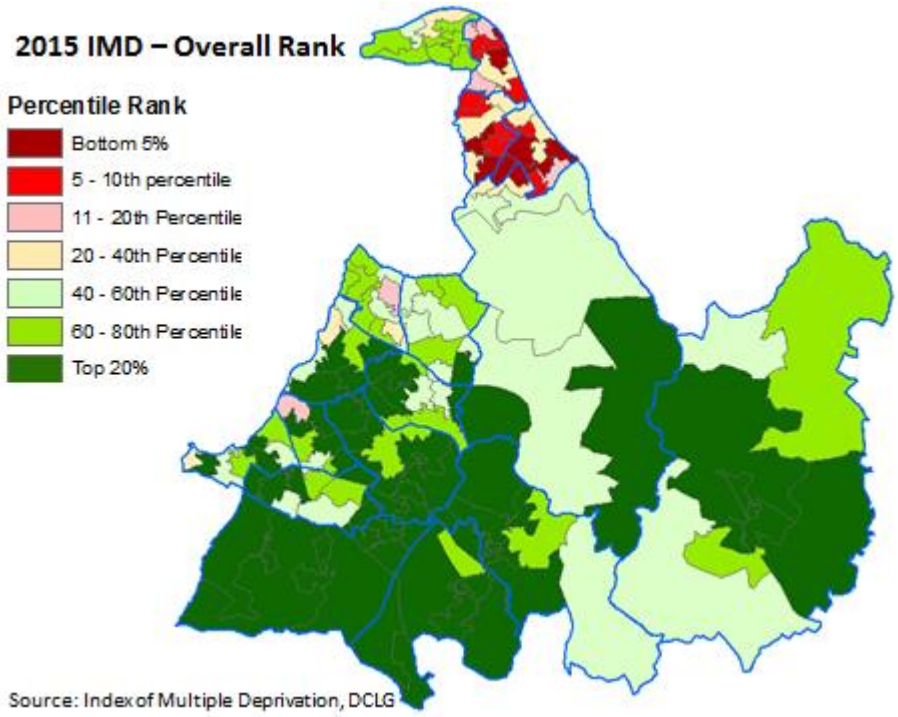
In this report we aim to provide a rigorous and transparent assessment of performance and effectiveness of local services to safeguard children. We aim to describe the challenges we have identified and their causes. We set out what we are doing about them and what we have learned from our reviews of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

The report begins by analysing our progress in relation to the priorities and areas for development set in 2018-2019. We show how our learning has led to improvements, and how our activities have informed our decision to retain our priorities in 2019-2020. An analysis of key child protection performance indicators for the year 2018-2019 is also provided, followed by our overall analysis of the current LSCB effectiveness and future challenges.

The report also sets out the activities the LSCB will be undertaking to ensure continuous improvement in the efficiency and effectiveness of multi-agency working within Solihull, and how we will monitor the difference we make to the lives of children and young people within the local area.

Contents

1. Facts about Solihull



1.1 Solihull is a broadly affluent borough characterised by above-average levels of income and home ownership. For instance, 74% of households are owner occupied compared to 63% for England and 47% of households have an income of more than £20,000 compared to the England average of 41%.

1.2 The borough as a whole is subject to relatively limited levels of deprivation. 40% of Solihull's population live in the 20% least deprived Lower Super Output (LSOA) neighbourhoods in England, compared to just 16% in the most deprived 20%. This includes 8 LSOAs in the most deprived 5% in the country containing 6% of Solihull's total population.

1.3 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.

1.4 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 the 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 this 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.

1.5 Solihull is in the midst of dynamic and rapid socio-demographic change. The Black and Asian Minority Ethnic (BAME) population more than doubled between

the censuses of 2001 and 2011, at which point people from a BAME background represented 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.

1.6 Whilst Solihull's population is ageing, the age profile of the North Solihull regeneration wards is significantly younger than the rest of the Borough. 39.6% of the population in north Solihull are aged under 30 compared to 32.6% in the rest of the Borough. At the other end of the spectrum just 18.1% of the North Solihull population is aged 65 and over and 2.1% is aged 85+, compared to 25.4% and 4.0% in the South. This difference in age profile is important in our deliberations about the development of services, particularly in relation to the development of early help support to families.

2. LSCB Effectiveness: An account of progress made on priorities set for 2018/2019

The LSCB agreed on three key priorities for 2018-2019:

- To support the delivery of Early Help services.
- To promote positive and promising practice on neglect, and gather evidence of the impact.
- To help children at risk of exploitation and provide support into adulthood.

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

2.1. LSCB priority: To support the delivery of Early Help services.

2.1.1. Achievements

2.1.2 Our 2017/2018 annual report highlighted that Solihull LSCB recognised we needed a means by which to consistently monitor the efficiency and effectiveness of the delivery of early help by partner agencies in Solihull. As set out in that annual report, we included specific questions in relation to early help within the single agency audits that we conducted during 2018/2019. The results of these audits confirmed that Early Help remains an area for development in across the Solihull partnership. In particular, the audit demonstrated that partners are more likely to contribute to and support Early Help work, but less likely to initiate the work themselves. It was also clear however that many partners have plans in place to improve their organisation's Early Help response in the coming months. This is encouraging as demonstrates that partners recognise their responsibility in this area and are being proactive in developing their services to meet those.

2.1.3 The findings from the most recent Solihull LSCB multi-agency audit (2018-2019) identified that early help processes need to be developed and more rigorously understood with regards to assessments, record keeping and inclusion of others. In addressing these areas for development, practitioners from other agencies will have access to the correct tools and guidance to initiate early help work themselves, which will in turn support those single agencies in their efforts to promote this within their own organisations.

2.1.4 The outline of an early help assessment tool was discussed with Children Social Care during 2018, however this work had to have due regard to the local authority's ongoing changes to their early help offer, as it was recognised that those changes may have a potential impact on any proposed early help assessment tool, which needs to be compatible with the early help offer available. That change process has now been completed and the proposed assessment and review tools have been considered and agreed by partners.

2.1.5 The early help assessment and review tool will support practitioners when working with children at level 2 on the levels of need (children with additional needs that can be met by a single agency or practitioner or straightforward working with one or more partners), but particularly at level 3 when dealing with children with complex needs that can only be met by a co-ordinated multi-agency plan. The Solihull Threshold Guidance recognises that delivering early help to this group of children and their families requires structure and leadership, and a common early help assessment and review tool that practitioners have received training in the use of will provide a structure and focus for practitioners when assessing children and families for early help requirements, improve record keeping, and provide any multi-agency meetings/discussions in relation to early help with structure and clarity of purpose. In doing so they will ensure that partner agencies within Solihull are compliant with Working Together to Safeguard Children 2018, which sets out a requirement to have an early help assessment process;

> *"Children and families may need support from a wide range of local organisations and agencies. Where a child and family would benefit from co-ordinated support from more than one organisation or agency (e.g. education, health, housing, police) there should be an inter-agency assessment. These early help assessments should be evidence-based, be clear about the action to be taken and services to be provided and identify what help the child and family require to prevent needs escalating to a point where intervention would be needed through a statutory assessment under the Children Act 1989." (Page 13, Para 7)*

2.1.6 To support the introduction and roll out of the early help assessment and review tool, the Solihull Local Safeguarding Children Board learning and development modular programme, Module 1 has been prepared as a half day input. This training programme will begin in 2019/2020.

2.1.7 The development in partner agencies' identification and assessment of the need for early help is supported by structural changes being introduced in some areas of Children's Services from 1st April 2019. A new Family Support Service has been introduced, which incorporates the former Engage (Early Help) service and the Children's Assessment Team and Children in Need Team (from the social work service). A new Community Development Team has also been created which will work alongside the Family Support Service to support people to find help from within their own communities. They will do this by making sure there are places to go and things to do.

2.1.8 In addition, Children's Services has introduced Family Group Conferencing to Solihull, which will provide a dedicated network meeting service to bring families together for children suffering or likely to suffer harm from within their own families. They will help co-ordinate and facilitate a family generated response to

the child or young person's needs to help prevent further intervention from children's services.

2.1.9. Early Help: What we need to do to improve

2.1.10 The introduction of these tools provides an opportunity to strengthen the assessment of early help need for children and families, improve the recording and sharing of information, provide a common structure for early help conversations and meetings between practitioners from the same and different agencies and with children, young people and families, review progress against agreed targets and evidence outcomes. In doing so we will be addressing the areas for improvement in relation to a multi-agency approach to the delivery of early help in Solihull.

2.1.11 The related challenge for the safeguarding partnership in the coming year is to provide sufficient training and development resource and opportunity in relation to the use of the early help assessment and review tool to meet the needs of all those across the partnership who will be in a position to work with children and their families in this way.

2.2. LSCB Priority: To promote positive and promising practice on neglect, and gather evidence of the impact.

2.2.1. Achievements

2.2.2 In relation to tackling childhood neglect within Solihull, the LSCB's focus has been on increasing the knowledge and skills of the multi-agency workforce in identifying and responding to instances of neglect, and improving the assessment of neglect cases through the use of the Graded Care Profile 2 tool.

2.2.3 Solihull LSCB has continued to offer a comprehensive training programme on childhood neglect and associated subjects; 163 members of the workforce have now been trained to use GCP2. By completing this training participants become licensed to use the tool, which is designed to provide an objective measure. It is primarily based on the qualitative measure of the commitment shown by parents or carers in meeting their children's developmental needs.

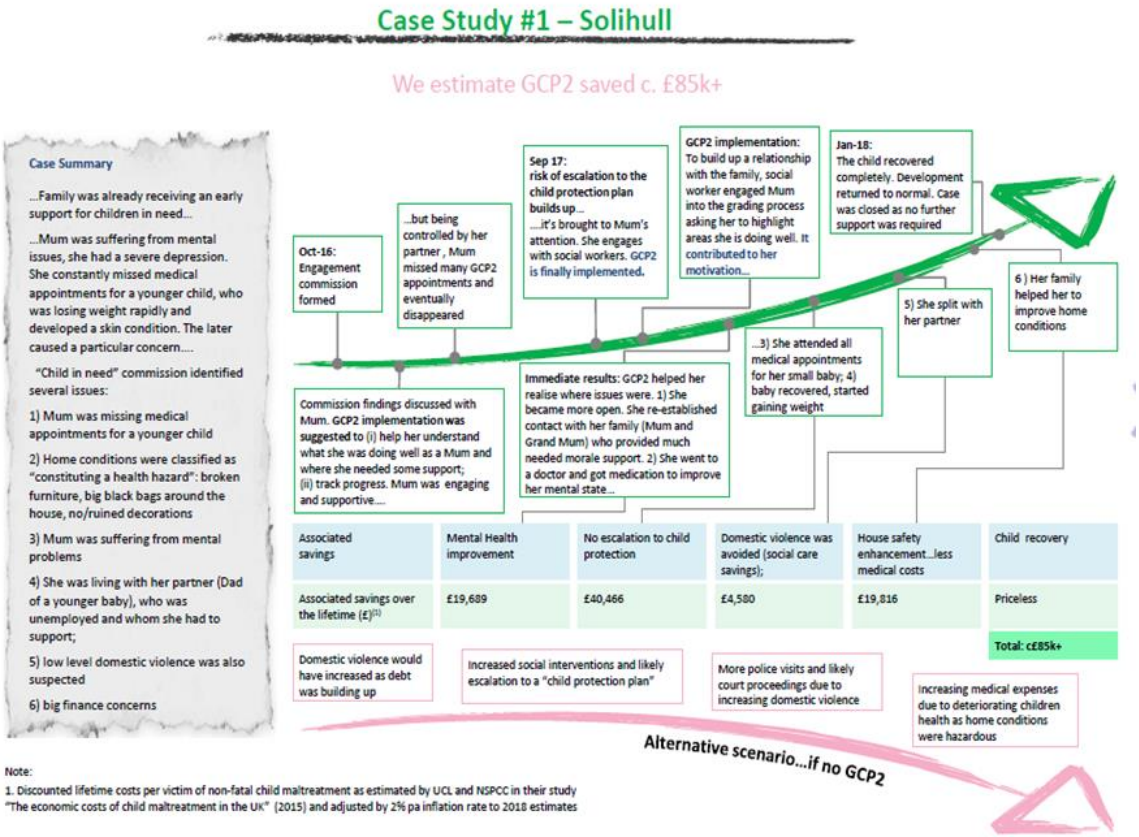
2.2.4 Solihull is an NSPCC pilot site for GCP2 and returns quarterly figures to demonstrate the number of people trained and the use of GCP2 in Solihull. The following information reflects statistics returned to the NSPCC in this financial year:

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Total number of people trained to date	141	148	158	163
Number of Practitioners using tool this quarter	10	10	6	5
Number of families this quarter	9	9	8	7
Number of children this quarter	36	40	26	16

2.2.5 This year representatives from Solihull LSCB attended an event organised by the

NSPCC about the Graded Care Profile 2. Hosted at Harrods offices in Knightsbridge, the event was attended by Dame Ester Rantzen and the Countess of Wessex along with Dr Srivastava who designed the tool. Sue Evans (pictured left below) and Gina Godwin (pictured right below) from Wise Owls nursery in Chelmsley Wood and Smiths Wood received the prestigious 'GCP2 Elephant Practitioner Awards' to acknowledge their enthusiasm and effectiveness in using GCP2:

2.2.6 Sue and Gina contributed to a case study completed by the NSPCC, who working jointly with an assigned team from Morgan Stanley developed a cost avoidance analysis tool. The diagram below shows the cost benefit analysis for Sue and Gina's case:



2.2.7 In order to support the introduction and use of the GCP2 tool, the LSCB has continued to promote a good understanding of neglect through the multi-agency neglect training module (module 6). This module supports practitioners to understand the impact of neglect on child development through the use of national research and practice experience.

2.2.8 Feedback from practitioners who have completed this course has revealed that attendees now understand the complexity of neglect. In particular a theme that arose in almost every evaluation was delegates coming back with an improved understanding of the different types of neglect, for example nutritional or emotional neglect, and the signs to be aware of. This, practitioners wrote, has allowed them to share information with other agencies more confidently, and has made them more likely to identify information which is worth sharing. Further, the course made participants realise that parents are not always aware of what may constitute neglectful parenting for a variety of reasons, such as their own childhood experiences or lack of education. Evaluation showed that attendees were made aware that in some circumstances, parents simply need support in considering the needs of their child. Multiple delegates reported that they had now introduced support for parents/children with better understanding of the best way to approach them. Finally, feedback showed an increased awareness of the importance of multi-agency working in neglect cases and its function in building up a holistic picture of life for the child.

2.3. LSCB priority Neglect: What we need to do to improve

2.3.1 Our multi-agency audit process identified that the LSCB should consider practitioners' understanding of the impact of traumatic childhood experiences and methods of ameliorating the on-going effect of these experiences for families, including how to intervene in cases where multiple complex needs are identified and where children are being exploited in the community. Traumatic or adverse childhood experiences can have an impact on parents' abilities to provide appropriate standards of care for their own children, and work is needed on our threshold guidance to support practitioners in recognising this.

2.3.2 The partnership recognises that we need to increase the use of GCP2 to properly reflect the number of practitioners who have been trained and are now licenced to use it. Further, we need to promote the use of the new early help assessment and review tool to provide effective intervention in early identified neglect cases across the wider partnership.

2.3.3 Our recent section 11 audit highlighted that 50% of agencies are not routinely making referrals to the Trouble Families Programme. The link between the types of challenges faced within those families meeting the Troubled Families criteria and childhood neglect is well established, and it therefore important that full advantage is taken of the opportunity to intervene via the Troubled Families programme where appropriate.

2.4. LSCB priority To help children at risk of exploitation and provide support into adulthood.

2.4.1 LSCB partners took the decision at the start of 2018/19 to widen the then existing priority of 'safeguarding children from sexual exploitation' to include all wider forms of exploitation. This decision was supported by a number of factors; the need to broaden focus as identified in the Local Government Authority CSE Peer Review carried out in Solihull in December 2017, the wider understanding of child criminal exploitation such as 'county lines' that was being developed both regionally and nationally, and the findings of Solihull LSCB's multi-agency case audit process which was identifying the need for us to strengthen certain areas of our response to children and young people affected by wider forms of exploitation.

2.4.2 The 2018/2019 LSCB multi-agency case audit process included a ‘deep dive’ review of eight child exploitation cases. This was completed using the published Joint Targeted Area Inspection (JTAI) criteria, in order to ensure both a thorough examination of the cases and to test our multi-agency response to the requirements any future JTAI inspection may place upon us. This audit process identified the need to agree a definition for wider exploitation and to develop policy, procedures and screening tools to inform this work and enhance the understanding of contextual safeguarding. Further, the case audits identified that work needed to be undertaken to support practitioners to confidently intervene where they are concerned about exploitation.

2.4.3 Since the case audit, work at a West Midlands regional level has been completed via the Protecting Vulnerable People group to agree an all age definition for wider exploitation and accompanying screening tool, supported by both Solihull Local Safeguarding Children Board and Solihull Local Safeguarding Adult Board. This work has been particularly relevant to Solihull as we are in a position to recognise the importance of adopting an ‘all age’ approach to tackling exploitation as a result of the ‘Rachel’ Safeguarding Adult Review which was commissioned by Solihull Local Safeguarding Adult Board and examined the circumstances leading up to the tragic death of this young woman, who had been at risk of exploitation both as a child and young adult.

2.4.4 Following on from the regional work to define wider exploitation, the Solihull partnership via the Safeguarding Children Board, Safeguarding Adult Board and Safer Solihull (Community Safety Partnership) has further developed that work to ensure that the definition supports the local need of focusing on particular types of exploitation, without becoming so wide that any response is diluted to the detriment of its effectiveness. Both the proposed definition and screening tool have been shared widely with representatives of the various Solihull partnerships and feedback has been returned to the regional Heads of Exploitation Group which is leading on this. The proposed definition can be seen below.

2.4.5 Once the regional definition and screening tool have been agreed, local policies and procedures can be reviewed, and contextual safeguarding incorporated into those as required in line with the further findings of the Solihull LSCB Case Audit Group. (See section 3.6 below)

2.4.6 Managing the safety of those young people who are victims or at risk of exploitation through the transition into adult services was also identified within the LGA Peer Review as an area for development in December 2017. The peer review was very positive about the support provided to care leavers and identified that this support had continued even when there was no longer statutory duty to do so. It was highlighted however that transitions was not systemic and further work was needed to achieve this. An agreed and well understood definition of exploitation and risk assessment tool which can be applied to and used with all those who are victims or at risk of exploitation, whatever the form that may take, is an important step in which to build robust transition processes between services as young people reach the age 18 years and begin to receive adult focused services.

2.4.7 In response to the need to consider wider forms of exploitation and provide greater support to those victims Solihull Children Social Care has introduced an Exploitation and Missing team. This team has taken over from the existing Child Sexual Exploitation team and expanded their remit to cover the wider exploitation agenda. This includes modern day slavery, criminal exploitation, human trafficking, gang related exploitation and county lines. The team will also quality assure responses to young people reported as missing from home or care.

2.4.8 On the 14th March 2019 a multi-agency conference was held in Solihull to raise the awareness of partners of wider forms of exploitation of children, young people and adults, and help to embed learning from the 'Rachel' Safeguarding Adult Review. This conference was organised by the Solihull Local Safeguarding Adult Board with support from the Solihull LSCB Learning and Development Officer. The day was very well attended, and participants were able to see a performance by the Geese Theatre highlighting the signs of exploitation and impact on the victim. There was an input from a representative of Bedfordshire University on contextual safeguarding and Police colleagues delivered a presentation on a recent case in the West Midlands where a male had been convicted of exploiting young people through a 'county lines' network and the learning from that, and representatives from the National Working Group were able to update participants on national developments and available resources in relation to the exploitation of children, young people and adults.

2.4.9 Child Exploitation: What we need to do to improve

2.4.10 The recently published Safeguarding Adult Review into the case of 'Rachel' contained the following recommendation;

2.4.11 Solihull Safeguarding Adult Board, Solihull LSCB and Solihull Community Safety Partnership should agree to establish a single joint strategy group, reporting to all three boards, with responsibilities to develop strategic priorities, co-ordinate actions and oversee delivery of these, in respect of both children and adults who are victims, or at risk of exploitation. This group would replace the existing CSE Steering Group.

2.4.12 As a result of this recommendation a Solihull Exploitation Reduction Board has been introduced which will incorporate the work previously undertaken through the LSCB's Exploitation Steering Group. The Exploitation Reduction Board is a shared undertaking between the Solihull Safeguarding Adult's Board, Children's Board, Safer Solihull and the Health and Wellbeing Board. It has direct line of reporting to the latter, and is supported by a Delivery Group with responsibility for delivering the priorities set by the Board.

2.4.13 In order to improve the overall response to the exploitation of children and young people within Solihull and strengthen the transition arrangements into adult services for those affected, it is important that the Solihull LSCB fully supports the work of the Exploitation Reduction Board and Delivery Group. The LSCB are keen to do this by increasing the awareness and understanding of practitioners on contextual safeguarding, and this process has already begun through the conference and it being incorporated into multi-agency training modules.

2.4.14 A key task for the Delivery Group will be to review our structures in relation to Multi-Agency Sexual Exploitation (MACE) meetings and the CSE and Missing Operation Group (CMOG) to ensure it incorporates all age and wider exploitation.

2.4.15 The recent Solihull LSCB Section 11 audit asked specific questions about individual agencies' understanding of the National Referral Mechanism and their awareness and use of the West Midlands Police Force Intelligence Bureau (FIB) forms. The FIB form can be used by practitioners to submit intelligence which they may receive in relation exploitation, whether that relates to a victim, perpetrator or location. These audit returns showed that although in some organisations knowledge of these the FIB form was high; in others there is a need to promote understanding and use. This is therefore an area for development during 2019/2020.

Performance analysis: Progress on areas for development identified in the annual report of 2017-2018		
Action identified on annual report 2017-2018	**Update**	**Next steps**
CSE – Review of our MASE and CMOG processes to ensure they are as simple and effective as possible.	This work is being taken forward as part of the expansion to an 'all age' approach to tackling exploitation. Draft procedures have been written and will be considered by the new Exploitation Delivery Group.	Agreement and implementation of the new wider exploitation procedures, incorporating changes to MASE and CMOG.
CSE - Young people reaching adulthood that are at risk of sexual exploitation; Include cases which involve transition within the Case Audit activity for 2018/2019. Incorporate learning from an ongoing review which	Exploitation cases included in the 2018/19 audit and a 'JTAI' audit approach was used. Learning from that audit is now being used to improve practice. The 'Rachel' Safeguarding Adult Review has now been	Check the learning from the 2018/19 audit has been embedded within practice, using the 2019/20 audit process. Local Safeguarding Children Partnership to support the Exploitation Reduction

encompasses current transition arrangements into business case to ensure any identified gaps in provision as a result of that learning are addressed, and submit business case.	published and learning from that was incorporated into the business case. This has been submitted and sits with the Exploitation Reduction Board.	Board in implementing any changes resulting from business case and other learning from the review.
CSE - Broaden the LSCB focus on CSE to include other forms of child criminal exploitation. Review of the Senior Management Group (SMG) Procedure.	LSCB priority and activities broadened to include all types of exploitation. Introduction of a cross partnership Exploitation Reduction Board and Delivery Group. All procedures relating to exploitation being reviewed to incorporate wider exploitation and an 'all age' approach.	Implementation of new exploitation approach and procedures.
Neglect/Early Help - Review of the availability and quality of multi-agency early help provision for children where there are concerns about neglect, by including a particular focus on early help within the forthcoming Section 11 audit.	Section 11 audit scores demonstrate that partners are more likely to contribute to (support) early help work, but less likely to undertake (initiate) work themselves. Many partners do however have plans in place to improve their organisation's early help response in the coming months.	Support partner agencies' in their plans to improve their own organisation's early help response through the provision of an effective early help assessment and review tool.
Neglect - Monitor progress against neglect strategy using key measures set out within the document.	Performance monitored on a quarterly basis via the Executive Group.	Ensure the new Local Safeguarding Children Partnership arrangements retain the ability to monitor performance in relation to tackling neglect. Continue to focus on the quality of the multi-agency response to concerns of neglect via the Case Audit process.
Neglect - Increase the use of the Graded Care Profile in assessing neglect by encouraging and supporting all practitioners who have attended the training to apply it in the workplace whenever appropriate.	Use of the multi-agency Graded Care Profile remains relatively low compared to number of practitioners trained to use it.	Continue to promote the use of GCP2 tool amongst practitioners. Ensure the correct staff are attending the training.
Early Help - Support the	Early help assessment and	Roll out of early help

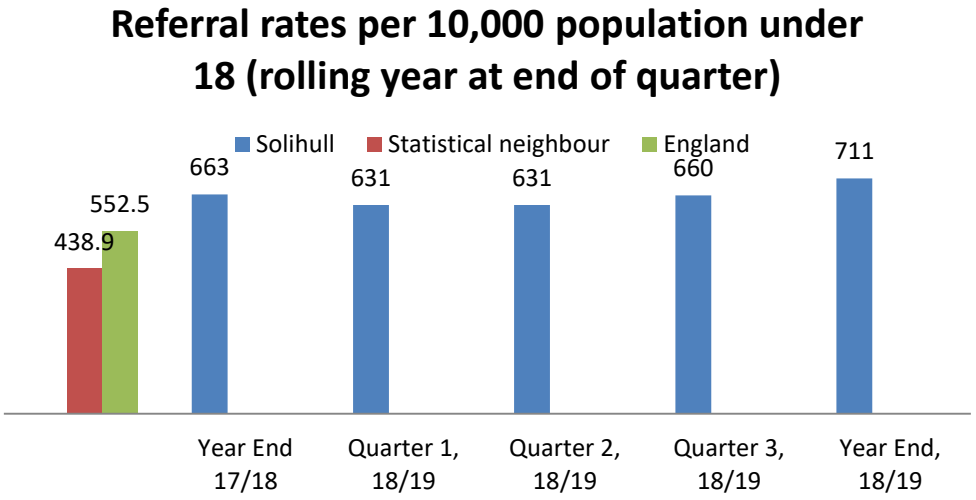
ongoing development of the early help provision in Solihull, and the strategy to support that provision.	review tools developed. Multi-agency training module developed to support roll out of assessment and review tool. A new Family Support Service has been introduced by Children and Social Care, supported by LSCB communications and awareness in multi-agency training courses.	assessment and review tools. Encourage attendance on early help training module. Monitor use and effectiveness of both the assessment tool and the associated training.
Early Help - Early Help training module to be developed in line with new early help strategy when available.	Early Help training module now developed.	Ensure the attendance of the appropriate practitioners from across the partnership on the new Early Help training module.
Performance - Continue to improve practitioners' knowledge of the threshold guidance and abilities to apply it to the referral process through multi-agency training.	Audit activity shows a continual improvement in the general understanding of thresholds and application since the last round of audit activity.	Develop clear guidance for practitioners in relation to the need to seek consent when making a referral, and the impact of General Data Protection Regulations on that.
Performance - Continue to receive audit results and use these as part of monitoring of efficiency and effectiveness of multi-agency arrangements.	Audit results continue to be shared with Board.	
Individual agency accounts - Proposed changes to local partnership arrangements as a result of the Children and Social Work Act 2017 will incorporate a redesign of the current performance and accountability framework.	Partnership and single agency performance and accountability is now addressed within the Assurance and Review Group.	Monitor the impact on outcomes of the performance and accountability activity within the business cycle of the new arrangements.

3. Performance analysis: Child protection data.

3.1 Referral rates

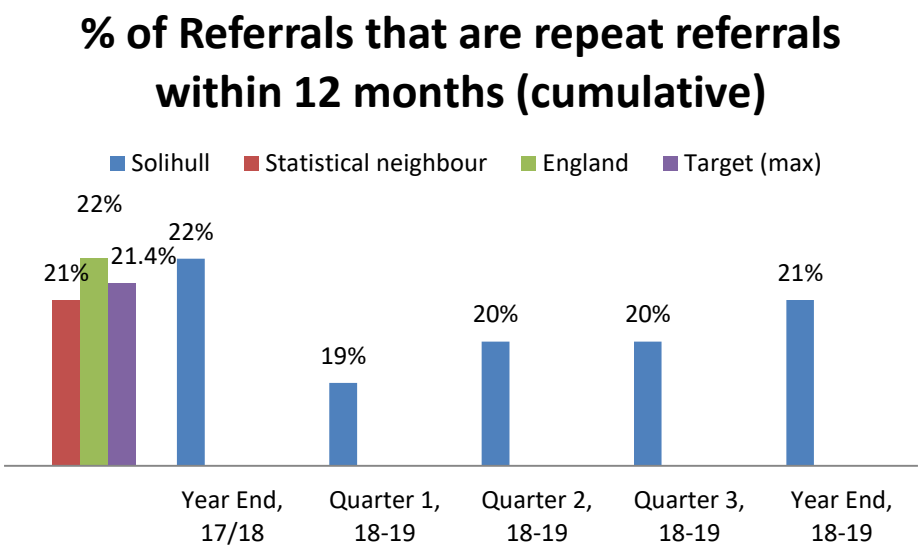
3.2 Referral rates per 10,000 remain higher than both national and statistic neighbour rates. Solihull has seen a significant increase in the number of referrals for Level 4 intervention since the turn of the year. Practitioners and managers within the multi-agency safeguarding hub (MASH) are working hard to make sure thresholds are applied properly and only children requiring social intervention are referred in for a social work assessment. We have also continued to see a significant increase in the complexity of cases referred to children services over the past few months. MASH managers have liaised with partner agencies in order to provide support and guidance around application of the threshold criteria. This trend is being addressed by relevant managers and Heads of Service via briefings and various means of communication with partners.

3.3 In March 2019 Children Social Care began a significant restructure, and as part of this process managers worked hard to limit any potential impact on other partners by widely sharing information about the changes and new services being offered. The Board is also aware of the potential for the very positive future impact of the new model, for example family group conferencing, in reducing the number of referrals at Level 4 through earlier and targeted intervention with children and their families before situations can escalate to that level, and further reducing instances of repeat child protection plans.



3.3 Repeat referral rates

3.5 Solihull has very similar repeat referral rates to both the national and statistical neighbour rates. Improved front door response and screening of referral is supporting professional's implementation of the threshold criteria. On-going work around improving quality of assessment in the service and use of Signs of Safety and better understanding of need when cases are closed will ensure a reduction of re-referrals. Case learning meetings are taking place and reviewing the decision making process as well as historical intervention with families in order to identify patterns and ways of working in order to support sustainability of change.



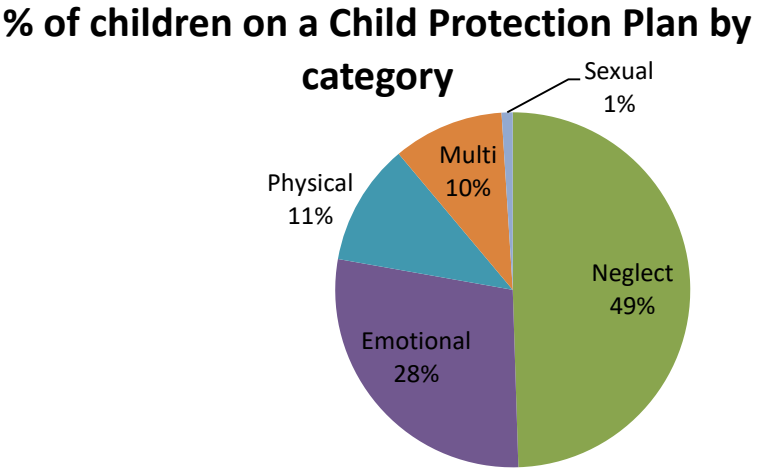
3.6 Proportion proceeding to Section 47 enquiry or single assessment

3.7 2022 out of 3339 (61%) of referrals resulted in further Social Work action being taken during the year, specifically a strategy discussion and/or a social work assessment. There is now a continuing decreasing trend of the proportion of referrals proceeding to an assessment or a section 47 enquiry, from 81% in 2016/2017 to 75% in 2017/2018, then a further reduction to 61% this year.

3.8 In 2018/2019 the proportion of enquiries were as follows;

- 65% of the assessments initiated were social work assessments under S17 Children Act 1989 (child in need).
- 29% of the assessments undertaken were social work assessments under S47enquiries (child at risk of significant harm).
- 7% of the assessments undertaken where strategy discussions concluded or a section 47enquiry was not required.

3.9 Percentage of children on a Child Protection Plan by category



3.10 There were 273 initial child protection conferences during 2018/19, of which 243 resulted in a child protection plan (90%). At the end of March 2019 there were 43 children per 10000 on a child protection plan. Using January 2019 data as a

comparator, in England the figure was 45 per 10000, and the figure for our statistical neighbours was 38 per 10000. Over the course of the year, child protection plan totals in Solihull fluctuated above and below our statistical neighbours, but remained below the national rate.

3.11 The distribution of plans across the available categories is also broadly in line with the most recent national picture. There is a slightly higher rate of neglect child protection plans which is a reflection of work undertaken to understand and raise the awareness of neglect, which is a Local Safeguarding Children Partnership priority. Considerable work has been done to introduce and promote the Graded Care Profile tool to inform decision making in cases of possible neglect.

3.12 Analysed by concern category,

- Neglect accounts for the largest proportion of plans open at year end – the third year in a row that this has been the case. This year 49% of all plans open were attributed to neglect (47% in 2017/18; 36% in 2016/17). The national average is 46.6%.

- Emotional abuse is the next most prevalent concern, with 28% of all plans open at year end attributable. This compares with 20% in 2017/18 and 32% in 2016/17. The national average is 36.9%. Solihull data for emotional abuse plans is lower than the national average but is reflective of focused consideration by the child protection conference chairs to ensure that domestic abuse concerns have the appropriate category selected when identifying primary concern.

3.13 The remaining plans open are attributable to physical abuse (11%; 19% in 2017/18), multiple categories of concern (10%; 8% in 2017/18) and Sexual Abuse (1%; 6% in 2017/18).

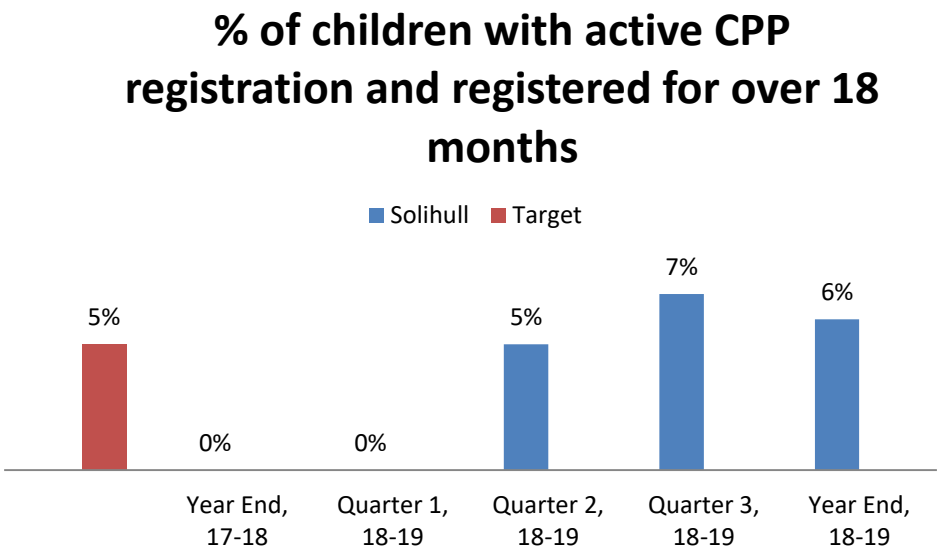
3.14 It is important that a focus is also retained on the quality of the child protection conferences being held. In support of this, from 1st January 2019 to 31st May 2019, 198 feedback forms were provided for 46 conferences. Of these, 46 were completed by family members including parents, grandparents and children themselves who attended their conferences in person. There were only 8 forms (representing 4% of the total completed) whereby attendees did not make responses of ‘agree’ or ‘strongly agree’ to all statements, covering the opportunity to share views, how effectively strengths and areas for concern were explored and understood, and their understanding of the plan.

3.15 Drift and delay

3.16 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 and this is by measuring the duration of plans.

3.17 The proportion of children with child protection plans for 18 months

3.18 This performance year started with there being no children in Solihull who had been on a child protection plan for 18 months or over. The performance year ended with thirteen child protection plans (6%) open over an eighteen month duration. This remains an area of focus for both the social work teams and the Child Protection and Review Unit, with all cases being actively managed.

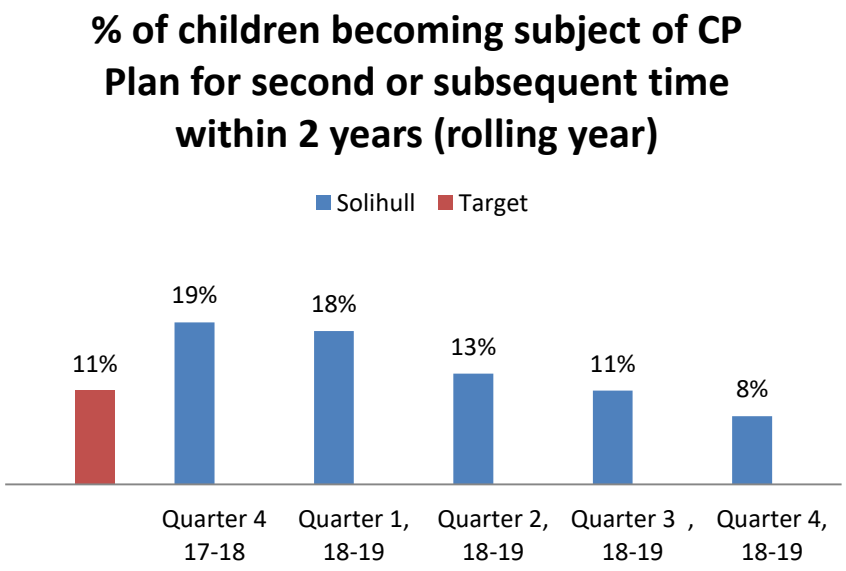


3.19 The proportion of children becoming subject of a Child Protection Plan for a second or subsequent time within 2 years (rolling year)

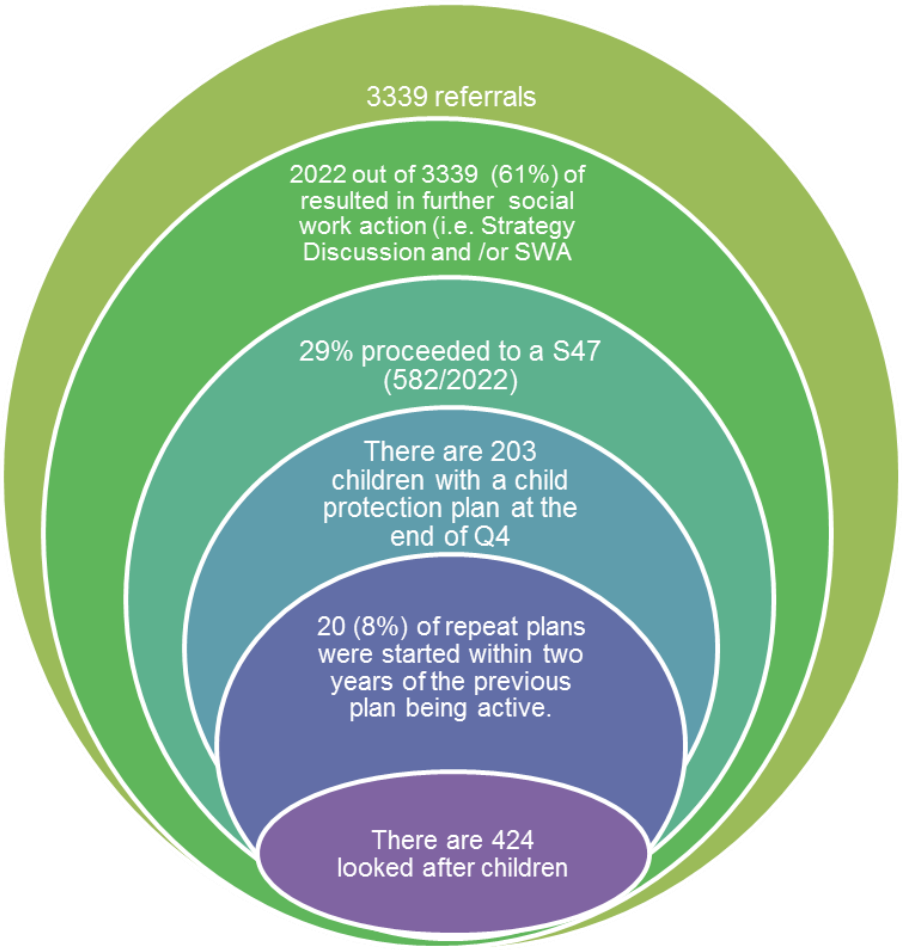
3.20 There were 8% of child protection plans commencing in the last (rolling) 12 months where the child became subject of a plan for a second or subsequent time within 24 months of an earlier plan being active. This equates to 20 children.

3.21 The rolling year data at end of the fourth quarter shows a decrease in percentage against previous quarters and is below the West Midlands benchmark figure, and this is therefore a positive picture. This performance indicator is based on a rolling 12 months so rate of change is likely to be gradual. The Child Protection and Review Unit (CPRU) process for cases with a subsequent child protection plan within this timeframe involves allocating a different Chair. Case Learning Meetings are now held to ensure that learning from the previous child protection plan period is considered and informs the baseline of concern for the current intervention. Further, particular attention is being paid to reviewing those children who were removed from a child protection plan at the first review and subsequently return to a plan. This is to identify whether all of the actions developed as part of the original plan had been fully completed prior to the decision being taken to remove them from that.

3.22 There is clear evidence that these measures to prevent repeat child protection plans are having a positive effect; the proportion of children who started a child protection plan during 2017/2018 and who had repeat child protection plans within 2 years was 19%, in 2016/2017 it was 13% and 2015/2016 it was 10.5%. A marked improvement has therefore been achieved in 2018/2019, with the previously upward trend being reversed.



3.23 2018/19 workflow:



3.24 The number of looked after children for whom Solihull was responsible at 31 March 2019 was 424. This is an increase of 11 children compared to last year (2017/18; 413 at 31st March 2018), which represents an increase of 3% since 31 March 2018. For 2018, the national average increase was 4%. Although there is a continuing upward trend in Solihull, this would appear to be slowing, after increases in yearend numbers of looked after children of between 6-8% each year for the previous three years. Solihull Local Authority commissioned a themed audit of new admissions to care which took place in April 2018. 21 cases

were audited, and the conclusion drawn from this work was that it was appropriate that all of those children had become looked after.

3.25 Performance summary

3.26 The LSCB multi-agency case audit process provides a qualitative view of the child protection processes from the perspective of the multi-agency professionals working within the system. The 2018/2019 audit identified that the majority of practitioners involved had an understanding of thresholds and their application and where practitioners were involved with children directly, they were able to speak authoritatively and knowledgably about their cases and about the experiences of the children with whom they are working. This is important to ensuring that cases are entering the system at the correct level, and that practitioners can contribute confidently and with authority at multi-agency meetings so ensuring the right decisions are reached. The audit also indicated that professionals are involved and receive appropriate information from those meetings.

3.27 Overall performance continues to indicate timely decision making and children are moving through the system in good time. The use of the Signs of Safety model continues to have a positive impact on the quality of assessment. There is a continued effort to support partner agencies in making timely and appropriate referrals. The Children Social Care restructure is intended to link more closely the Early Help offer to Children Social Care, and this alongside family group conferencing is designed to help address child and family circumstances before a point is reached at which social work intervention and possible care proceedings are required. Such an impact should be identifiable within the data over the medium to long term.

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.

Policy development (Regulation 5 1(a))

4.2 In February 2019, the LSCB Policies and Procedures Sub-Group formally agreed to join Coventry LSCB and Warwickshire LSCB's joint procedures currently hosted by Tri-x. This provides a number of advantages for both practitioners and organisations within all three areas. Firstly, the sharing of procedures across Local Authority boundaries will simplify matters for those whose work covers more than one local authority area. This is particularly important as we do have a number of partner agencies who have a footprint across two or more of the three Board areas involved. Secondly, it will provide the three Board areas with an opportunity to share best practice, experience and resources in developing and reviewing multi-agency procedures in the future. Finally, it provides greater financial efficiencies for the areas as a result of the reduction in duplication of resource and effort.

4.3 Work is now well underway to align our procedures wherever possible with those procedures already shared by Coventry and Warwickshire. This has involved a review and comparison between Solihull LSCB policies and procedures and

those of Coventry and Warwickshire boards to identify common areas, those areas which need discussion and agreement, and finally those areas where local area policies will need to be retained.

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

4.4 The new Working Together to Safeguard Children guidance published in July 2018 has retained the statutory requirement for safeguarding partners to publish a threshold document, which sets out the local criteria for action in a way that is transparent, accessible and easily understood.

4.5 The multi-agency case audit process for this period identified that there has been a continual improvement in the general understanding of thresholds and application amongst practitioners since the last round of audit activity in 2017/18. This is encouraging as it shows that the performance in this area continues to improve year on year.

4.6 It is recognised however that with the recent changes to information sharing, particularly in relation to consent, introduced by the General Data Protection Regulations (GDPR), the local work ongoing to introduce multi-agency early help assessment and review tools, the increasing understanding of contextual safeguarding in relation to tackling exploitation and the impact of adverse childhood experiences, now is an appropriate time to review the Solihull threshold guidance document. This will be a priority for the partnership in the coming year.

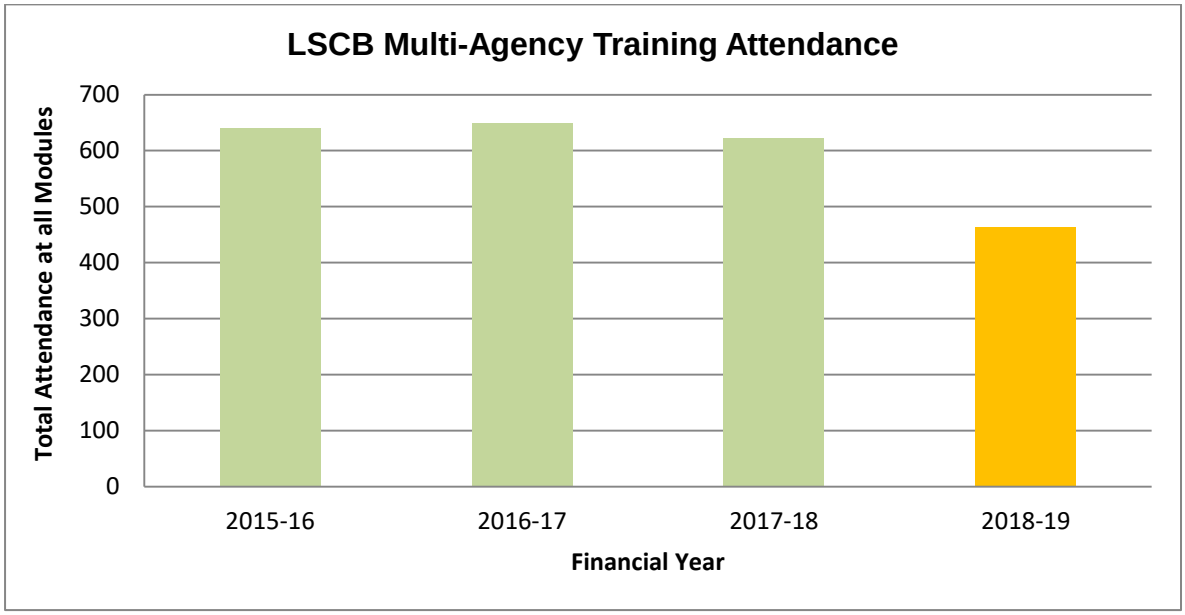
Training (Regulation 5 1(a) (ii))

4.7 LSCB Multi-Agency Training Pool

4.8 In the financial year 2018-19, the LSCB trained 463 delegates from a wide range of agencies.

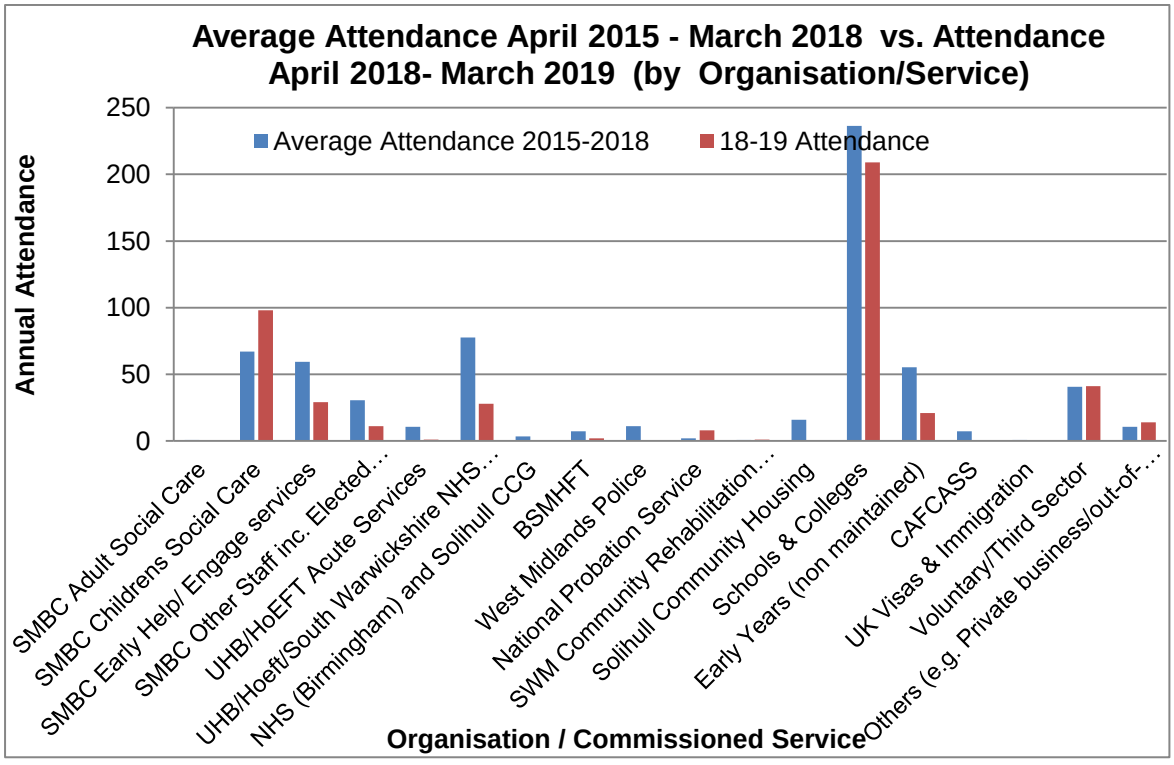
4.9 Many training evaluations continue to be overwhelmingly positive, with good evidence that LSCB/P training is not only increasing knowledge and confidence, but challenging practitioners thinking to allow them to succeed in a multi-agency environment. This is evidenced through both the quantitative and qualitative data analysed in full in the report.

4.10 However, while each module continues to be positively received, in the 2018-19 financial year 25% less delegates benefited from the training than have on average in the past. Although some of this reduction might be explained by large commissioning/structural changes, partners must work to improve attendance. In particular they should be aware that the LSCB multi-agency safeguarding workforce development strategy introduced as a general guide that all those who regularly make child protection referrals, are regularly expected to attend child protection conferences and core groups, and/or manage or supervise those who do, should receive a minimum of 3- 6 hours of multi-agency training; ideally at least 1 module per year. This is in addition to any single agency training. Therefore partners need take appropriate action to ensure this trend is reversed, as the low number of attendees ultimately means that the positive impact of multi-agency training is being felt by fewer practitioners and in turn, fewer children.



4.11 The graph demonstrates that historically, total attendance at all modules has been 600-650. Since last year, attendance has dropped by 160 people. That translates to a 25% decrease.

4.12 In order to better understand the decrease in attendance, analysis was undertaken which compared how attendance from various organisations/commissioned services has changed last year compared to the preceding three years. Figure 2, shows a number of organisations/sectors which can be highlighted as having changed substantially, either increasing or reducing their overall attendance on SLCB training modules. These are: SMBC Children's Social Care, Early Help/Engage, Acute Services (Health), Community Services (Health), Schools and Colleges, and Early Years.



Evaluation of Training

4.13 When an individual registers for any LSCB training they are required to complete a pre-training questionnaire which asks them to rate their skill, knowledge and confidence in the subject out of 10. In order to measure the effectiveness of LSCB training an evaluation form is then sent out 3 months after the course to both the practitioner who attended and their manager. It asks them the same questions as the pre-training evaluation, as well as requesting written evidence of how the training has impacted on their practice/organisation. This allows the LSCB to track how training has impacted upon an individual's practice, and is analysed below on a 'module-by-module' basis.

4.14 Particularly insightful are the post course written evaluations. These are made up of answers to four questions which ask delegates for examples of how the training has impacted on their own and their teams, knowledge, practice, and outcomes for children they work with. An example of the responses for one such module, Module 2 Child Protection: An introduction to multi-agency working is provided below.

Module 2 Child Protection: An introduction to multi-agency working

4.15 Description: Module 2 is the LSCB's most popular course. This module is aimed at those who identify child protection concerns and make child protection referrals. It enhances competence around sound, evidence informed communications and making child protection referrals; contributing to child protection conferences and core groups; identifying and challenging drift and delay (with specific reference to the complexities of the child's experience when living with domestic violence, substance misuse and/or parental mental health problems) and using escalation procedures.

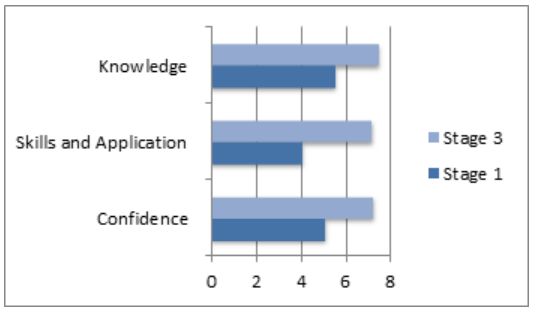
Courses: 7
Attendees: 125
Completed pre-evaluation forms: 125
Completed post- evaluation forms (delegate): 67*
Completed post- evaluation forms (manager): 26*

4.16 Finally, Module 2 is described as an 'introduction' which is reflected in the evaluation forms. Many practitioners stated that it gave them an effective understanding of the foundations of safeguarding children. In particular confidence was a common theme throughout the evaluation forms, with both practitioners and their managers reporting a difference in the individual's confidence

4.17 This confidence is seemingly down to improved knowledge of what information to include in MASH referrals and better understanding of the thresholds for referral. Practitioners also regularly reported an improved understanding of what language to use in referrals as well as a better understanding of the 'child safeguarding' terminology.

4.18 Two practitioners also mentioned that they felt more knowledgeable at Child Protection or Core Group Conferences as a result of this course.

4.19 They also reported how useful it has been to go back to their organisation and disseminate their learning to others. Many of the evaluation forms also stated that they had recommended others in their organisation attend the training.



4.20 Module 2 is attended by a broad mix of staff from a huge number of organisations, with various levels of experience. Those more experienced staff felt the course served as a good 'confirmation' or 'refresher' of their knowledge.

4.21 This graph indicates the rating out of ten each trainee gave before the course for their knowledge, skills, and confidence on the content of a module (labelled as 'Stage 1') and after the module (labelled as 'Stage 3'). This data allows the LSCB to quantifiably demonstrate its impact by averaging delegate scores at each stage.

4.22 The evaluation forms also revealed that the course serves as a reminder to practitioners that safeguarding is everybody's responsibility and that the child should always be the centre of focus.

Multi-agency Training Pool

4.23 The LSCB could not develop and deliver such highly valued training without the contributions and support from many agencies and individuals. In addition to the agencies and individuals mentioned above, the LSCB would like to acknowledge the commitment and support provided by members of multi-agency training pool who contribute to development and support delivery of a wide range of courses:

Ceri-Lisa Murland -National Probation Service
Deborah Adams -SMBC Social Care
Francesca Crossfield - WMP
Gina Godwin -Wise Owls Nursery
Nicky Thomas –HoEFT/UHB Community Services
Rebecca Brown – SMBC Social Care
Toni Clifton -SMBC Social Care

LSCB & SSAB Learning Faculty (Now known as Learning and Development Forum)

4.24 The purpose of the faculty/forum is to provide an open consultative forum to enable multi-agency practitioners and managers who access LSCB/SSAB training programmes to review previous training, monitor existing training and engage in the planning and design of future training provision in order to meet front-line needs as well as national and local drivers including legislation, policy and practice development. The faculty/forum is an opportunity for practitioners to influence training.

4.25 There were 3 meetings during the 2018-19 financial year: May 2018, which featured a discussion on exploitation, September 2018, which discussed mental

health and wellbeing, and January 2019, which included a presentation on Deprivation of Liberty and Mental Capacity.

4.26 The notes and further information about the learning faculty can be found on the LSCB website http://www.solihulllscb.co.uk/training.php

Conclusions

4.27 The purpose of LSCB training is not only to increase knowledge and confidence, but to challenge practitioners thinking and allow them to do this in a multi-agency environment. Both the quantitative and qualitative data from evaluations demonstrate that these goals are being met. However, while each module continues to have this positive impact, in the 2018-19 financial year 25% less delegates benefited from the training than have on average in the past. This drop might be partly be explained by large commissioning/structural changes in some sectors. Nonetheless, this attendance is disappointing, as attendees who were able to attend training and took part in the evaluation process regularly reported that the training has given them confidence. This was confidence in their own knowledge, confidence that they could act if a situation presented itself, and confidence to challenge practitioners in single and multi-agency meetings.

4.28 Delegates also felt that the knowledge they had gained in the various assessment tools, types of abuse and signs and indicators of that abuse had armed them with the ability to spot, assess and act upon worries with the children they work with. In terms of this action, a great number of practitioners left training with a better understanding of the LSCB thresholds, who to refer to and what to include in referrals. This action was not limited to theory either; there are numerous cases of delegates telling us about specific action with children, inspired by something they learnt on a course.

4.29 Communication is a key factor in safeguarding children and, again, delegates benefitted both from the contents of the courses and the opportunities to work and network with participants from other agencies.

4.30 Finally, managers who have responded reported improved confidence and awareness of issues from staff members who had attended and often reported learning had been disseminated amongst other staff through the attendee.

4.31 Nevertheless, the low number of attendees ultimately means that this impact is being felt by fewer practitioners and in turn, fewer children.

Training: Next steps

4.32 From the 1st May 2019 the LSCB ceased to exist and the new Local Safeguarding Children Partnership will come into existence.

4.33 Through the Safeguarding Partnership, the Assurance and Review Group will inform what needs to be considered within the multi-agency training strategy which will be designed and delivered through the Response and Delivery Group.

4.34 There is commitment for the current delivery of training modules to continue; however it is envisaged that there will need to be an increase in recruitment to

the Multi-Agency Training Pool to support delivery the Early Help Module 1 with the introduction of a new multi-agency early help assessment.

4.35 There will also be changes to those courses provided in Module 5 as the LSCP continues to work with the Solihull Safeguarding Adults Board (SSAB) and The Safer Solihull Partnership (SSP) to form a collaborative Exploitation Reduction Group. The group is to focus on wider exploitation, incorporating contextual safeguarding, sexual & criminal exploitation, modern slavery, and trafficking. New training will reflect these changes.

4.36 In addition to the modules there will be some reflection sessions planned around learning from serious case reviews or case learning reviews. These will be free of charge and will take place in 2 hour late afternoon sessions. They will be facilitated in a style that compliments the suggested agenda for a case learning meeting; to promote the use of this mechanism for reviewing multi-agency work in practice; highlighted as a need in the recent case audit cycle.

4.37 The Learning Faculty ran in partnership with SSAB was reviewed in January as attendance numbers have dwindled; although those who regularly attend reporting that they find it a very useful forum. Its name has been changed to the Learning and Development Forum, as attendees felt Learning Faculty may have been putting some people off attending; dates are set for a further 3 meetings through the next financial year and this will be reviewed again in January 2020.

4.38 All multi-agency training provided is advertised and booked via the website: https://www.solihulllscp.co.uk/training.php In addition to this regular updates are provided in every LSCB/P newsletter. The LSCB multi-agency safeguarding workforce development strategy introduced as a general guide, that all those who regularly make child protection referrals, are regularly expected to attend child protection conferences and core groups, and/or manage or supervise those who do, should receive a minimum of 3- 6hours of multi-agency training; ideally at least 1 module per year; this is in addition to any single agency training; therefore partners will either need to take appropriate actions to ensure this attendance happens, or this guidance will need to be reconsidered when the strategy is revised.

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

4.39 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

4.40 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 2018. The work undertaken is quality assured by the LADO.

LADO threshold

4.41 The threshold for LADO cases is described in Working Together 2018. The threshold for referral is reached when an allegation is made which may relate to a person who works with children having

- 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.

4.42 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

4.43 Total number of referrals received over the last 3 years

Table 1 - Total number of allegations referred to the LADO			
Year	**2016/17**	**2017/18**	**2018/19** 01 Apr – 31 Mar 2019
Number of allegations	75	94	**79**

4.44 The number of contacts leading to formal referrals during the reporting year 2018/19 represents a decrease of 20% against the previously reported 12 month period (2017/18). This is a return to the referral rate shown in 2016/17. The number of referrals evidences continued awareness within the various agencies working in the borough of the ‘managing allegations’ process.

4.45 In terms of other contact activity, there were a further 58 contacts 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. This figure shows consistency against the previous reporting period (when 59 such contacts were also recorded). Quality assurance activity was undertaken by the LADO on half of these contacts – 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.

4.46 85% of cases meeting the relevant threshold and progressing from referral through the managing allegations progress were completed within 3 months. Only 2% of completed cases took longer than 12 months (these cases had additional complexity - due to the number of allegations, number of roles held by the subject of the allegation, or, the need to progress a criminal investigation).

Managing allegations training

4.47 During 2018/2019 The LADO provided three multi agency training sessions on behalf of the LSCB on the 'managing allegations' process. These training sessions have been well attended and the evaluations were very positive.

4.48 Following the courses delegates reported finding the training helpful updating their knowledge of the procedures and processes relevant to managing allegations against staff. Some delegates reported subsequently revisiting and reviewing their own in-house procedures and the awareness of staff within their settings. A common theme from the evaluations of attendees was that they felt they would be more confident in responding effectively to an issue if it was to arise. There was recognition of the importance of handling any allegations in a sensitive and appropriate manner whilst ensuring that relevant investigative processes were not compromised.

Conclusions

4.49 These figures confirm suggests that awareness and understanding of the 'managing allegations' process in the borough is generally sound. There is evidence of agencies contacting the LADO to talk issues through appropriately, and, evidence of matters being progressed in a timely way.

4.50 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.

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

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

4.53 The Solihull Local Authority Fostering Team is responsible for managing the response to private fostering notifications, which includes the need to assess the suitability of the carers and provide ongoing support to private foster carers in the event the arrangement is suitable and agreed. In 2018-2019, there were 5 new notifications of private fostering arrangements. Four arrangements did not progress due to;

a) the child not arriving in the UK,
b) the arrangement not being deemed as a private fostering arrangement,
c) the carer securing an alternative arrangement through the Court in the form of a Child Arrangement Order and
d) the child returning to the care of the parent before the completion of the private fostering assessment.

In respect of the remaining private fostering arrangement the child was seen within 7 days of the notification of the arrangement and was seen at regular intervals thereafter and within statutory timescales. The arrangement continued for 9 months when a change in the child's family circumstances resulted in the child becoming accommodated under section 20 of the Children Act 1989 and placed within a Connected Persons fostering placement.

4.54 The Local Authority continues to promote awareness about private fostering in the community, and it is important that the Board supports that work through similar awareness raising amongst its partner agencies.

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

4.56 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 communication work carried out in 2018/2019 are set out below.

4.57 The LSCB has continued to update the multi-agency workforce about important safeguarding developments and learning. The LSCB has a well-established website containing key information for both public and practitioners. Regular newsletters are also produced which are widely circulated. The Board currently has 325 subscribers to the newsletter, many of whom then circulate it further within their own organisations. The following are examples of subjects that were covered within the newsletter during 2018/2019;

- the new Solihull Local Safeguarding Children Partnership arrangements.
- Safeguarding training opportunities, both internal and external.
- learning from the multi-agency case audit process.
- updates on a range of safeguarding topics such as 'county lines', private fostering and position of trust concerns.
- the new Joint Targeted Area Inspection (JTAI) criteria.
- learning from 'out of area' serious case reviews.

Communications: Next steps

4.58 During 2019/2020 the LSCB will continue to communicate the learning from our case audit activity and learning reviews. The LSCB Learning and Development Officer is exploring new ways of delivering key messages to practitioners who may find it difficult to get to daytime training events. One such proposal for 2019/2020 is to arrange twilight briefing events at different locations around the borough, to encourage practitioners to attend and receive updates on key learning and other important safeguarding messages.

4.59 The new arrangements for the Solihull Local Safeguarding Children Partnership were published early in 2019/2020, and work will continue to ensure that as many professionals as possible are aware of them, their own organisation's role within them, and how they will contribute to ensuring efficient and effective safeguarding arrangements in Solihull.

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

4.61 The Solihull LSCB multi-agency case audit programme is well embedded in LSCB business with an annual cycle enabling partners to manage the complex task. For the year 2018/2019 practitioners audited a total of 24 cases, focusing on the Board's three priorities; early help, neglect and exploitation. Practitioners were provided with 6 Key Lines of Enquiry (KLOE's) and 24 accompanying standards to assist them in auditing. For the first time the eight exploitation cases were audited using the Joint Targeted Area Inspection (JTAI) audit

methodology. The advantage of this was two-fold; firstly it ensured a rigorous examination of the cases, and secondly it provided partners with an opportunity to test their preparedness for any future JTAI inspection which may take place in Solihull.

4.62 The audit process culminates in a multi-agency learning event where the findings from the individual agency audit activity is shared and conclusions drawn from the information available. This event is invariably well supported, with over forty practitioners attending from thirteen different agencies. The conclusions reached as a result of this round of audit activity are set out below.

What is going well?

- Areas of improvement highlighted in previous audits have either been addressed, or progress continues to be made to do so.
- There has been a continual improvement in the general understanding of thresholds and application since the last round of audit activity.
- Consent issues seem generally well understood.
- Where practitioners were involved with children directly, they were able to speak authoritatively and knowledgably about their cases and about the experiences of the children with whom they are working.
- Risks appear to be identified and where concerns were identified in respect of practice, the auditors acted to address the concerns within their agencies.
- The audits indicate that professionals are involved/ receive appropriate information from meetings and generally received feedback from referrals where these have been made.

4.63 The feedback from the learning event was positive in that agency representatives felt there was value in the day and that learning can be brought back to their respective organisations. It is evident through this audit that practitioners in Solihull demonstrate good practice and agencies involved are committed to identifying both what they are doing well, and areas for improvement.

What needs to improve / what are we concerned about?

- The findings from the mock JTAI have supported the need for the work already started by the LSCB to agree a definition for wider exploitation and to develop policy, procedures and screening tools to inform this work and enhance the understanding of contextual safeguarding. Work needs to be undertaken to support practitioners to confidently intervene where they are concerned about exploitation.
- Progress has been made in raising awareness of the dispute resolution procedure; however there is more work to be undertaken to inform the understanding of its correct use and support practitioners to use it.

- There is potential for confusion regarding the need to seek consent (specified in Working Together 2018) and the circumstances with which consent can be dispensed with (General Data Protection Regulation).*

- Although information sharing is generally positive, minutes from multi-agency meetings are not always sent in a timely manner to GPs who cannot attend.

- Multi-agency processes and policy (including, for example, meetings) need to be further developed for Early Help and Youth Offending.

- The next audit should consider practitioners' understanding of the impact of traumatic childhood experiences and methods of ameliorating the on-going effect of these experiences for families, including how to intervene in cases where multiple complex needs are identified and where children are being exploited in the community.

The learning identified from the audit process will be carried into the activities of the new Local Safeguarding Children Partnership in 2019/2020 and will be used to improve responses and services.

*This is recognised as a national issue, and not one unique to Solihull practitioners.

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

4.64 In February 2018 the Board commissioned a learning review into the tragic death of a young person in November 2017. The Board received the final report in July 2018. The recommendations from this review were accepted by the Board, and the associated learning has been used to review the pathway for specialist assessments for children who may have learning difficulties, has contributed to the review of the local school inclusion strategy, and prompted specific questions within our audit processes in relation to partners' use of intelligence forms and knowledge of early help.

4.65 During this period the Board has supported the regional programme, led by Birmingham LSCB, to develop a rapid review process for considering whether serious cases meet the threshold for a serious case review, and the future child safeguarding practice reviews. The Board has used this process on several occasions during 2018/19, and provided feedback to support its development. Within Solihull, the rapid review process has also been found to be effective in identifying potential learning at a very early point after the incident has taken place.

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

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

4.67 During 2018/2019 local partners, led by Birmingham and Solihull CCG and local authorities have been working hard to plan the transition from current to future arrangements. This has been necessary as a result of the revised statutory guidance issued through 'Working Together to Safeguard Children 2018' and the associated 'Child Death Review: Statutory and Operational Guidance (England)', published in September 2018, which introduces fundamental changes to child

death overview arrangements. One such change is that ownership of these arrangements moves away from local safeguarding children partnerships. That said, Solihull LSCB has remained in close contact with partners responsible for planning and implementing the new arrangements, and have designed a reporting mechanism into the new safeguarding children partnership arrangements so the safeguarding partnership remain aware of any emerging

Monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children, and advising them on ways to improve (Regulation 5(c))

4.68 The Children Act 2004 places on a statutory footing the obligation for named agencies and individuals to co-operate to safeguard children and promote their welfare. Section 11 of the Act makes clear to whom this duty applies and indicates that they must make arrangements for ensuring that: "their functions are discharged having regard to the need to safeguard and promote the welfare of children". The 'Section 11 Audit' process allows the Local Safeguarding Children Board to assure itself that agencies placed under a duty to co-operate by this legislation are fulfilling their responsibilities to safeguard children and promote their welfare. The previous Section 11 audit in Solihull took place in 2015/16. It was therefore agreed that a further audit would be undertaken during 2018/19.

4.69 The single agency audit returns showed that the overall picture of safeguarding in Solihull is positive. The vast majority of agencies have met their safeguarding requirements detailed in Working Together to Safeguard Children 2018. The Board could be assured that its partners are broadly fulfilling their responsibilities to safeguard children and promote their welfare. There were however areas identified where those arrangements could be strengthened and improvements made. These were;

- **Whistle Blowing Policies:** Responses indicated that all partners have a whistle blowing policy in place but a number indicated that it has not been widely disseminated nor shown to be working effectively.

- **Managing Allegations:** Responses indicated that senior managers are not consistently taking managing allegations training, and although the Local Authority has a well-established Local Authority Designated Officer process, not all partners have an appropriate procedure to track and follow up on allegations.

- **Focus on the Child:** The response for this standard indicated that not all agencies consistently, and as a minimum, evaluate outcomes from the perspective of the child or young person. Further understanding of this result is need however, as not all of the agencies audited would have the opportunity to conduct such an evaluation following contact, and as such the absence of this may be understandable.

- **Early Help:** Early Help is an area for development in Solihull. In particular, scores demonstrate that partners are more likely to contribute to (support) Early Help work ,but less likely to undertake (initiate) work themselves. It was also clear from responses that many partners have

plans in place to improve their organisations Early Help response in the coming months.

- **Troubled Families Programme:** A number of agencies are not routinely making referrals to the Trouble Families Programme.

- **NRM:** In terms of the National Referral Mechanism (NRM) to be used by First Responders for trafficking incidents, evaluations indicated that staff are either 'generally unaware' or have a 'basic awareness' of the process for referral. A balanced view of this finding should be taken however as the awareness of the NRM is more important in some partner agencies (those with a statutory responsibility to refer) than others.

- **Force Intelligence Bureau (FIB) forms:** Although all partner's staff are at least 'generally aware' of FIB forms, two thirds of agencies reported they are only rarely (or never) submitting them.

The section 11 audit process was completed at the very end of this reporting period, and the response to the above findings will be managed via the new partnership arrangements during 2019/2020.

4.70 ***Children Missing Education***

4.71 The Local Safeguarding Children Board monitors the effectiveness of the response to children missing education. A child missing education is one who is of compulsory school age who is not on a school roll, and who is not currently receiving a suitable education otherwise than being at a school. It is recognised that there is a risk of increased vulnerability for this group of children who have less contact with professionals from universal services.

5. Our new multi-agency safeguarding arrangements

5.1 The Children and Social Work Act 2017 has brought about significant change to local children's multi-agency safeguarding arrangements. This Act amends certain safeguarding provisions within the Children Act 2004 by removing the statutory requirement for areas to have Local Safeguarding Children Boards (LSCB's). This has been replaced by the requirement for the safeguarding partners (which are the local authority, chief officer for police and the local clinical commissioning group for the area) to make arrangements to safeguard children and promote their welfare within their area. Additionally, the safeguarding partners should name relevant agencies that they consider appropriate to work with in exercising their functions, and those named agencies then have a duty to co-operate. The legislative changes introduce a great degree of flexibility as to how the three safeguarding partners achieve these responsibilities.

5.2 The Department for Education required that all areas must have agreed and published their new multi-agency child safeguarding arrangements by 29th June 2019 at the latest, and have adopted those arrangements as their way of working by 29th September 2019. Solihull are one of a small number of areas across England who have worked with the Department for Education as an 'early adopter', and as such both published and adopted our new arrangements on 1st May 2019, ahead of the required date. In doing this we were able both to provide

a possible model and guidance for other areas across the country, and to develop and strengthen our current local working arrangements.

5.3 The new Solihull Local Safeguarding Children Partnership arrangements have been subject of considerable discussion and design involving all partners involved in the previous safeguarding board. This work has resulted in the arrangements which can be viewed at https://solihulllscp.co.uk/.

5.4 The local impact of the legislative changes to multi-agency child safeguarding arrangements was first considered by Solihull LSCB Board members in a development session in January 2018, which focused on how Solihull partners might respond to these changes and the opportunities they presented to improve on the effectiveness of the current Board arrangements. All current Solihull LSCB activities were considered individually in the context of their effectiveness in supporting the delivery of efficient and effective child safeguarding arrangements. This process led to the new model being developed, which is intended to promote a more dynamic and flexible approach to continuous improvement within our children's safeguarding arrangements.

5.5 The development of these new arrangements has included particular consideration of both the framework for independent scrutiny, and the strength of contribution of schools, early years and other education providers in Solihull in view of their importance to safeguarding children. Independent scrutiny will be provided by both internal and external mechanisms, and schools, early years and other education providers will retain their own forum within the safeguarding arrangements, with a direct route into the Local Safeguarding Children Partnership via their own representative. Further detail can be found via the above link.

6. Statutory Partners accounts of their safeguarding responsibilities

6.1 Voluntary and Community Sector Enterprise Reference Group (VCSERG)

6.1.1 The third sector, voluntary, community and statutory sector continue to work effectively together and remain essential to making a huge difference to supporting and enriching the lives of children and young people in Solihull. The sector has a high degree of awareness amongst staff and volunteers of safeguarding issues and their roles in protecting children and young people from harm.

6.1.2 The Voluntary, Community Sector Enterprise Reference Group (VCSERG) continues to play an important role within a framework of multi-agency activity to safeguard and promote the welfare of children in Solihull. The work of voluntary sector is underpinned by safeguarding and makes us well placed to advocate and represent the voices of children and identify potential safeguarding issues.

6.1.3 The sector are key to delivering the early help framework as our work prevents referrals and enables quicker transition in and out of the MASH team. Our wider work with families and whole life circumstances helps reduce repeat referrals to children's services. We enable the statutory sector to undertake its duties and thus target scarce resources more efficiently.

6.1.4 The VCSERG engages with the 3 priorities by applying the tools, training and assessment frameworks that result from LSCB work We attend training

delivered by LSCB and are resourceful enough to organise our own training, tailored to our work with children and young people that complies with the Children Safeguarding Multi Agency Policies and Procedures in Solihull.

6.1.5 This year we have contributed to the preparation of JTAI Inspection and turned strategic plans into operational action such as applying thresholds, partnership working, attending multi agency meeting and advocating the voice of the child. 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.

6.2 West Midlands Police Public Protection Unit and Solihull Neighbourhood Policing Unit

6.2.1 The LSCB's CSE subgroup has evolved to a broader Exploitation agenda in line with developing LSCB priorities, and this group has continued to be chaired by West Midlands Police. This work has continued to focus on the protection of young people and children who are vulnerable to exploitation and to the identification of perpetrators and locations, and the development of strategic and tactical responses to these threats.

6.2.2 Multi-Agency Sexual Exploitation Meetings (MASE) and CSE and Missing Operational Group (CMOG) continue to be chaired by Police and we are driving the agenda to try and improve intelligence gathering and ensure plans are robust to safeguard victims.

6.2.3 We also remain committed to the Multi-Agency Safeguarding Hub (MASH) approach and to support partners in their safeguarding responsibilities.

6.2.4 In February 2019 the Public Protection Unit was redesigned to strengthen and enhance our MAET functions, meaning there are now more officers available to respond at pace to initial joint visits. As part of the redesign, other local authority areas covered by West Midlands Police also introduced MAET teams, increasing resilience throughout this critical function.

6.2.5 We have continued to support all LSCB audit activity and are present on every Serious Case Review panel, where we are keen to adopt learning and improve our response.

6.2.6 We attend initial case conferences in a timely manner through the Case Conference attenders, and we are continually focussed on improving our response to this commitment to support partners.

6.2.7 Our main challenges with partners are to continue to support the work in relation to CSE transitions, low risk CSE prevention and intervention, and the wider exploitation agenda .

6.2.8 We continue to provide the LSCB with quarterly updates on essential child safeguarding data, including the provision of PACE beds for minors who are

remanded, missing data and criminal justice outcomes around child abuse offences.

6.2.9 Solihull Police and School panels now operate in the North and South of the borough and act as a strategic meeting between senior leaders from the police and all secondary education settings, including PRUs. This is supported by a weekly data share ensuring schools are updated on the contact students have with the police, for safeguarding, welfare, crime and ASB reduction purposes.

6.2.10 All hotels within Solihull have had updated training from Police on CSE and county-lines as part of the national ‘See me, hear me” campaign. This annual delivery was executed between February and April 2019.

6.2.11 All Solihull Town Centre Licensed Premises have attended Police Partnership training on CSE and county-lines. This has since been supported by the addition of conditions onto 8 premises licenses across the borough with a specified requirement that staff have annual training on the matter. This ensures critical locations (including football clubs, eateries, clubs and bars) are best placed to safeguard young people inside and outside their premises, forming part of their obligations under the licensing objective “to protect young people from harm”. This puts the onus on the premises to ensure their staff are informed.

6.2.12 Police have ensured annual taxi training on CSE has been extended to cover county-lines as part of their annual renewal of license. This has been supported by numerous taxi enforcement exercise where drivers have been given additional information and reminded of their responsibilities.

6.2.13 Solihull Police and Central Motorway Policing Group have organised numerous partnership MAVEs, supported by HMRC, WMFS, DVSA, DLA, HM Courts Warrants Officers and SMBC Trading Standards, Environmental Crime Team and Licensing Team. During these MAVEs perpetrators of child exploitation and abuse have been disrupted including the seizure of vehicles and gathering of vital intelligence.

6.2.14 Solihull Police supported school DSL (designated safeguarding leads) training days in October 2018 with training on County-lines including the model of exploitation, case studies, spotting the signs, reporting and intelligence gathering mechanisms.

6.2.15 During the last year Solihull Police have rolled out Operation Encompass, a national process which shares standard risk domestic abuse data with schools so they may better protect the welfare of their students who live within households subject to incidents. The data broadens information already shared on high risk cases and has allowed schools to consider their student’s needs in a more holistic manner. The data share occurs daily, shares the details of approximately 80 incidents a week and involves every school within Solihull including primary, secondary, PRU, Private, free and faith.

6.2.16 Solihull Police continue to work with SMBC to prioritise individuals not in Education, Employment or Training (NEET) for intervention and diversionary work. 50% of those NEET this year were known to the police and 25% were

actively involved in criminality or ASB. All have been subject to intervention ranging from low level letters and joint calls to visits and direct action.

6.2.17 Solihull Police have worked closely with SMBC Education Services to offer schools and colleges a range of Counter Terrorism Awareness Sessions including National Act and Argus packages. Delivered by West Midlands CTU these have been designed to inform education settings of the current threat profile, place them in a virtual scenario and allow them to test their internal policies and procedures, this included the application of the national 'Run, Hide, Tell' guidance.

6.2.18 Solihull Police have undertaken joint patrols with Trading Standards to identify children and young people involved in labour exploitation on building sites and working in the scrap metal trade across the borough. Most recently this has taken place under the Operation Aidant.

6.2.19 Solihull Police are in the process of rolling out the National Mentors in Violence Prevention Campaign funded by the office of the Police and Crime Commissioner, so far two schools have already taken up the training and have mentors in place, further schools are in the early development stages.

6.2.20 Solihull Police have delivered a sustained piece of partnership work with the aim of tackling knife and weapon related crime in the borough. This includes:

I. Educational inputs at all schools, delivered by the police in secondary schools and PRUs and delivered by schools in primary settings.

II. Search operations at secondary schools supported by all schools across the borough. This involves use of a knife detector (pole) delivered by both teaching and police staff.

III. The search of all parks in the borough recovering knifes and weapons hidden by offenders for later use.

IV. The mandatory attendance of all young offenders (for weapon and knife related crime) on a knife crime awareness and diversion scheme, delivered by Solihull Youth Offending Team.

V. The offer of the national 'Street Doctors' programme to all young people at risk of becoming involved in knife or weapon related crime, this includes a hard hitting education programme delivered by doctors focusing on the health risks.

VI. In May 2019 the offer to all secondary schools in the borough of a presentation by Loudmouth Theatre Company on knife crime and county-lines for all year 7 pupils, including PRUs. This was funded by the West Midlands Police and Crime Commissioners Active Citizen Fund.

VII. Visits and checks at all Solihull knife retailers to ensure they're abiding by the law and selling knives responsibly.

VIII. Intervention visits to all suspects who police suspect (through intelligence) may be at risk of carrying a knife.

IX. Public place search operations focused on disrupting young offenders including the use of knife detectors and drones. These have taken place across the borough in key locations such as bus stops, local parks, key fast food restaurants and during the night time economy in the town centre.

6.3 NHS Solihull Clinical Commissioning Group (NHS CCG)

Introduction – Who we are and what we do

6.3.1 On 1st April 2018, three Clinical Commissioning Groups (Birmingham South Central, Birmingham Cross City and Solihull) merged to form Birmingham and Solihull Clinical Commissioning Group (the CCG). We are now the largest CCG in England, serving a population of around 1.3m people and managing a budget in excess of £1.8 billion; almost 2% of the NHS Budget in England. Birmingham and Solihull CCG is one of the three Safeguarding Partners for Birmingham's multi-agency safeguarding arrangements.

6.3.2 The CCG covers two main local authority areas: Birmingham City Council and Solihull Metropolitan Borough Council. Citizens have different needs and localities have therefore been created to co-ordinate with Parliamentary boundaries. In turn, this facilitates integration with wider providers and councils, as collectively we seek to achieve a flexible commissioning approach. We are a commissioning organisation, as opposed to a provider of services. We are a membership organisation with currently 177 Member Practices.

6.3.3 The number of providers that the CCG commissions changes year on year: at the end of March 2019, we had on file 217 independent contracts assigned under the title of 'Healthcare Contracts', 19 assigned under 'Goods and Services', 204 listed under Primary Care Contracts, with an additional 7 large NHS Providers, including 2 Mental Health providers and community services across multiple sites. Total of 447 contracts

6.3.4 The CCG Executive team and Designated Professionals Safeguarding Team, including Named GPs, work across local authority boundaries and are active at national, regional and local levels to work together to keep citizens safe and to contribute to the local Safeguarding Adults Boards, Community Safety Partnerships and Safeguarding Children Partnerships' priorities. We maintain a statutory and non-statutory meeting schedule and work with partners at Community Safety Partnerships, Safeguarding Adults and Children's Boards and sub-committee levels seeking to improve outcomes for children and young people, and for adults with care and support needs, as well as their families/ main carers.

Delivering on Strong Leadership and Strong Partnership

6.3.5 The Designated Safeguarding Professionals and Executive teams are strategic and fulfil our responsibilities through influencing and senior leadership across health, policing and social care systems. There is also senior operational support delivered through sub-group or panel activity and through a designated nurse advice line. The advice line operates from 9.00am – 5.00pm, Monday to Friday and provides timely case management guidance and expert advice to Primary

Care professionals, acute and independent providers and occasionally members of public.

6.3.6 Our Safeguarding Vision has been developed and is contained within the Birmingham and Solihull CCG Safeguarding Arrangements Policy, which is due to be ratified by the CCG's Quality and Safety Committee on 30th April 2019.

6.3.7 However, and as a commissioning organisation, we encourage change through influencing policy and bringing about change through how we work together, sharing intelligence, commission and contract services. In the past year, we have made improvements to enable a standardised way of obtaining an initial bench mark across our commissioned services about the quality of the safeguarding arrangements in relation to children (including children looked after by the local authority).

6.3.8 In 2018/19, the CCG's Safeguarding Assurance Group (SAG) was established as a sub group of the CCG's Quality & Safety Committee (QSC) to support its work streams in regards to quality improvements across the safeguarding agenda. The SAG has responsibility for:

- Improving the way in which children at risk are safeguarded, with a particular focus on design, commissioning and provider services;
- Sharing good practice;
- In conjunction with NHS England, supporting the education and development of Designated Professionals and the internal and external workforce;
- To provide specialist advice via the Designated Professionals for Safeguarding (adults and children), Children in Public Care, and Named GPs;
- Monitoring the regular supervision of designated health professionals

Continuously Improving Child Protection/ Safeguarding Practice

6.3.9 In addition to the remit of the Safeguarding Assurance Group, a schedule of Practice Safeguarding Leads Network meetings has been implemented across Birmingham and Solihull CCG footprint to help deliver strategic priorities at the front line. In addition, and through formalised meetings, case discussions and advice guidance provides the:

- Delivery of system learning and learning arising from complex cases and case reviews;
- Method of supporting improvements of health outcomes for vulnerable children;
- Balancing of wellbeing and risk (risk enablement);
- Primary method of delivery for system learning, delivery of the Learning and Development strategy, and the Designated Professionals and Named GPs working directly with Practice Safeguarding Leads across Primary Care.

6.3.10 Patient Safety Panels were strengthened during 2018/19. These panels bring together members across the medical, nursing and primary care directorates to provide a structured approach to tackling reportable complex incidents that have occurred in provider services. The Patient Safety Panels are led by the Chief Medical Officer and Deputy Chief Nurse and are managed by the Patient Safety

Team. The panels cover all ages and enable and support a cross-directorate approach, seeking to analyse reported patient safety incidents to improve provider learning from incidents.

6.3.11 During 2018/19, Birmingham and Solihull CCG reviewed our approach to safeguarding and complex cases, which included children's continuing care and adult continuing health care. To support system learning we commissioned specialist safeguarding supervision training from a subject matter expert although this is an on-going process, with further training planned during 2019/ 2020.

6.3.12 In addition to utilising national e-learning platforms and multi-agency safeguarding learning development opportunities, we have commenced a participatory Learning and Development programme across the Birmingham and Solihull CCG footprint for Primary Care and to help embed the safeguarding children and Prevent competency frameworks. It is acknowledged however, that this area of work has been slower to commence than originally planned in the CCG Learning and Development strategy owing to capacity problems within the CCG. However, throughout 2019 and 2020 we will introduce more courses to our learning and development programme.

Embedding Early Help and early intervention into mainstream partnership activity

6.3.13 The Identification and Referral to Improve Safety (IRIS) programme is a good example of cross-partnership working to protect those most vulnerable from harm, and making a difference to identify, intervene early, and enable people to help change their lives by putting individuals in touch with supportive services.

6.3.14 IRIS is a General Practice-based domestic violence and abuse (DVA) training and support referral programme that has been implemented / tested in a randomised controlled trial. The programme delivers training and education to Primary Care Teams and encourages clinical enquiry, care pathways and an enhanced referral pathway to specialist domestic violence services. IRIS has been independently evaluated and shown to be good at identifying and facilitating the referral of 'hidden' victims into specialist domestic abuse services. By hidden, we mean those who are least likely to report to the police, directly contact specialist support or be involved with other services such as housing and social care. This has led to an increase in the numbers of children and young people who are vulnerable to risks presented by domestic violence and abuse are safeguarded.

Looking Ahead - Challenges and Focus for the Next Year (2019/20)

6.3.15 BSol CCG has much more to do as we embed and refine our commissioning and contractual arrangements. As mentioned above we have strengthened our system assurances to gain sustained evidence for the CCG and partnership boards about the quality of services delivered around safeguarding and contributing to the partnership priorities. However, there also remains internal and external challenges to embedding sustained change and capacity of the workforce to deliver. Some specific challenges related to safeguarding and commissioning are:

- Safeguarding and working arrangements between children's and adults' services so that effective care pathways and plans support vulnerable individuals as early as possible through periods of change. For commissioning of services and existing provision, this means wherever possible, aligning and bridging gaps of existing commissioned services.

- The Children and Social Work Act 2017 introduced a new legal framework in respect of local safeguarding arrangements for children (see Working Together to Safeguard Children, 2018, Chapter 4). 2019-2020 implements changes through published Safeguarding Partners' plans, the process for implementing local and national learning including from serious child incidents across the West Midlands region and our arrangements as Child Death Review Partners, as detailed within the Child Death Review Statutory and Operational Guidance (England), published on 15th October 2018[1] (now known as the 'Operational Guidance').

- Our Designated Professionals' Children in Care team is involved in an initiative to address the often complex health needs of unaccompanied asylum-seeking children (UASC). With partners, we have developed an integrated pathway to support the Birmingham (and Solihull) UASC/young people population. In 2018/19, a Task and Finish group was formed to look at ways of working effectively to improve service and outcomes for these young people to ensure that the health needs of UASC/ young people are addressed appropriately. The young people have been engaged in this process and their views and experiences captured to ensure the pathways are young person focused and inclusive of their needs. This work and the challenges it presents will continue into 2019/20.

6.4 Birmingham and Solihull Mental Health Foundation Trust

6.4.1 A Introduction – Who we are and what we do…

6.4.2 Birmingham & Solihull Mental Health NHS Foundation Trust (BSMHFT) is a mental health service provider which delivers a range of specialist mental health services for children and young people in Birmingham and Solihull. We work with individuals affected by mental illness and with their families and friends in order to promote recovery. BSMHFT work in partnership with others to fulfil its statutory responsibilities to safeguard and promote the wellbeing of children and young people. The Director of Nursing oversees safeguarding arrangements in the trust and employs a corporate safeguarding team to support frontline staff and the wider organisation in their execution of safeguarding requirements.

6.4.3 Safeguarding team functions are to:

- ✓ Ensure that effective safeguarding structures, policies and processes are in place;
- ✓ Offer specialist advice, support and safeguarding supervision;
- ✓ Provide a safeguarding learning and development function;
- ✓ Conduct internal and external reviews and disseminating learning/findings;
- ✓ Engage with partners and offer specialist advice as required;
- ✓ Govern and obtain assurances of the effectiveness of safeguarding arrangements.

[1] HM Government, Child Death Review Statutory and Operational Guidance (England), published October 2018.

6.4.4 **Safeguarding Priorities:**

6.4.5 During 2018-19, the Safeguarding Team chose the following three priorities; progress to date is detailed below.

6.4.6 **Priority One - Strong Leadership and Strong Partnership**

6.4.7 **Leadership**: During 2018-19 BSMHFT's Safeguarding Team included in their strategic plan a priority to improve operational safeguarding leadership. The aim was to encourage senior managers to support each mental health team to take ownership of their own safeguarding improvements. The team established a baseline in order to measure evidence of improvement. We reviewed our governance and assurance arrangements to ascertain if local clinical governance forums had clear work plans regarding safeguarding improvements and quality goals and we requested evidence for assurance purposes regarding the implementation of recommendations and learning from serious case reviews (or other types of review). We also appraised our model of using local safeguarding leads to promote safeguarding within their teams. As a result of our review, we have suspended the safeguarding leads model and are making improvements to our governance arrangements. We have implemented new monitoring measures within the Safeguarding Team to evidence our disseminating of learning from serious case reviews. We conducted a thematic review of recommendations from Domestic Homicides and have provided a face to face briefing to Senior Leaders to enable them to benchmark their own service areas against the themes identified and to implement any required actions.

6.4.8 **Partnership:** Multi-agency partnership is embedded in BSMHFT's organisational links to LSCP and its subgroups. We contribute (virtually) to Solihull's Multi Agency Safeguarding Hub (MASH) to enable effective information sharing regarding adult mental health in order to rapidly progress the safeguarding of children and young people.

6.4.9 **Priority Two - Continuous Improvement of Child Protection Practice:**

6.4.10 During 2018-19 BSMHFT's Safeguarding Team have used findings from audit and from our data intelligence and incident reporting to develop and improve child protection practice. Some examples of how we have done this are as follow; the strengthening of our safeguarding children policy to overtly state the importance of managerial oversight, the progressing of our quality assurance framework and practice guides to ensure staff have a clear link from policy to practice and skills, and the review of our provision of advice and support, which will pilot the development of local safeguarding facilitation in Solihull during 2019-20. Our training also has been subject to review and we aim to develop practitioner confidence and autonomy regarding safeguarding practice by using a new approach in the upcoming year. Recommendations from a recent audit indicate that introducing the use of the Graded Care Profile (2) in Solar and in our Perinatal and other specialist Child and Adolescent Services would be beneficial and will be considered in the next financial year.

6.4.11 **Priority Three - Mainstreaming Early Help and Early Intervention:**

6.4.12 During 2018-19, BSMHFT have strived to improve the provision of early help and intervention for mental ill health by improving access to perinatal services. Our Perinatal Service has undergone significant growth and development. The expanding service's operational policy has been developed to explicitly include

early help interventions. The service will employ a safeguarding facilitator with a responsibility to support practitioner's delivery of early help. With this in mind, the safeguarding team have promoted the use of an early help practice guide which sets out how each mental health team within BSMHFT can provide an early help offer. The guide helps staff to clarify how their specific service can participate in early help assessment plans with regard to the mental health services they offer to their patients who are parents. Improvements have been made to our recording of family composition on electronic records by introducing a "Childrens and Siblings document" to support a whole or think family focus to care planning and risk assessment. The Safeguarding Team have also driven forward work towards the Early Help aspect of Birmingham's Domestic Abuse Strategy and held an annual conference "Domestic Abuse – Improving our Response and Practice" which focused on early recognition and intervention.

6.4.13 **Looking Ahead - challenges and focus for the next year (2019/20)**

6.4.14 The emerging themes that will shape safeguarding priorities and areas for improvement during the next twelve months are as follow:

- ✓ "Back to Basics" (internal driver);
- ✓ Responding to the findings from safeguarding reviews (internal and external driver);
- ✓ Shaping the Safeguarding Culture in BSMHFT (internal driver).

6.4.15 This diagram illustrates how each priority interlinks to deliver holistic organisational safeguarding improvements

6.4.16 **Back to Basics:**

6.4.17 The Safeguarding Team think is important to do the simple things right. This year we will be concentrating on improving the quality of staffs basic understanding of safeguarding including recognition and responding to abuse and neglect. This will include developing skills in routine enquiry, curiosity, respectful challenge and analysis of past information to support ongoing care and risk management. We will be piloting face to face safeguarding facilitation in key teams in Solihull. We will be encouraging the use of safeguarding policy, practice guides and specialist tools such as the Graded Care Profile (2) and Signs of Safety.

6.4.18 **Responding to findings from Safeguarding Reviews:**

6.4.19 BSMHFT understand that it is imperative to learn from Serious Case Reviews and would like to be able to actively demonstrate the changes made in response to such reviews. The Safeguarding Team will be embarking on a Quality Improvement Project to discover how to improve training and supervision in order to aid the application of learning into clinical practice. We will also seek improvement in our governance and assurance of recommendations from reviews.

6.4.20 **Shaping the Safeguarding Culture:**

6.4.21 Evaluation of current BSMHFT safeguarding provision suggests that despite last year's priority to improve operational leadership there still needs to be a shift from "corporate safeguarding" driving and providing safeguarding developments to a mainstream approach to the implementation of safeguarding improvements. This shift requires an embedded and positive safeguarding culture within all clinical services at both managerial and practice level. In order to avoid implementing another potentially silo'd approach to safeguarding, the team are recommending that BSMHFT implement an organisation wide "Think Family or Whole Family" Strategy which includes integrated safeguarding work streams within operational developments.

6.5 University Hospitals Birmingham

6.5.1 Introduction

6.5.2 In April 2018 University Hospitals Birmingham NHS Foundation Trust (UHB) Queen Elizabeth Hospital Birmingham acquired, as part of a merger, Birmingham Heartlands Hospital, Good Hope Hospital and Solihull Hospital making the Trust one of the largest teaching hospital trusts in England. The Trust also runs Birmingham Chest Clinic, Sexual Health Services for Birmingham and Solihull (Umbrella), a range of community services in Solihull (including community paediatrics, community paediatric nursing. special school nurses and Looked After Children Services).. The Trust has a 20.000 workforce and it is a priority that all members of the workforce are fully engaged in the safeguarding children agenda and can confidently advocate for the rights of children.

Our Vision:
Building Healthier Lives

Our Strategy

- Excellence as a hospital
- Excellence as a group of hospitals
- Excellence as a healthcare system

Facts and figures – our service activity in 2018-19:

79,927 children (0-18) seen in ED annually with **32834** admissions for children (0-18years).
272,381 A&E attendances, including parents of children where their ability to care for children may be compromised.

Total number of beds in the Trust -2274 . Number of Paediatric beds **115**.

New Births annually -9,697 Supported new births

New investment for children - New **£112,000** refurbished dental x-ray room support specialist room support specialist children dental care.

6.5.3 The organisation ensures that all statutory responsibilities to safeguard and promote the wellbeing of children are met and that this is regularly reviewed.

6.5.4 **Leadership and Partnership**

6.5.5 The internal leadership of the safeguarding children agenda is a clear Trust priority. The accountability for effective safeguarding arrangements is carried by the Executive Chief Nurse as part of her portfolio and she oversees the internal safeguarding arrangements closely including safeguarding governance and the leadership and management of the Safeguarding Team:

The, highly visible, safeguarding team is positioned corporately to maximise their sphere of influence across the Trust. They are responsible for delivery of:

- Safeguarding advice, support and supervision to empower the workforce to meet safeguarding challenges
- Education and staff development to ensure the workforce has the skills and competence to safeguard effectively
- Encouragement and maintenance of staff engagement in relation to safeguarding
- Ensuring that policies and procedures are in place, are clear and accessible and regularly reviewed to reflect best practice
- Audit and 'testing out' the effectiveness of arrangements to safeguard children
- Internal review and dissemination of learning from safeguarding cases
- Working with partners and ensuring they have access to specialist health advice as required

6.5.6 The Trust has contributed to the work of the Solihull Safeguarding Board in a variety of ways in 2018-19 including the completion of internal reviews as part of the serious case review process and multi-agency audits and provision of health support to a variety of sub groups.

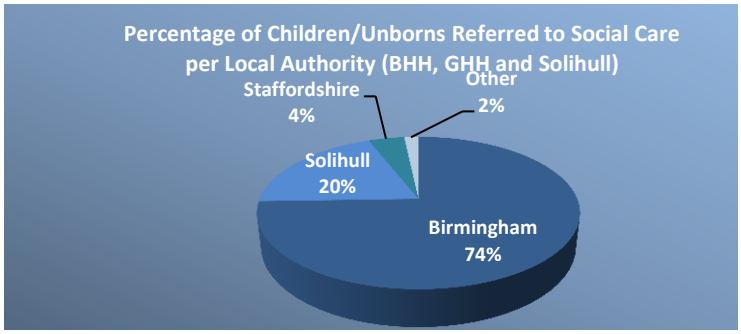
6.5.7 The Trust works closely in partnership with organisations in the delivery of safeguarding outcomes. There is strong evidence of effective partnership with Solihull Local Authority at every level. The Trust has committed to improving the timeliness and effectiveness of information sharing in child protection cases by ensuring a staff presence in Solihull MASH. There are regular multi-agency case discussions on site to ensure discharges are planned safely. Staff participate in a variety of multi-agency meetings including Case Conferences. There are strong links between the Safeguarding Team and the Social Team Managers and Heads of service. The Trust can demonstrate use of the professional disagreement policy to resolve differences of opinion about how children can best be kept safe.

6.5.8 The Trust has maintained consistency within partnership arrangements throughout a period of organisational change since the merger in April 2018.

Total Number of Children referred to SW services due to safeguarding concerns (all sites) 2018-19	**4126**
Total Number of Children referred to Social Work services from Birmingham Heartlands, Good Hope and Solihull	**3,181**
Total Number of children referred to social work services from Queen Elizabeth Hospital Birmingham	**945**
Average number of children referred for social work services across all sites in 2018-19 per quarter	**1,031**
Average number of children referred for social work services per quarter in 2018-19 (Birmingham Heartlands Hospital, Good Hope and Solihull)	**795**
Average number of children referred for social work services at the QE hospital site per quarter in 2018-19	**236**

Safeguarding Children Referral Activity in the Trust during 2018-19

As the graph below illustrates **20%** of safeguarding children referral activity from the Heartlands, Good Hope and Solihull part of the Trust relates to Solihull



The category of concern most frequent cited in referrals is neglect. There are approximately 10 cases each quarter where non-accidental injury is investigated and a significant number of referrals identify concerns with parental capacity (the most common cause for concern being mental health problems).

6.5.9 **LADO**

6.5.10 The Trust completed **17** LADO referrals during 2018-19 with only 1 of these relating to Solihull.

6.5.11 **Continuously Improving Child Protection Practice**

6.5.12 The Trust uses the following levers to ensure effective safeguarding children practice and to drive continuous improvement.

6.5.13 **Safeguarding Children Policies and Procedures**

6.5.14 The Safeguarding Children Policy and Procedure was re-drafted in 2018-19. Policies and procedures are regularly reviewed and updated to reflect best practice and are clear and easily accessible to staff via the intranet. Implementation of the policy and procedure is monitored on a quarterly basis. Policy and procedure reinforce the use of tools to ensure effective assessment.

6.5.15 **Safeguarding advice and support**

6.5.16 There is dedicated resource for provision of safeguarding advice, and support with a high and growing uptake from frontline staff.

6.5.17 **Supervision**

6.5.18 The Trust has arrangements in place for safeguarding supervision across the organisation and during 2018-19 has increased the availability of supervision to key groups of staff. Supervision rates are monitored quarterly as a key performance indicator. Staff feedback demonstrates a high level of satisfaction with safeguarding supervision. Overall end of year compliance rates are illustrated below:

Cohort	Percentage of Supervision Achieved 2018-19
Acute Overall	**94%**
Maternity Overall	**92%**
Safeguarding Nurses overall	**94%**

6.5.19 **Safeguarding Education – Safeguarding competences for health care staff**

6.5.20 The Trust completes an annual Training Needs Analysis, annual review of safeguarding educational resources and there is regular monitoring in relation to compliance (Safeguarding Training compliance rates at level 1, 2 and 3 are maintained at over 90% see table below). All training is evaluated positively in relation to staff confidence in relation to identifying and managing safeguarding concerns.

Safeguarding Children Level	Overall Trust compliance Q 4	Community Compliance Q 4
Level 1 (Target 90%)	**99%**	**99%**
Level 2 (Target 90%)	**97%**	**99%**
Level 3 (Target 85%)	**95%**	**88%**
PREVENT (Target 85%)	**95%**	**97%**
CSE (target 85%)	**87%**	**89%**

6.5.21 **Safeguarding Audit and Review**

- There is an annual audit programme for safeguarding children which is focused on testing out the effectiveness of internal and partnership safeguarding arrangements.
- The use of the Child Protection Information System in the Emergency Departments is subject to regular audit to ensure compliance rates remain high.
- The Trust completes a variety of safeguarding reviews including those completed as part of the Serious Case Review process and uses a variety of mechanisms to ensure that lessons from reviews are learned and embedded. Good safeguarding practice is identified and praised and staff are encouraged to look critically about how improvements can be made.
- During the last 12 months the Trust completed a review of all learning from serious case reviews and domestic homicide reviews and an assessment of to what extent this learning could be seen to have become embedded.
- There is close monitoring of incidents and patient experiences to ensure that learning from these areas is incorporated into safeguarding improvements.
- Assessments for children include important history and cross reference safeguarding alerts and use of the Child Protection Information System which is implemented in unscheduled care settings in the hospital.
- The Trust has reviewed its safeguarding governance structure in 2018-19 and a range of quality indicators are scrutinised as part of the governance

of safeguarding children including: safeguarding children activity; patient experience; audit data; incidents.

- During 2018-19 the Trust completed an audit against all section 11 requirements and is progressing work to enhance capture of patient views in assessments and in service development and to enhance the capture of early help data.

6.5.22 Embedding Early Help and Early intervention into mainstream activity

- As a provider of acute services, mainly on an episodic basis contributions to early help have been difficult to demonstrate.
- During 2018-19, along with all the other acute health providers in Birmingham, the early help notification criteria was implemented across all Emergency Departments in the Trust. This criteria ensures that cases where early help is required, a notification to community health services is sent. An audit completed in January illustrated that this has improved notifications to community staff f for children and families who would benefit from early help.
- This criteria is also used for inpatient paediatric patients.
- All of the maternity units in Birmingham are now engaged in a piece of work with the community Trust to ensure that there is a similar notification criteria driving early help support and notification to health visitors.
- There is weekly oversight of cases in the NNU through safeguarding supervision and this also drives early help approach where this is indicated.
- Red Thread youth service works in both Heartlands and QE Emergency Departments and aims to engage young people in intervention when they have been involved in assault and trauma and ultimately ensure that they develop strategies for staying safe . The service has been well received by patients and staff.

6.5.23 Looking Ahead - challenges and focus for the next year (2019/20)

- In April 2019 the Trust is scheduled to launch its new safeguarding team structure and implementing related work plans and governance arrangements.
- The Trust will be defining an overarching safeguarding strategy
- The Trust will continue to audit the effectiveness of safeguarding arrangements across the Trust.
- The Trust will complete further work to align procedures related to safeguarding children across the Trust.
- Complete work to ensure that the views of children are sought in assessments
- Explore findings from the Red Thread interventions offered.
- Contribute to the new safeguarding partnership arrangements in Solihull as the Safeguarding Children Board is replaced.

6.6 South Warwickshire NHS Foundation Trust

6.6.1 Introduction

6.6.2 South Warwickshire Foundation Trust (SWFT) is a multi-site provider of acute and community health care to the population of Warwickshire, Coventry and Solihull. The Trust covers three Local Safeguarding Children Partnerships (LSCPs) Coventry, Warwickshire and Solihull. The Trust works with Solihull Safeguarding Children Partnership (SSCP) to fulfil its statutory duty to promote the welfare of children and protect them from harm.

6.6.3 The Safeguarding Team is employed as part of a statutory process for all NHS Trusts to ensure all staff are supported to respond to their safeguarding responsibilities, there is no "opt out" for anyone. The Law is clear that we must be compliant with our Section 11 safeguarding functions and we are measured against this currently by Section 11 audits delegated by the LSCP.

6.6.4 The Trust is committed to working as an effective partner that contributes to multi-agency working that is compliant with policies and procedures and is an active Partner and Sub Group member of SSCP.

6.6.5 The Trust aims to ensure that staff are supported with expert knowledge of child protection to minimise risk and ensure that the child is "paramount". Section 10 of the Children Act (1989/2004) is clear that everyone has a duty to "discharge function" and the Trust Safeguarding Team are tasked with ensuring that the Trust support safeguarding as "everyone's business."

6.6.6 The Safeguarding Team have supported SSCP appropriately including attending Child Sexual Exploitation Missing Operational Group (CMOG) meetings and Signs of Safety (SOS) sessions and contributing to Safeguarding Practice Reviews (SPR) using the new Rapid Response process for scoping and multi-agency audits. The Trust has actively participated in the transition process from Local Safeguarding Children Board (LSCB) to becoming a Safeguarding Childrens Partnership (SCP).

6.6.7 The Health Visiting and School Nurse service attend all appropriate multi-agency meetings that rely on the effective sharing of information between partner agencies. The Safeguarding Team support staff to undertake these responsibilities appropriately ensuring liaison with partner agencies, confirming that messages are disseminated that improve outcomes for children.

6.6.8 This report seeks to demonstrate how SWFT has strengthened and improved the safeguarding support provided to Solihull staff.

6.6.9 **Training**

- The Trust has introduced Domestic Abuse Stalking & Harassment (DASH) training to support all staff to reflect on family dynamics, recognise risk and to embed the culture of the "Think Family" ethos for all practitioners to adopt.

- The Safeguarding Team has reviewed its training provision and is in the process of offering bespoke training packages that will meet the unique requirements of all staff.

6.6.10 **Supervision**

- The Trust has introduced a supervision model that is designed to capture multi-disciplinary engagement, supporting staff to ensure that they are

competent safeguarding practitioners who contribute effectively, listen and understand the child's journey.

- The Safeguarding Team recognises that practitioners have diverse learning requirements and is strengthening the supervision provision in Solihull by offering group and 1-1 supervision. The format is designed to help all members of the multi-disciplinary teams feel safe and comfortable to discuss any safeguarding concerns.

6.6.11 **Data Collection**

- The Safeguarding Team has introduced and implemented two databases which will support the team to work more effectively.

- The Advice and Support database will enable them to give more timely written feedback to operational practitioners. This has helped them to gain confidence when dealing with complex safeguarding issues. It is envisaged that this database will allow the Safeguarding Team to draw out themes that will contribute to learning events and training going forward.

- The information captured in the Safeguarding Supervision database enables the Safeguarding Team to inform Clinical Leads of their staff supervision compliance.

6.6.12 **Safeguarding Team Restructure**

- In support of the "Think Family" model of safeguarding the Trust has appointed a Named Professional Safeguarding Adults. This raised the profile of how safeguarding adults in need of care and support impacts on the lived experience of the children within the family.

- The Safeguarding Team has been able to recruit additional Named Nurses who have substantial safeguarding experience; they come with a range of special interests that will further enrich the learning and support that is already provided for practitioners.

- There is now a Safeguarding Midwife in the team who will enhance the support offered to practitioners working with families of the "unborn" and the immediate post-natal period.

6.6.13 **Conclusion**

6.6.14 Over the past year the Safeguarding Team has effectively engaged and participated with implementing the National guidance from Working Together (2018) for the new Multi-agency Safeguarding Partnership arrangements and looks forward to embedding this new process.

6.6.15 Changes implemented within the Safeguarding Team have enabled practitioners to fulfil their safeguarding responsibilities with increased knowledge and confidence.

6.7 Cafcass

6.7.1 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.

6.7.2 The demand on the family justice system and on Cafcass services remained very high throughout the year, with rises in local caseloads varying across the country. Overall Cafcass has seen a rise in private law applications (involving arrangements for children following parental separation) and a small decrease in public law applications (involving the local authority), Cafcass is actively contributing to the Care Crisis Review, a sector-wide initiative that aims to stem the increase in care cases and promote safe and beneficial outcomes for children. We are also undertaking innovative projects that seek to improve practice, promote good outcomes for children and make better use of limited resources. An example is the three assessment pathways that we have been developing – domestic abuse; high-conflict; and parental alienation.

6.7.3 Cafcass' strategic priorities in 2017/18 were to: continue to improve our performance and the quality of our work; contribute to family justice reform and innovation; use our influence to promote knowledge and best practice; bring the uniqueness of each child (including diversity considerations) to the court's attention; be efficient and effective in light of high demand and financial constraints.

6.7.4 In February and March 2018 Ofsted undertook its second national inspection of Cafcass, making an overall judgement of outstanding. Ofsted found that practice was effective and authoritative, helping courts to make child-centred and safe decisions, adding value and leading to better outcomes for children. The overall judgement was influenced by many factors including: the exceptional corporate and operational leadership; sensitive and knowledgeable direct work undertaken with children in relation to a wide range of diversity issues; the culture of continuous learning and improvement; and a strong aspiration to 'get it right' for vulnerable children. The inspection identified some areas for Cafcass to improve relating mostly to the quality of recording and to explaining to court consistently when issues of diversity are not relevant to the application. We will be working on these in the year ahead and will continue to try to improve our services, and to contribute to family justice reform.

6.7.5 Locally the Interim Head of Practice and Service Manager for Birmingham and Solihull have met with the Independent Chair of the Safeguarding Board and the Interim LSCB Business Manager. Cafcass management team will be meeting with Director of Children's Services in June 2019 to discuss advancing their partnership working. Whilst the Service Manager will be attending LSCP Assurance & Review Group meeting in September 2019.

6.8 Solihull Community Housing

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

6.8.2 SCH is governed by a Board of 12 members, a third of which are Council nominees, one-third tenants and one-third independent representatives, chosen for their specialist skills and experience. A Scrutiny Panel made up of tenants

and leaseholders assists in reviewing performance across all areas of our business.

6.8.3 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 wellbeing 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.

6.8.4 Changes to homelessness legislation introduced by the Homelessness Reduction Act 2017, became effective from April 2018. SCH delivered a re-modelled homelessness service to meet the new obligations, which included additional 'prevention' and 'relief' duties. SCH and St Basils, who provide homelessness prevention, relief and support services to young persons aged 16 to 25 through the Solihull Youth Hub, continued to work closely with Childrens Services to support homeless 16 and 17 year olds in accordance with the joint protocol arrangements.

6.8.5 SCH is committed to corporate parenting principles and works with Childrens Services to support young people in making the transition to independent living through an agreed Care Leaver Protocol. During 2018/19 SCH liaised with Children's Services on measures to provide enhanced support to care leavers when moving into their new settled homes.

6.8.6 Looking forward, our Safeguarding Champions group has been revised under the new name of the Safeguarding, Exploitation and Domestic Abuse group (SEDA). This will increase the focus on, and broaden the scope of, SCH work which contributes to safeguarding children and vulnerable adults. Senior managers on the group will share responsibility for attending relevant multi-agency meetings, including participation in the new safeguarding children partnership arrangements as a relevant agency. We continue to be a virtual member of the Multi-Agency Safeguarding Hub (MASH).

6.8.7 In 2019/20, building on the comprehensive programme of safeguarding awareness training already undertaken, we will be implementing a revised competency framework for housing practitioners requiring a more advanced level of training because of the nature of their work.

6.9 Community Rehabilitation Company (CRC)

6.9.1 We have had a challenging year which has included a necessary reorganisation of services in Solihull to provide added resilience to service delivery through a greater integration with the Coventry CRC team. This includes greater access to interventions being delivered at that office that work to reduce reoffending, promote safeguarding practices and protect the public. We have undertaken locally, professional development work with practitioners around best practice in safeguarding and domestic abuse cases as part of our organisational improvement plan.

6.9.2 We have also introduced a quality assurance process into our work that provides a level of audit of our casework including aspects around safeguarding practice.

This is starting to identify areas for improvement that we are building into our local planning.

6.9.3 We continue to encourage practitioner engagement in local safeguarding training and have also undertaken work to develop a trauma informed approach to our probation practice. With the upcoming probation reforms coming into effect over the next two years, there will be further challenges ahead however we remain committed going forward, to meeting the safeguarding expectations that our partners have of us and we have of ourselves.

6.10 Solihull Local Authority Childrens Social Work Services

6.10.1 Despite changes taking place in the senior management group this year, there has been a continuous focus around improving practice in all areas of the service. Managers continue to be visible and are actively involved in providing support, challenge and oversight of social work practice. Successes are routinely acknowledged, celebrated and shared within the service. The conversations arising evidence a practice culture focussed on supporting professional challenge, development and drive for excellence.

6.10.2 The Children, Young People and Family senior leadership team (SLT) and Children's Services directorate leadership team (DLT) both scrutinise performance data 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 which has been commented on and reported within internal and external audits as well as from formal external scrutiny.

6.10.3 Management oversight across Children's Services evidences a clear view, understanding and application of the LSCB thresholds and decision making throughout the child's journey

6.10.4 Following a 12 months review of the Early Help offer in Solihull, the decision was made to reconsider along with our specialist services the way we support and deliver services to the children and families in Solihull. The term Early Help has been synonymous with early intervention, and early intervention is not specific to a single provision or service but based on an approach that means children, young people and their families receive the services they need at a time they need it which are delivered by many different 'specialists 'and agencies as well as community based groups and the voluntary sector. Families do far better by having services delivered that are targeted to meet their individual needs at the earliest opportunity irrespective of what that need is.

6.10.5 So with this drive to deliver a more integrated and multi-faceted early intervention offer within Solihull, we launched on the 1st April 2019 a new Family Support Service which incorporates the former Engage (Early Help) service and the Children's Assessment Team and Children in Need Team (Social services). This new service was designed to target intervention at the earliest opportunity in order to prevent escalation into Statutory services. Family Support Workers and Social Workers would be expected to work alongside each other to bring about positive changes and provide the support required to our most vulnerable children and families in a timely way.

6.10.6 A new Community Development Team was also created which is working alongside the Family Support Service to support people to find help within their own communities. They will do this by making sure there are placed to go and things to do.

6.10.7 In addition, we have introduced Family Group Conferencing to Solihull, which will provide a dedicated network meeting service to bring families together for children suffering or likely to suffer harm from within their own families. They will help co-ordinate and facilitate a family generated response to the child or young person's needs to help prevent further intervention from children's services.

6.10.8 The Exploitation and Missing team has taken over from the existing Child Sexual Exploitation team and expanded their remit to cover the wider exploitation agenda. This includes modern day slavery, criminal exploitation, human trafficking, gang related exploitation and county lines. The team offers similar support for young people 18 to 25 years where there are existing concerns regarding exploitation. The team also has a role in quality assuring responses to young people reported as missing from home or care.

6.10.9 Underpinning this drive for improved performance and practice is the consistent application of the Signs of Safety model within social care interventions. The approach provides a simple structure for child protection processes and has been further embedded in other Childrens Services processes (including referral for MASH, helping children in need of targeted or statutory intervention, supporting analysis of risk in complex strategy meetings and within interventions with looked after children). Feedback from partner agencies and from service users continues to be positive demonstrating widespread support for the use of the model.

6.10.10 The Local Authority has contributed to the learning arising from notifiable incidents though the completion of scoping documents, individual management reviews (IMRs) where required, and, involvement in the Rapid Review process arising from the new safeguarding partnership arrangements. There has been learning arising from a learning review undertaken and finalised in July 2018 – the outcomes from which have been shared and have been considered within future training (in terms of importance of sharing intelligence with police colleagues and considering the potential for extra familial abuse being a factor for individual young people. There are individual case examples of the local authority recognising and acting upon evidence of exploitation through ensuring NRM referral and also through the use of court remedies to secure and protect young people.

6.10.11 Regular audit by Managers and use of an external consultant to undertake some themed audits has provided 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

6.10.12 Practice learning meetings have continued to be embedded into our social work practice and support learning from decisions to end a child protection plan when a further plan is required within 18 months. Learning has supported the activities of the core groups for individual children reflection within the social work teams

upon how to further improve analysis of risk and progress through the application of the signs of safety model.

6.10.13 The number of unaccompanied asylum seeking children continues to rise and remains at a much higher rate than local and regional averages. The implementation of National Transfer Scheme has not brought with it a reduction of the numbers during the year within Solihull. This is reflective of a national rather than solely regional picture, with the Local Authority taking the position of providing support for those children and young people wishing to seek asylum in our area so as to safeguard and promote their welfare in the first instance. The Local Authority ensure that cases are progressed sensitively and that age assessments are conducted to inform appropriate planning where this is required.

6.10.14 The workforce strategy, including recruitment and retention has seen an increase in permanent staff across children services. There is greater stability at the front line with social worker caseloads averaging 20 or 23 children (but there are still peaks and troughs) which has in turn seen an improved response and quality in the work undertaken in addition to greater retention of social workers and improved outcomes for the children and young people we work with.

6.10.15 In addition to retaining Social Workers within Solihull, the Local Authority has continued to work in partnership with the Frontline program to provide the training and recruitment of seven social workers for the second year running. Due to the success of the first and second cohort of candidates, the Local Authority has agreed to a third year of the programme.

6.10.16 This commitment to the work force and recruitment of new staff is in response to the Local Authority wishing to be the employer of choice for social workers, which has seen a rise in the number of agency social workers seeking permanent appointment within the Local Authority. 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.

6.10.17 With regard to looked after children, the rate per 10,000 of children looked after is higher than statistical neighbours and the England average. However, individual decisions to bring children into care appear safe and proportionate which has been regularly tested both internally and through external scrutiny through Ofsted or externally commissioned audit activity as mentioned above.

6.10.18 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.

6.10.19 Work has also been undertaken to:

- Improve social work assessments so that they are succinct, analytical, reflect an understanding of the child's history and clearly shape plans and interventions.
- Improve core group processes and quality, including revised templates, so that they drive practice for children on child protection plans in line with the Signs of Safety model.
- Ensure all Childrens Services staff understand and apply the new data protection legislation.
- Procure a new electronic case management provider to enable efficient and user friendly recording. (This work is being led corporately).

6.11 National Probation Service

6.11.1 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).

6.11.2 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.

6.11.3 During 2018-19 the NPS in Solihull has undertaken the following:

- completed core child safeguarding training to ensure that all NPS employed staff have received the new customised NPS core training.
- Engaged with LSCB to establish business priorities

- ensured that the office systems for child safeguarding are in place and acting to ensure staff are following the systems.
- monitored the checking and referral tracking system and supported offender managers in chasing responses and when necessary escalating the referral to a manager in Children Services.
- provided 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 supported them in clarifying what actions are required to manage the risks posed.
- reviewed 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.
- contributed to the development and engagement with multi agency arrangements including MAPPA, MARAC, Children Protection Conferences, Multi-Agency Safeguarding Hubs and Youth Offender Services.
- set up arrangements for transfers of children transitioning to young adults, to either the NPS or CRC, which include an up to date risk assessment and three-way meetings.
- liaised with CRC colleagues to set up and maintain arrangements for risk escalation

6.11.4 In the year ahead the NPS will maintain all of the above activities and will also seek to develop its policy and practice with care leavers, ensuring opportunities are taken to maximise continuing support from the Local Authority care leaver provision and to understand the specific needs of care leavers in the Criminal Justice System.

6.12 Youth Offending Services (YOS)

6.12.1 Awaiting The Youth Offending service is committed to supporting the aims of Solihull Local Safeguarding Board Partnership (LSCP).

- Like many other specialist services the young people entering the Youth Justice System lead complex and troubled lives. In order to support and achieve the aims of the LSCP the YOS offers preventative (early help) and statutory support to young people who are:
    - Children in Need
    - Looked After Children
    - Young people known to CSE services
    - At risk of offending
    - Engaged with the wider prevention agenda
    - At risk of or entrenched in wider exploitation
    - Probation – VISOR and MAPPA

- The YOS continues to operate across thresholds and works in partnership with key agencies to support vulnerable young people these include the Police, Health Services, Probation, Childrens Services and more.

- The table below reflects young people open to the YOS during 2018-2019 compared to previously recorded data. During 2018 – 2019 the YOS saw an increase in the number of young people with social and emotional problems, low level emotional wellbeing.

Specialist Childrens Services Teams	Number of young people open to YOS and specialist teams April 2016-March 2017	Percentage of overall YOS cohort April 2016 – March 2017	Number of young people open to YOS and specialist teams April 2017-March 2018	Percentage of overall YOS cohort April 2017 – March 2018	Number of young people open to YOS and specialist teams April 2018-March 2019	Percentage of overall YOS cohort April 2018 – March 2019
Child In Need	17	21%	46	30%	53	43%
Child Protection	Data not recorded*	Data not recorded*	30	20%	19	15%
Looked After Child	10	12%	23	15%	13	10%
CSE	6	7%	20	13%	15	12%
*HSB Intervention delivered by YOS * Harmful Sexualised behaviours	Service not delivered	Service not delivered	5	6%	7	5%
MAPPA					2	

6.12.2 The table above outlines the following increases or decreases to the number of young people opened to the YOS and other Children's area's services:

- Data was not recorded due to the case management assessment not providing a report in this area of work
- a 13% increase in young people that are also subject to a child in need plan
- a 5% reduction in young people that are on a child protection plan
- a 5% reduction of those that are looked after by the local authority
- a 1% decreased to young people also know to the Child Sexual Exploitation Service
- For 2019-2020 the number of young people with Education Health and Care Plans will also be provided

6.13 West Midlands Ambulance Service

6.13.1 Introduction

6.13.2 In 2018 / 2019 West Midlands Ambulance Service University NHS Foundation Trust (WMAS) has continued to ensure the safeguarding of children, young people and adults at risk is a priority in accordance with the Working Together 2018 and the Care Act 2014.

6.13.3 WMAS serves a population of 5.36 million people covering an area of more than 5,000 square miles made up of Shropshire, Herefordshire, Worcestershire, Warwickshire, Staffordshire and the Birmingham, Solihull and Black Country conurbation.

6.13.4 The West Midlands is full of contrasts and diversity. It includes the second largest urban area in the country (Birmingham, Solihull and the Black Country) where 43% of the population of the region live. However, over 80% of the area is

rural. Parts, such as the Welsh Marches in Shropshire and Herefordshire, are classed as some of the most remote in England. It contains areas of high deprivation, particularly in Birmingham, the Black Country, Coventry and Stoke-on-Trent, but also very prosperous areas like Solihull, South Warwickshire and the Vale of Evesham. With around 200,000 Asian and 60,000 black residents, we are the second most ethnically diverse region in the country after London. As a service, we respond to between 3500 - 4000 999 calls every day and around 2000 Patient Transport movements a day.

6.13.5 This report seeks to provide evidence of WMAS' commitment to effective safeguarding measures. The report details the structure and the assurance measures within the Trust to ensure compliance with Care Quality Commission (CQC) Standards and key legislation.

6.13.6 **Key Facts**

Adults
During 2018/19 23,105 adult safeguarding referrals/welfare concerns were completed by WMAS staff. This is a 9.3% increase from 21,130 in 2017/2018.

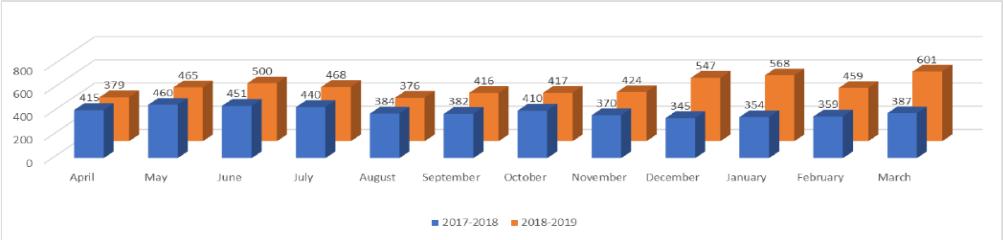
Children
During 2018/19 5,609 child safeguarding concerns were completed by WMAS staff. This is a 17.9% increase from 4,756 in 2017/2018.

Prevent
During 2018/19 32 Prevent referrals were completed by WMAS staff – there were 23 completed last year, a 30.1% increase.

Highest number of incidents 2018/19
On the 1 January 2019 the Trust attended the highest number of emergency incidents, 3,353, resulting in 2,002 transports.

Child Safeguarding Referral Activity
2017/18 and 2018/19 Comparison
Child safeguarding referrals comparative to 2017/18 and 2018/19

6.13.7 **2017/18 and 2018/19 Comparison**



Child safeguarding referrals comparative to 2017/18 and 2018/19

	April	May	June	July	August	September	October	November	December	January	February	March	YTD
2017-2018	415	460	451	440	384	382	410	370	345	354	359	387	4756
2018-2019	379	465	500	468	376	416	417	424	547	568	459	601	5620

6.13.8 Child Safeguarding Case Studies

999 emergency call to a building site early evening. Child is homeless, told crew he left school a long time ago. He states he has taken a large amount of cocaine as well as an unknown tablet. He has been sleeping in a building that is under construction. Police have escorted patient to hospital and placed him under child protection. Care home had put out a missing children's report. Police also involved.

999 call to a street in Coventry during the afternoon. Call Assessor reports intoxicated male, approx. 50-60yrs. Intoxicated people in the street whilst in charge of 2 preschool children. Believed to be his Grandchildren. Guardians today were Grandad and Children's Dad. Children's Dad went to Bookmakers for 2hrs leaving children with his Father in law. Father in law was extremely intoxicated. Children left with Grandad regularly for child care. Average height and weight for age, pale complexion, brown hair. Referral made, and child taken to a place of safety. Police informed.

Child alleged sexual abuse from a family member. Call was for an unrelated issue. The child was taken out of the environment into hospital (would not normally have been transported for the presenting complaint). The crew handed the patient over to staff at the hospital. Did not discuss the allegation with the parents as the child was scared and the situation potentially volatile. A referral was made to the Local Authority and police updated who met the crew at the hospital. The child was protected.

6.13.9 Priorities for 2019/2020

- Embed level 3 Safeguarding training for adults and children throughout the organisation in accordance with the intercollegiate documents.
- Continue to invest in engagement with adult, children boards, CDOP's and other partner agencies, building on existing relationships.
- Ensure focus remains on quality assurance, including further audits on staff knowledge and quality of referrals.
- Continue collaboration with NHS England to deliver Prevent strategy, ensuring Level 3 WRAP training for frontline staff, targeted training for specific staff groups such as mental health triage car and engagement with local universities delivering Student Paramedic Programme.
- Continue to embed lessons learnt from SCR's, DHR's, SAR's and CDOP's and share with wider organisation through the internal Learning Review Group (LRG) and key staff communications.

6.13.10 Key Achievements

- Pilot of CP-IS in both the Emergency Operations Centre and for frontline staff.
- Relocation of the Single Point of Contact into the Emergency Operations Centre providing resilience and consistency.
- West Midlands Ambulance Service have consistently achieved Level 1 in our Prevent responsibilities evidenced in reporting via NHS England.

7. LSCB Budget and Spending 2018/19

The budget for the LSCP is set annually based on contributions from partner agencies. This funds the Board's Business Support Unit, key functions and training. It was previously agreed that agency contributions in 2018/19 would be set at 2017/18 levels, with further discussion on future funding would be provided for the new safeguarding arrangements.

The final outturn for 2018/19 and the base budget for 2019/20 are set out below. For 2018/19, the Board's operating budget underspent by £29,426 which has been carried forward into 2019/20. This primarily reflects an underspend on staffing costs.

	Outturn 18/19	Prov Budget 19/20	
	£	£	
Pay and Overheads	153,730	209,390	
Training	0	2,000	
Car allowances	1,407	1,500	
Telephones	535	500	
IT Equipment and Related	9,630	9,700	
General Office Expenses	3,122	3,000	
Professional fees - CSPR/Other	16,215	4,000	
Other fees - CDOP	13,000	13,000	
Other fees - Independent Chair	20,778	18,000	
Grants and Subscriptions	939	900	
Internal Room Hire	3,610	3,000	
Internal ICT	2,166	2,000	
Income			
Schools Forum	-13,540	-13,540	5.1
Childrens Services	-118,640	-118,640	44.4
CCG	-60,300	-60,300	22.6
Police	-12,650	-12,650	4.7
HEFT	-12,400	-12,400	4.6
SCH	-10,000	-10,000	3.7
National Probation Service	-480	-480	0.2
CAFCAS	-550	-550	0.2
External/Other income	-25,998	-9,000	3.4
Carry forward	29,426	-29,430	11.0
Net Budget	0	0	100.0

		19/20 Proposed	
Role	FTE	£	Comments
Business Manager	1.00	23,900	Interim*
		34,350	Mid H**
Training Manager	1.00	56,900	Top F
QA/Support Officer	0.50	22,900	covered by Graduate Intern role
Admin	1.00	39,100	Top D
Admin	1.00	29,240	Top C
Other staff costs		3,000	
	4.50	209,390	

* interim arrangements until Sept 19
** then p/t manager post say Band H at mid poi

Gross Expenditure	225,132	266,990
Gross Income	-225,132	-266,990
Net Shortfall /-Surplus	0	0

Income Summary	Revised 2018/19 £	Prov 2018/19 £
Council	-132,180	-132,180
CCG/HEFT	-72,700	-72,700
Police	-12,650	-12,650
Probation	-480	-480
LSCB Reserve	29,426	-29,430
Other - incl. SCH, CAFCAS	-36,548	-19,550
	-225,132	-266,990

8. LSCB Attendance at Board Meetings 2018/19

Attendance at LSCB meetings 2018/19[2] (1st April 2018 – 31st March 2019)	Agency attendance
Birmingham & Solihull Mental Health NHS Foundation Trust	50%
CAFCASS	0%
Clinical Commissioning Group	100%
Community Rehabilitation Company	25%
Coventry & Warwickshire Partnership Trust	25%
National Probation Service	75%
NHS England	0%
School Representatives	25%
Solihull Metropolitan Borough Council	100%
Solihull Community Housing	75%
South Warwickshire NHS Foundation Trust (School Nursing and Visiting Services)	100%
Third Sector	75%
UK Visa and Immigration	25%
University Hospitals Birmingham (HGS)	100%
West Midlands Police	100%
The Lead member for children and young people is a participant observer and attended 100% of meetings in 2018/19.	
West Midlands Fire Service received papers and minutes of LSCB meetings.	

[2] 3 Board meetings and 1 Development Day

Appendices: Performance data

Improve outcomes for children where there are concerns about neglect				
Progress Against Objective				
	Q1 2018-19	**Q2 2018-19**	**Q3 2018-19**	**Q4 2018-19**
Case Audit	Case Audit in completed – Signed off by Executive Group, to be considered by this group (ARG).			
Children with child protection plans for 18 months	0% of children (active/open cases) at end of Q1 have been on CP plan for over 18 months.	At the end of Q2, 5% of open CP plans had duration of over 18 months.	At the end of Q3, 14/195 (7%) of open CP plans had a duration over 18 months.	At the end of Q4, 13/203 (6%) of open CP plans had a duration over 18 months.
Children with repeat plans within 2 years.	18% (46 out of 261) children becoming the subject of CP plan for a second or subsequent time during the year within 2 years of previous plan ending (rolling year data at end of quarter 1).	13% of children. (Rolling year data at end of quarter 2).	11% (27 out of 242) children. (Rolling year data at end of quarter 3).	8% (20 out of 243) children. (Rolling year data at end of quarter 4).
To promote the application of the Graded Care profile tool				
Progress Against Objective				
	Q1 2018-19	**Q2 2018-19**	**Q3 2018-19**	**Q4 2018-19**
Practitioner evaluation.	Training evaluations on the course are consistently positive with enthusiastic support for new model of training and emphasis on neglect and non-compliance. See narrative report.	Evaluations of the courses where positive. Some highlights include: 'I am successfully able to use guided tools in order to spot neglect', and 'Tina [Safeguarding Lead] brings a great deal of experience to the role; understanding Solihull policies, procedures and thresholds has been critical.'	On GCP 2: Angela [Family Support] is able to utilise this assessment process with her families; she has already began identifying families she can complete this with. 'I consider the children's voice more. I have reinforced my learning and implementation around domestic abuse when working with victims and consider the barriers to engagement more, focusing on how to overcome the barriers.'	Neglect course: 'Improved understanding of what Neglect is. Able to have better conversations with parents if needed.' 'More informed discussions with peers around levels of neglect. Better equipped to identify signs of neglect and report concerns.'
Number attending neglect and domestic abuse training	25	5	8	26
No trained on graded care profile	16	7	10	5
Improve the awareness and understanding of neglect, both within and between agencies working in Solihull				
Progress Against Objective				
	Q1 2018-19	**Q2 2018-19**	**Q3 2018-19**	**Q4 2018-19**
No of professionals attending all LSCB training	132	95	86	150

PREVENT – Year End Data- 18/19 (Cumulative)			
CSE Strategic Objective 1:			
Action	**Data Owner**	**Progress Against Objective**	
Raise awareness among children and young people about safe and healthy relationships, including online safety	Bev Petch Head of Alternative Provision	No. of primary schools (Key Stage 2) where happy and safe relationships learning is embedded in the PSHE curriculum: **100%** Note: Under the Children and Social Work Act 2017, the government committed to making relationships education (primary) and relationships and sex education (secondary) statutory in all schools, including LA maintained schools, academies, free schools and independent schools.	No. of secondary schools where healthy and safe relationships is embedded in the PHSE curriculum: **100%** Note: Under the Children and Social Work Act 2017, the government committed to making relationships education (primary) and relationships and sex education (secondary) statutory in all schools, including LA maintained schools, academies, free schools and independent schools.
CSE Strategic Objective 2: Increase community awareness about CSE			
Action	**Data Owner**	**Progress Against Objective**	
Raise awareness in business establishments	Inspector 1204 Wilson Solihull Police Partnerships	No. of businesses reached: **60** - Solihull Police are currently in the process of revisiting sites which could be at risk of CSE. Solihull Police train staff present at the location in 'See Me, Hear Me' a package. This year over sixty sites across the borough have been visited, this work is on-going and scheduled throughout the year 2019- 2020).	**No. of taxi drivers who have received CSE training:** Are undergoing a service review at the moment and this will be included as part the offer for taxi drivers and applicants. (Anne Bettison)
Under 12's Screening Tool Data Owner: MASH			
No. of under 12's screening tool carried out	Angela James	No. of these screening tools that have led to MASH referrals:	No. of schools where at least one staff member has been trained in using the tool:

PROTECT				
CSE Strategic Objective 3: Children who are sexually exploited are protected and supported				
Action	**Data Owner**	**Progress Against Objective**		
Target children at risk of CSE using regional problem profile and intelligence **(Cases Currently 'Open')**	Rebekah Jackson/Angela James	No. at risk of CSE : By age: Under 11: **1** Age 11: **1** Age 12: **4** Aged 13: **12** Aged 14: **19** Age 15: **23** Age 16:**28** Age 17: **13** Age 18: **7** Age 18+: **2**		
		Gender: Girls – **91** Boys- **19**	Ethnicity: White British- **96** Mixed- **4** Black British- **2** White Irish -**0** Pakistani- **0** Asian British – **0** Indian – **0** White Other- **1**	
Assess quality of help to these children by ensuring the risks are reduced (CMOG) **(Cases Currently 'Open')**	Rebekah Jackson/Angela James	Total Nos. **120**	Level 1: **99** Level 2: **18** Level 3: **3**	CIN: **10** CP: **9** LAC: **14**
Ensure we understand the experience of children missing from home or care by analysing return interview data. **(Q1- Q3)**	Children's social care (Karen Norton) 1st April 2018 to 31st Dec 2018 **(Q1- Q3)**	Missing from home no:**23** Episodes: **29** Missing from care no: **24** Episodes: **137** Unauthorised Absence from Care no: **18** Episodes : **30** • Home: Number and % with completed return interviews : 26/29 = **90%** (reasons for WRI not completed : not required as original notification incorrect) • Care: Number and % with completed return interviews: 126/137 = **92%** (reasons for WRI not completed : 3 x WRI not required as original notification incorrect, 8 x WRI outstanding) • Unauthorised Absence from Care : Number and % with completed return interviews: 19/30 = **63%** (reasons for WRI not completed : 11 x WRI not required as original notification incorrect) • Breakdown of completed return interviews: **Home 18 undertaken 8 refused = 26. Care 55 undertaken 71 refused = 126.** Unauthorised absence 4 undertaken 15 refused = 19		

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 **(Cumulative Q1 –Q4)**	ADS Sarah Rose (WMP)	No. of SMG meetings: **3**	No. of harbouring notices: **10** No. CSE disruption notices: **2**	No, on remand: **0**	Other civil interventions: **0**	No of NRMs: (Awaiting figure from NRM department)	No. of arrests: **5**	No. of criminal investigations/ prosecutions: **11**

www.solihulllscp.co.uk

lscp@solihull.gov.uk