Solihull Local Safeguarding Children Partnership

Annual Report 2020/21

Contents

Foreword

As delegated representatives of the three safeguarding partners – Solihull Metropolitan Borough Council, West Midlands Police, and Birmingham and Solihull Clinical Commissioning Group – who make up the Solihull Local Safeguarding Children Partnership, we commend to you our second annual report.

The Local Safeguarding Children Partnership (LSCP) is the statutory mechanism for making multi-agency arrangements to safeguard children and promote their welfare within the local area. As safeguarding partners we are required to name other relevant partners agencies that we consider appropriate to work with us in exercising these functions, and those relevant partner agencies have a duty to co-operate. In Solihull we experience good levels of strategic engagement with the safeguarding children agenda.

2020/21 has been an extraordinary and particularly challenging year for the partnership as a result of the Coronavirus pandemic. As safeguarding partners we have been required to make some difficult and pragmatic decisions as we have steered our way through exceptional circumstances. We collectively extend our thanks to all our relevant partners for the way they have adapted their delivery models in response to the pandemic to ensure that services have continued to be delivered to our most vulnerable children and their families. We acknowledge, however, that this year has been particularly difficult for some families, with tragic consequences for a small number of Solihull children, and we remain committed to seeking out learning from these cases and to drive improvements in safeguarding where this is required.

Finally, we would also like to take this opportunity to thank our Independent Scrutineer, David Peplow, for the support and challenge he has brought to the Partnership over the last four years and we welcome and look forward to working with Stephen Cullen, our newly appointed Independent Scrutineer, as we push the safeguarding children agenda forward into 2021/22.

Tim Browne
Director of Children's Services

Chief Superintendent Ian Parnell
West Midlands Police

Diane Rhoden
Interim Deputy Director of Nursing and Quality
NHS Birmingham and Solihull Clinical Commissioning Group

1. Introduction

1.1 Purpose of the report

This is the second annual report to be produced by the Solihull Local Safeguarding Children Partnership. The partnership is required under Working Together 2018 to publish at least one report in each twelve month period and this report covers the period April 2020 to March 2021.

In this report we aim to provide a transparent assessment of the effectiveness of the local safeguarding children arrangements during the reporting period. 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 the partnership.

The report begins by analysing our progress in relation to the priorities and areas for development set for 2020-2021. We show how our activities have led to improvements, or where there have been challenges, and the rationale for making decisions to retain certain priorities in 2021-2022.

We provide an analysis of our quality assurance activities, to include a review of high level performance data and our findings from audit activity, and demonstrate how this supports a continuous cycle of learning and improvement. We set out how we have responded to the statutory requirements for undertaking Rapid Reviews following serious incidents and Child Safeguarding Practice Reviews and how we have worked with Partners to ensure that learning is implemented.

The report sets out challenge to the safeguarding partners about key aspects of multi-agency practice which need to improve and concludes with an overall analysis of the effectiveness of multi-agency safeguarding activity in Solihull during the year.

2. Solihull demographics

The Solihull Metropolitan Borough Council area has 213,900 residents and is made up of the two constituencies of Meriden and Solihull, 17 council wards and 3 locality areas: north, east and west each supporting populations of 50-70,000.

The wider partnership is made up of:

- 1 local authority
- 1 NHS Clinical Commissioning Group
- 3 NHS Foundation Trusts (and we also commission services from Coventry and Warwickshire NHS Partnership Trust)
- West Midlands Police/Solihull Neighbourhood Policing Unit
- Solihull Community Housing
- Probation Service
- UK Visa and Immigration

- West Midlands Fire Service
- Children and Families Court Advisory and Support Service (CAFCASS)
- 5 schools collaboratives involving 76 primary, secondary and special schools
- 6 Primary Care Networks made up of 24 GP practices
- Third Sector organisations

Solihull is a broadly affluent borough in both the regional and national context, characterised by above-average levels of income and home ownership, but is also challenged by a prosperity gap, with the wards of Chelmsley Wood, Kingshurst & Fordbridge and Smiths Wood to the north of Birmingham International Airport significantly lagging the rest of the borough. Alongside below average income levels, these areas represent relatively higher population density, less green space per head and a substantially greater proportion of socially rented housing (62% of the borough total). The cumulative impact is felt across a broad range of outcomes, including educational attainment, employment, crime and health.

Solihull is in the midst of dynamic and rapid socio-demographic change. The Black and Asian Minority Ethnic (BAME) population has more than doubled since the 2001 Census and now represents nearly 11% of the total population. On this basis 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 17% of those aged 15 and under) this representation is set to increase.

3. LSCP Governance and Resourcing

The Multi-Agency Safeguarding Arrangements for Solihull have been in operation since 2019 and are located at: https://www.safeguardingsolihull.org.uk/lscp/wp-content/uploads/sites/3/2022/01/1.-Solihull-New-Arrangements-updated-Feb-21.pdf

The governance structure is located at: https://www.safeguardingsolihull.org.uk/lscp/wp-content/uploads/sites/3/2022/02/Solihull-LSCP-Governance-2.pdf

The LSCP budget for 2020/21 can be found at Appendix 1. During the year the budget was underspent due to a staffing vacancy in the LSCP Business Unit and significantly reduced operating costs associated with the pandemic.

A number of contributory partner agencies have started to withdraw from the previous funding arrangement which, combined with a significant reduction in income normally generated from the delivery of multi-agency training (suspended due to Coronavirus restrictions), LSCP income during this reporting period was down by approximately £6,500. Safeguarding partners note that reserves will need to be utilised to fulfil spending commitments during 2021/22 and that a review of the funding formula is required by 2022/23.

4. LSCP Effectiveness: an account of progress made against the priorities set for 2020/2021

The LSCP agrees priorities for development work during the year where it is evident that improvements are required in respect of the multi-agency response to children, young people and families. The agreed priority areas for this reporting period were:

- To support the improvement outcomes for children who experience Neglect in Solihull
- To support the implementation of Solihull's All Age Exploitation Strategy

4.1 LSCP Priority: Neglect

"How we respond to and protect children from the harmful effects of neglect is one of the most pressing and challenging aspects of safeguarding work in this country. Neglect is consistently the most common initial category of abuse for children on a child protection plan, accounting for nearly half of all plans".

(Complexity and challenge: a triennial analysis of SCRs 2014-2017, DfE, 2020)

Neglect is defined as:

'The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:
a. provide adequate food, clothing and shelter (including exclusion from home or abandonment)
b. protect a child from physical and emotional harm or danger
c. ensure adequate supervision (including the use of inadequate caregivers)
d. ensure access to appropriate medical care or treatment
It may also include neglect of, or unresponsiveness to, a child's basic emotional needs'.

(Working Together to Safeguard Children A guide to inter-agency working to safeguard and promote the welfare of children, DfE 2018)

4.1.1 What the data tells us

Last year it was reported that nearly half of all child protection plans in Solihull were due to concerns about neglect. At the end of this reporting period, however, the percentage of child protection plans due to neglect had reduced to 29% (43/149) which represents a significant reduction compared to 49% in 2019/20. It is evident that during the year there has been a significant swing towards emotional abuse – often associated with domestic abuse concerns – most likely linked to the increase in referrals received about children's exposure to domestic abuse during periods when Covid-19 restrictions were in place.

Traditionally neglect concerns have been the most significant issue in terms of risk to children and young people, both locally and nationally, and so this will continue to be actively monitored going into 2021/22 to establish whether the trend towards emotional abuse continues, or whether there is a swing back towards neglect as the primary category of concern.

Three quarters of all child protection plans active at snapshot for 12 months or longer are under the category of neglect (15/20).

This indicates that of the four categories of abuse – physical abuse, sexual abuse, emotional abuse and neglect – it is plans due to neglect which are significantly more likely to be in place for over one year. In cases of serious neglect it is important that targeted interventions result in timely changes for children and young people to avoid drift and delay. tween professional over-optimism (which can lead to plans ending too soon) and targeted interventions which bring about timely changes for children and avoiding drift and delay.

During this reporting period no children in Solihull were made subject of a child protection plan due to neglect for a second or subsequent time within 24 months of an earlier neglect plan being active which suggests that interventions are effective.

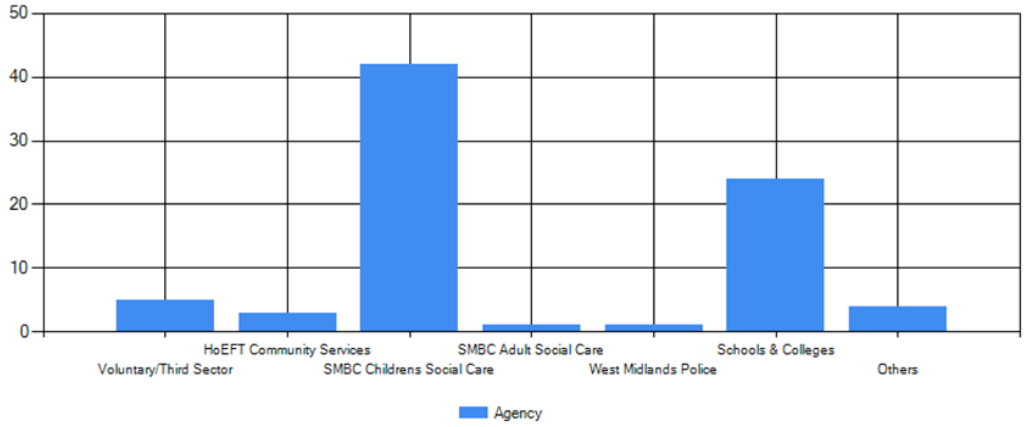
The percentage of child protection plans for neglect which last for 18 months remains low and has been relatively stable over the last year. The number of repeat plans has remained relatively small following a significant reduction from 13% since 2018/19. These indicators provide some assurance about the timeliness of decision making and the effectiveness of interventions.

	Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21
CP Plans for neglect which last for 18 months	7%	9%	5%	6%	7%	6%	5%	6%
Repeat CP plans for neglect within 2 years	6%	4%	3%	3%	5%	4%	4%	4%

4.1.2 Graded Care Profile 2

The Graded Care Profile 2 (GCP2) is a tool designed to provide an objective measure of the care of children. It is primarily based on the qualitative measure of the commitment shown by parents or carers in meeting their children's nine developmental needs. Solihull took the decision to endorse the GCP2 tool as the approach to be taken in direct work with families and the tool is referenced in the LSCP neglect procedures and also on the LSCP website: https://solihulllscp.co.uk/practitioner-volunteers/neglect-strategy-20/graded-care-profile-2-97.php

The LSCP delivers a series of neglect modules within its multi-agency training programme, one of which addresses the use of GCP2 specifically. To date over 200 practitioners have been trained in the use of GCP2 and the graph below illustrates the breakdown of those trained by agency:



A deep dive looking at a small sample of neglect cases was completed during the year which identified missed opportunities for practitioners to use the Graded Care Profile tool, or indeed other tools, to aid in the assessment of the child.

The LSCP promotes training on GCP2 through its newsletters and on its website. During this reporting period face to face multi-agency training was suspended due to Coronavirus restrictions. Demand for GCP2 training going forward will be monitored once face to face training resumes along with any barriers to partner agencies taking up training places.

4.1.3 Neglect: what we need to improve

During the year a task and finish group completed a review of the LSCP Neglect Strategy and partner agencies developed an analysis of the strengths, weaknesses, opportunities and threats (SWOT) in Solihull taking into consideration the findings of the deep dive looking at a small sample of neglect cases:

Strengths	Weaknesses
• Some partners include awareness of neglect in their single agency safeguarding training and in briefings for staff • During the Coronavirus pandemic families have continued to be seen (face to face and on virtual platforms) in a range of community settings and within their own homes • Solihull LSCP endorses the Graded Care Profile 2 (GCP2) and delivers NSPCC certified multi-agency training for all professionals in the use of the tool • Solihull LSCP has published a multi-agency Early Help Assessment tool, guidance & procedures which supports the early identification of neglect • Solihull LSCP delivers a range of multi-agency training modules which explore different aspects of neglect supported by practitioners from a number of specialist agencies	• Recognition of the cumulative impact of neglect is sometimes missed in frontline practice • There is an over-reliance on referrals to Children's Services at the higher end of threshold before co-ordinated interventions take place • Specialist assessment tools like the GCP2 are not yet fully embedded in practice and some agencies have not engaged in the training • Commissioning arrangements do not currently support embedding of specific tools (GCP2/ Early Help Assessment) into practice • There is an over-reliance on working with mothers and an absence of evidence in case audits of engaging with significant males • There is not yet evidence of a consistent approach to reflective supervision across the partnership • Neglect is sometimes obscured by domestic violence • Neglect continues to be associated with younger children • There is still an absence of professional challenge in respect of decisions taken in the Multi-Agency Safeguarding Hub (MASH) • There is evidence in some cases of the 'revolving door' principle where children are re-referred into MASH with the same presenting concerns
Opportunities	**Threats**
• To develop strategic engagement with other partnership boards • To link with other strategic developments - the First 1001 Days Strategy, Domestic Abuse Strategy, Strengthening Families approach • To work with partners to embed existing tools (GCP2, Early Help Assessment) into single agency practice • To develop models for supervision and reflective practice • To raise awareness of adolescent brain development & intersectionality to support practitioners in identifying neglect of adolescents	• The full impact of Covid-19 is not yet fully understood. Children and their families have been less visible to professionals and Child Protection Plans for neglect are significantly down on previous years • Whilst practitioners have worked hard to maintain contact with children and families during the pandemic, a reduction in direct work with children makes it more difficult to understand what a day in their life has looked like

At the time of writing, the multi-agency review of the LSCP Neglect Strategy has been completed and consulted upon, and a new Strategy has been developed.

Evidence of impact: The new Neglect Strategy will be implemented in 2021/22 and the safeguarding partners will be focussing on the evaluation of its impact going forward.

The new strategy is designed to:

- Implement a more strategic approach to embedding neglect as a priority across the partnership by securing engagement from strategic leads and taking a top-down approach
- Secure a high level commitment from commissioners and partner agencies to embedding the GCP2 into frontline practice
- Raise awareness of and promote the Neglect Toolkit
- Identify neglect champions within each partner agency and utilise this network to promote best practice
- Develop a neglect scorecard to evaluate the impact of Strategy

4.2 LSCP Priority: All-Age Exploitation

The Solihull Safeguarding Adults Board (SSAB) commissioned a Safeguarding Adult Review (SAR) in 2019 into the death of a young person who was a victim of sexual exploitation and trafficking. It recommended the establishment of a joint strategic group to take forward the wider exploitation agenda and to ensure that there was a focus on transition arrangements for young adults. The Exploitation Reduction Board sits within the Solihull Together structure and is ultimately accountable to the Health and Wellbeing Board, but also reports to the SSAB, LSCP and Safer Solihull. It is supported by the Exploitation Reduction Delivery Group which has responsibility for delivering the priorities set by the Exploitation Reduction Board.

For most of the reporting period there was a gap in terms of a co-ordinated multi-agency performance dataset for exploitation. Single agencies were developing their own datasets but were not yet reporting this data into the Exploitation Reduction Board. In January 2021 the Vulnerability Tracker (VT) was implemented to capture data about all individuals being exploited in Solihull. Going forward the VT will inform our understanding of the exploitation profile in Solihull.

4.2.1 Profile of child exploitation in Solihull

The following headlines were reported to the partnership from data made available by Children's Services:

- At the end of Q4 (2020/21) 35 children and young people had been identified as being exploited which represented a 20% reduction compared to the same period in the previous year. This reduction was reported to reflect the fact that 10 children and young people had moved from risk level 2 to risk level 1 (where risk is low enough not to require further Multi-Agency Child Exploitation (MACE) meetings) during the Q4 period. This compared to 12 children and young people moving from risk level 2 to risk level 1 in Q3.

- There were twice as many children and young people being criminally exploited (22/35, 63%) as those who are sexually exploited (13/35, 37%).

- Of the 35 children and young people in the Q4 cohort, all were aged 12 and above. The average age was 15 years (female) and 16 years (male). 8/35 (22 %) of young people were aged between 17 and 18 years and are being supported through the transition into adult social care.

- The data suggests that male victims are being drawn into criminal exploitation while female victims are more often being sexually exploited which is consistent with the regional picture. We do, however, need to be confident that this is not a reflection of professional bias or the barriers which make it difficult for young men to disclose sexual abuse.

- West Midlands Police confirmed that the Modern Slavery and Human Trafficking threat in the West Midlands Police area had remained constant in January and February 2021. Analysis of Police data showed that children who were being criminally exploited were mostly male. Those in county lines exploitation were almost exclusively British male children, while British females are most likely to be victims of sexual exploitation. The West Midlands Police area remains the second largest exporter of county lines activity in the UK.

- The majority of those being exploited (20/35) come from a white (British, Irish or other) backgrounds and 12/35 identify themselves as Black, Asian, or other minority ethnic group. (The background of 3 young people had not been fully described at the end of Q4 and work was underway to try to clarify this information.) These statistics represented some disproportionality when compared to the demographics in Solihull.

- Approximately one quarter (23%) of the cohort of children and young people were Looked After Children (LAC). 5/8 were placed outside of Solihull with the other 3 placed in Solihull.

- A high proportion of the children being exploited have additional needs and vulnerabilities with 28% (10/35) having an Education, Health and Care Plan (EHCP). This percentage is very high compared with the demographics in Solihull and leads to questions about the most effective approaches to delivering services or prevention resources.

- The data shows that there is currently a high proportion (22/35, 63%) of young people in MAACE who have been excluded from school (including historic exclusions). A national review of criminal exploitation cases undertaken by the National Child Safeguarding Practice Review Panel demonstrated a link between periods of time outside of education and increased risk.

- There is a correlation between children reported missing and those being exploited and in March 2021 there was a significant increase in missing episodes (42) involving 27 children. This increase was in line with the wider West Midlands region and was likely a result of the COVID-19 lockdown restrictions being lifted on 18 March 2021.

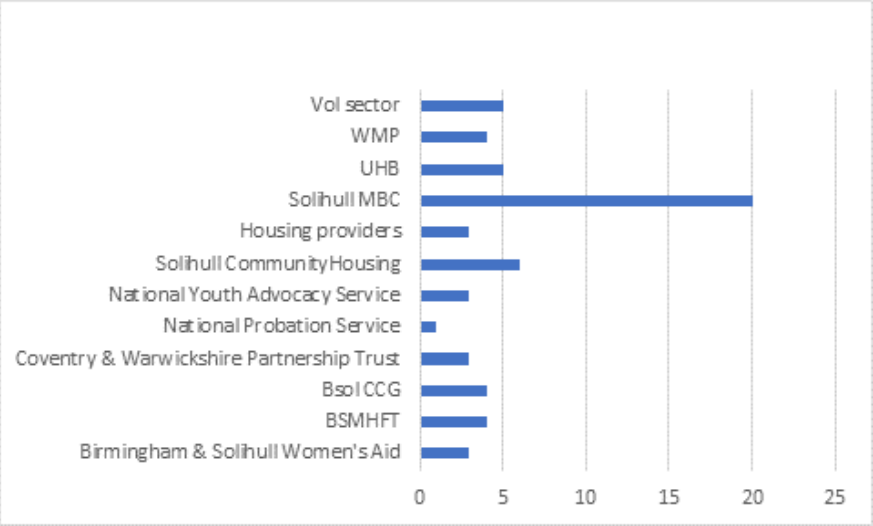
Some specific themes are emerging which will support a more targeted response locally. Emerging areas of concern relate to children who have; additional needs, been excluded from school, a history of going missing or a combination of these factors, as well as disproportionality in respect of ethnic background.

4.2.2 Strategic achievements during 2020/21

- Following sign off in September 2020 by the Exploitation Reduction Board, the All Age Exploitation Reduction Strategy was endorsed across the Partnership Boards. The delivery plan continues to be delivered through ERDG and is monitored on a monthly basis.

- In December 2020 the All Age Exploitation Reduction Strategy, Delivery Plan, along with the Exploitation Screening Tools and the Solihull Exploitation Capability Framework (2020), were circulated to the strategic leads within partner organisations to secure strategic engagement across the partnerships. Partners were asked to identify Exploitation Single Points of Contact for future targeted communications.

- The Solihull All-Age Exploitation Reduction Inter-Agency Safeguarding Procedures and Toolkit were launched in March 2021 to coincide with National Child Exploitation Day on 18 March. The procedures are located at: https://www.safeguardingsolihull.org.uk/lscp/multi-agency-procedures-and-practice-guidance/exploitation/. The launch event was held attended by 61 practitioners and managers who work with adults and children in Solihull. The breakdown of attendance by agency is shown below:



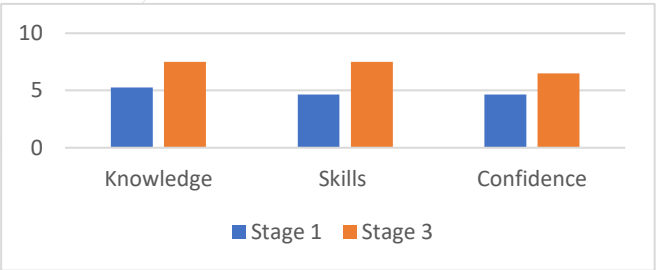
- The Exploitation Reduction Self-Assessment Tool was circulated to partner agencies to support organisations to understand what action they need to take to support implementation of the Strategy. The self-assessment tool will be used to benchmark where organisations are at on their exploitation journey at the point of launching the Strategy in order to measure impact going forward.

- The Vulnerability Tracker was launched on 26 January 2021 and captures data on individuals who are currently known to be at risk of criminal or sexual exploitation within Solihull. This data will inform the local needs analysis and will assist organisations in understanding demographics, locations and will inform resource provision and disruption tactics.

- Recruitment of an Adult Exploitation Social Worker to work alongside the Children's Missing and Exploitation Team to support young adults at risk of exploitation and ensure a smooth transition from children's to adult services.

4.2.3 Multi-agency Training on Exploitation

The LSCP ordinarily delivers two training courses on exploitation; 'Child Exploitation Awareness' and 'Exploitation: skills for those working with those being groomed or exploited'. The Child Exploitation Awareness course was adapted and delivered on virtual platforms during the reporting period, although attendance levels were lower than normal as partners struggled to release staff from operational duties due to pressures associated with Coronavirus. Post course evaluations indicated an increase in knowledge, skills and confidence as a result of the training.



In addition, two further virtual courses were delivered: 'Parents as partners in tackling child exploitation: working with and supporting parents affected by Criminal Exploitation' and 'An Introduction to Contextual Safeguarding'.

Case Study: A demonstration of working with parents as partners and recognising the influence of contexts outside of the family home:

In June 2020, a referral was received from a neighbouring authority in respect of concerns for a young person in a relationship with someone subject to a child protection plan in their area with concerns about links to possible exploitation. This young person was also open to the Youth Offending Team in their area.

The young person resident in Solihull had been stopped and searched by police on three occasions. On the first occasion, they were found in possession of cannabis and a police baton. On the second occasion, they were found to be in possession of more cannabis and on the third stop and search they were found in possession of a knife and cannabis. Each time this happened the young person was with the other from the neighbouring area, and this raised significant concerns about them also being introduced to exploitation.

Solihull professionals worked directly with the young person's parent to help them explore exploitation and recognise the signs, understand grooming, and how the internet/ social media/ gaming etc. can assist and enable exploitation. The parent demonstrated an increased knowledge about what to look out for and reported intelligence to professionals while understanding the need to care and support their child, despite some of the behaviours being demonstrated.

This became extremely important when the young person dropped out of college, however with support and encouragement they found a job initially offering a few shifts, that they were gradually able to increase over time, and this was a really positive experience for the young person.

The partner was arrested and charged with a crime that meant that they could not leave their house due to an imposed curfew. This meant that neither was socialising in the community they had been, and although there were initial concerns things would start again once the curfew ended, this enforced break appears to have given them the space to make a break from the harm occurring in those contexts.

Communication and multi-agency work was very strong within and across local authority boundaries with a variety of professionals. This has been essential in being able to effectively assess and manage the risk for the young people.

4.2.4 Exploitation: what we need to improve

A deep dive looking at a small sample of exploitation cases was completed as part of the multi-agency audit undertaken during this reporting period. The findings from the deep dive (acknowledging the small sample size) and the discussion held with auditors indicated:

- That the complexity of exploitation cases can promote high levels of professional anxiety about management of the risks to the child or young person.

- Sometimes partner agencies were not involved early enough; often by the time the young person was known to services they were too entrenched in the exploitation for interventions to have the desired impact raising questions about what early help looks like in exploitation cases

- Some evidence of cases being stepped down too soon or cases being closed too quickly, with an over-reliance on 'no news is good news' leading to professional over-optimism and resulting in children being re-referred

- Missed opportunities or delays in making a referral to the National Referral Mechanism (NRM)

- Not all relevant agencies were included in Multi-Agency Child Exploitation (MACE) meetings and more could be done to engage young people in the MACE process

- Lack of clarity about the circumstances in which a practitioner should complete a FIB form

- Contingency planning is not always evidenced in plans

A number of the issues identified above were already agreed work streams for the Exploitation Reduction Delivery Group, for example a review of MACE meetings and raising awareness of the NRM referral process, and a request was made for a review of the FIB process to be added to its work plan. It was acknowledged that the All-Age Exploitation Reduction Inter-Agency Safeguarding Procedures launched in March 2021 should, once embedded into practice, have a positive impact on the response to children at risk exploitation.

Evidence of impact: Children, young people and adults are now beginning to be identified as being at risk of exploitation in Solihull. Practitioners have been provided with the tools to enable them to screen for and respond to concerns about exploitation in a co-ordinated way.

Quarterly briefings from the Exploitation Reduction Board were received by the LSCP Assurance and Review Group and in January 2021 it noted the significant progress now being made to implement the Strategy and that our understanding of the profile of victims in Solihull is starting to develop.

The LSCP has both an assurance role in terms of the multi-agency response to children at risk of exploitation and an important role to play in supporting the implementation of the All-Age Exploitation Reduction Strategy across the partnership. The LSCP Business Manager sits on the Exploitation Reduction Delivery Group and has actively supported the delivery of a number of work streams within the work plan. The safeguarding partners remain committed to supporting the implementation of the Strategy in Solihull and have agreed to retain exploitation as a strategic priority for 2021/22.

5. Quality Assurance

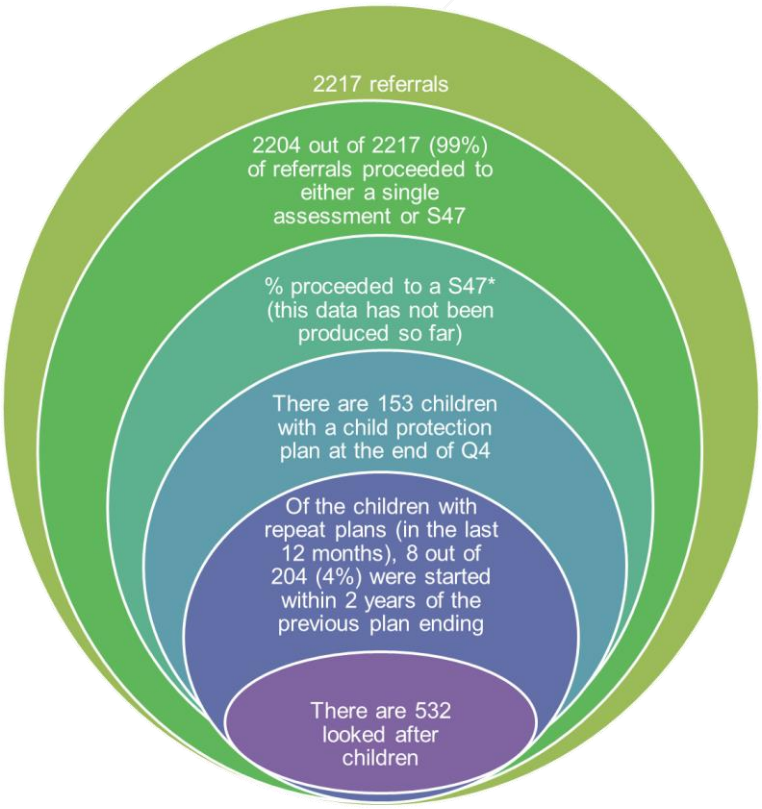
The evaluation of the safeguarding children response across the partnership is made up the following elements:

- Data
- Multi-agency audits
- Inspection findings
- Assurance reporting by partner agencies
- Service User feedback
- Evaluation of multi-agency training

5.1 Data

The LSCP has monitored a number of high level indictors during the reporting period which have related to initial response to referrals and the child protection system. This reporting period saw some unprecedented and unusual emerging patterns which clearly reflected the impact of the COVID-19 pandemic on risk and need.

The child's journey through the system in 2020/21



Key performance indicator	National average	Figures for 17/18 (end of quarter 4)	Figures for 18/19 (end of quarter 4)	Figures for 19/20 (end of quarter 4)	Figures for 20/21 (end of quarter 4)	Increase/decrease from previous year	Commentary
Referral Rates (per 10,000 children)	552.5	661	711	652	484	⬇	There was a significant decrease in the number of referrals in comparison to the previous year, with this year's referral rate dipping below the national average for the first time. This is thought to have been due to: • Partner agencies stepping down services • Children being less visible to other agencies during pandemic and during lockdown periods in particular • Children not attending school thus limited opportunities for them to speak to trusted adults about life at home
Repeat Referral Rates	22%	22%	21%	33%	21%	⬇	In 2019/20 the re-referral rate of 33% was significantly higher than the national average and for previous years. This was thought to reflect double counting of referrals as a result of the change-over during the year from the Carefirst system to Liquid Logic. The 20/21 percentage is within the target tolerance of 10% to 21%, is in line with previous years and is now slightly below the 2019/20 national average.
Proportion of referrals proceeding to Section 47 enquiry or single assessment	No data	75%	61%	56%	99%	⬆	The conversion rate for referrals to S47/SW Assessments has significantly increased for this year. An increase in risk has had an impact resulting in a high volume of Strategy meetings and S47 enquiries. The factors which have impacted on conversion rates are thought to be: • Whilst the referral rate is down due to the impact of the COVID-19 restrictions those referrals coming in have reflected higher levels of risk linked to domestic abuse and physical harm • The reduction in early help interventions as a result of the COVID-19 restrictions has led to cases escalating to higher levels of intervention and fewer requests for early help at level 3

Percentage of children on a Child Protection Plan by category							There has been a significant increase in CP Plans for Emotional Abuse taking this percentage for Solihull higher than the national average. CP Plans for Neglect have decreased significantly compared to previous years and is no longer the largest category. A dip sample audit of cases identified that Emotional Abuse had been selected in recognition of the emotional impact of domestic abuse which reflects the increase in domestic abuse which occurred as a result of the COVID-19 restrictions. It is important for this to be monitored closely to see if this represents a trend going forward or whether there is a swing back towards Neglect as the most prevalent category of abuse.
Neglect	47%	47%	49%	51%	29%	↓	
Emotional	37%	20%	28%	29%	56%	↑	
Physical	7%	19%	11%	12%	13%	↑	
Multiple categories of concern	5%	8%	10%	6%	1%	↓	
Sexual Abuse	4%	6%	1%	2%	1%	↓	
The proportion of children with Child Protection Plans for 18 months	No data	0%	6%	6%	6%	=	This indicator provides a marker as to the timeliness of decision making to prevent drift and delay. This remains consistent year on year and is only slightly above Solihull's established target of 5%.
The proportion of children becoming subject of a Child Protection Plan for a second or subsequent time within 2 years (rolling year)	No data	18%	8%	3%	4%	↑	The data shows a very slight increase against last year however, despite this, the percentage is still well within the established target which is a positive picture and significantly below The West Midlands target of 11%. A Case Learning Meeting process has been introduced to consider cases where there is a repeat CP plan. The aim is to support the core group of professionals to reflect on how they had worked together during the previous period of CPP so that they are best placed to work effectively during the new CPP period. There were only 8 cases where a repeat CPP was started in the reporting period. The core group of professionals for these cases had experienced change and, coupled with the complications arising due to COVID-19, no Case Learning Meetings were convened in respect of these cases.

Number of Looked After Children (LAC)	No data for national average	413	424	461	532		The number of looked after children has increased significantly in 2020/21 compared with previous years. The COVID-19 pandemic has had a significant impact in relation to numbers of looked after children. For example, during the year there were several months when the courts were not dealing with matters unless they were about securing immediate safety of children. A direct consequence is that cases have not progressed to end Orders and children have remained in the care system longer than they would otherwise have done. In addition children at increased and serious risk of harm have been accommodated by the LA.

5.2 Audits

5.2.1 Multi-agency Case Audit

The multi-agency audit process is delivered by the LSCP as part of a rolling programme of quality assurance activity. The themes of this audit are directly linked to the LSCP key priorities. This year it was agreed that the sample of cases to be audited would be reduced to reflect the pressures on partner agencies of the pandemic.

The findings in respect of general safeguarding practice (not already cited above) were:

Effective safeguarding practice	
What works well	**What needs to be addressed**
• In the main practitioners are aware of LSCP thresholds guidance and can apply thresholds appropriately when making referrals	• Feedback on referrals into the MASH is not routinely provided in a timely way and partner agencies do not actively seek out feedback if it has not been received
• In the majority of cases consent is sought appropriately	• The voice of the child is only reported as being 'met' in 50%-60% cases, albeit there was a COVID-19 impact.

• Practitioners are aware of, understand, and apply information sharing protocols including GDPR requirements	• Supervision can lack reflection and positive challenge and is not always recorded
• Supervision is generally provided on a regular basis and is in line with agency policy	• There is an absence of professional challenge particularly around decisions in the MASH
• Practitioners are aware of the LSCP Escalation Policy for resolving professional differences of opinion	• Gaps in Health representation within MASH and in multi-agency Strategy meetings impacts on the quality of decision making
• There is generally good information sharing, in particular between Education and Children's Social Care	• There are challenges in seeing children and young people and monitoring home environments when COVID-19 restrictions are in place

Evidence of impact: as a result of the audit findings the safeguarding partners commissioned the following improvement activity from its sub groups:

	Recommendation	**Who responsible**
Feedback on referrals	That the processes on the giving and receiving of feedback on the outcome of referrals into MASH are strengthened (repeat theme from Case Audit 2019/20)	**Response and Delivery Group 2021/22**
Voice of the child/lived experience	That agencies are asked to audit whether the VOC/lived experience of children (including those who are non-verbal or have additional communication needs) influences interventions and decision making within their own organisations.	**Case Audit Group 2021/22**
Reflective practice and positive challenge	Guidance to be issued to practitioners on reflective practice and positive challenge, including the appropriate use of the Dispute Resolution policy, and on different approaches to the provision of supervision/management support where cases are particularly complex and/or generating high levels of professional anxiety.	**Response and Delivery Group 2021/22**

5.2.2 NFA referral audit

Solihull's OFSTED report on their inspection in November 2019 outlined a number of issues in relation to referrals from partners and issues in delays or decision making being made by MASH:

"The quality of referrals from partner agencies is too variable, and some referrals are poor. Failure to include sufficient relevant information and detail leads to additional work for local authority staff and can add to delays in deciding on the appropriate next steps." (Page 3)

Partners had also identified during the Case Audit learning event held in November 2019 that they were not always receiving feedback as outlined in Working Together to Safeguard Children 2018:

"Feedback should be given by local authority children's social care to the referrer on the decisions taken. Where appropriate, this feedback should include the reasons why a case may not meet the statutory threshold and offer suggestions for other sources of more suitable support. Practitioners should always follow up their concerns if they are not satisfied with the local authority children's social care response and should escalate their concerns if they remain dissatisfied."

In addition, the Director of Children's Services had identified to the partnership concern about the high numbers of referrals coming into the Solihull MASH which resulted in no further action.

During 2020 an audit was completed of NFA referrals which identified that the existing referral form did not fully reflect the need for the referrer to consider information sharing and consent issues and did not encourage referrers to consider the application of thresholds when requesting support or interventions for families. It was recommended that the multi-agency referral form be reviewed to ensure that it provides the best possible information on which decisions within the MASH can be made.

Evaluation of impact: safeguarding partners agreed to a review of the referral form which was completed during 2021 when partner agencies had capacity to engage in this work. At the time of writing the review has been completed and the revised referral form has been approved by the safeguarding partners and is awaiting implementation as soon as technical specifications have been completed.

In addition, the LSCP produced a briefing on how to make a referral to Children's Services which is located at: https://www.safeguardingsolihull.org.uk/lscp/wp-content/uploads/sites/3/2021/12/Making-a-referral-CT-updated-1.pdf

5.3 Inspections

During the reporting period inspections were largely suspended due COVID-19 restrictions.

NHS England's regional team, Midlands Safeguarding, worked with partners on a virtual focus group approach which was well evaluated, strengthening its oversight and supporting development and improvement of the service of focus.

South Warwickshire Foundation Trust contributed to the multi-agency review requested by Vicky Ford, Under Secretary for Children and Families, to review Sudden Unexpected Deaths in Infancy (SUDI) in families where children are considered at risk of significant harm.

5.3.1 Children's Services Improvement Plan following Ofsted inspection 2019

The Safeguarding Partners were sighted throughout the year on the Children's Services ILACS Action Plan which set out the improvement activity being undertaken in respect of the ten areas identified by Ofsted in 2019. The Director of Children's Services provided assurance to the safeguarding partners about progress being made.

5.4 Assurance Reporting

5.4.1 Management of allegations against adults who work with children

Statutory guidance requires the Local Authority Designated Officer (LADO) dealing with allegations against adults that work with children to report annually about work undertaken and this report comes to the local safeguarding children partnership for assurance. In Solihull responsibility for the LADO function sits with the Head of Safeguards and Quality Assurance within Children's Services, supported by the Principal Officer and Independent Reviewing Officers (IROs) within the Child Protection and Review Unit.

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

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

Keeping Children Safe in Education 2020 came into force in September which included an additional element to the threshold:

- behaved in a way that indicates they may not be suitable to work with children

Total number of allegations referred to the LADO 2020/21			
Year	2018/19	2019/20	**2020/21**
Number of allegations	79	47	**49**

The majority of referrals to the LADO have come via Social Care, Education or Police however the numbers are relatively low and the majority (19/49) come from the Education sector.

Safeguarding Partners are able to provide assurance that there is appropriate awareness and understanding of the 'managing allegations' process in the borough. The data indicates evidence that agencies are contacting the LADO to talk issues through appropriately, that matters are being progressed in a timely way, and that the process is supporting learning within settings.

5.4.2 Safeguarding in Education

The Section 157/175 (Education Act 2002) audit process seeks assurance about the safeguarding compliance of education safeguarding provision in Solihull and is undertaken annually. There are 89 education providers in Solihull including local authority maintained schools, academies, independent schools and Post 16 provision with 100% compliance in completing the audit, which is extremely positive, and the evidence from the audit was again that education safeguarding provision in Solihull is at least good.

The education sub-group of the LSCP continues to have representation from across each collaborative, as well as post 16 and independent schools, and enables two-way communication between the safeguarding partners and the education sector. The representation from secondary schools in particular has strengthened this year. Membership of the group is now multi-agency following the recommendation made by the peer review in 2019.

During the reporting period the Local Authority maintained close contact with designated safeguarding leads who provided a weekly return on those pupils open to social care. This identified what contact the school had with the pupil and family, planned contact for the forthcoming week and identified any specific issues. This mechanism provided oversight of vulnerable pupils during lockdown. Emergency safeguarding guidance was issued to schools and vulnerable pupil intervention circles were established to rag-rate and monitor pupils who had been identified as being at risk.

The education supervision policy was implemented and during lockdown all schools were required to undertake supervision on Wednesday mornings in order to inform their weekly safeguarding returns. Schools reported the effectiveness of this approach which strengthened their safeguarding practice during an extremely challenging period.

Learning following two serious incidents was shared with schools where there were implications for education (ensuring the timely transfer of school records to a new education provider and the need to identify when changes in family composition remove previous protective factors) and support was provided to an independent school following a tragic pupil incident. Domestic abuse awareness was prioritised during the lockdown period: communications to schools included a link to domestic abuse awareness training, request to the police to reinstate Operation Encompass at the request of schools and regular attendance at MARAC meetings.

A virtual safeguarding awareness training course was developed which was welcomed by schools and the All-Age Exploitation Reduction Strategy was shared with all schools.

5.4.3 Private Fostering

The Children Act 2004 places a duty upon local authorities to satisfy themselves that the welfare of children who are privately fostered within their area is being satisfactorily safeguarded and

promoted to include children who are proposed to be, but not yet, privately fostered. A Private Fostering arrangement is one made without the involvement of the local authority for the care of child under the 16 (or 18 if disabled) by someone other than a parent or close relative for more than 28 days. A private foster carer may be a friend of the family, parent of the child's friend or someone previously unknown to the child who is willing to privately foster the child.

OFSTED feedback from the Children Services inspection at Solihull MBC in November 2019 stated that the awareness of private fostering remains underdeveloped in Solihull. No annual Private Fostering Report is produced, and the local authority and their partners have been too slow to develop this area of work.

During the reporting period only one private fostering referral was received which proceeded to full assessment and the end of year position was that the Local Authority was overseeing two ongoing private fostering arrangements.

It was noted by the partnership that it had been a challenging year due to COVID-19 in respect of progressing the recommendations made by OFSTED. Developments have included the building of an online training course on Private Fostering awareness with the aim that this will become mandatory training for all staff in Children's Services, and the development of a suite of information leaflets which can be accessed via the SMBC and the LSCP websites. There is a plan to deliver training to partner agencies which will be supported by the partnership and to ask partner agencies to identify private fostering champions going forward.

5.5 Service User Feedback

During the multi-agency case audit process family members whose cases were subject to the deep dive activity were provided with the opportunity to give feedback on their experiences of services. Two parents and one young person provided feedback.
Feedback was generally positive, particularly in relation to the neglect. The parent felt listened to all of the time, their concerns were dealt with and they considered that their situation improved, particularly since the involvement of the family support worker, and that their children were doing well. It was evident from the feedback that the family support worker had worked very closely with the family to ensure the parent is able to identify what they can do to help themselves and their family. Despite this, the service user considered that there can be too much emphasis on the past, and not enough focus on the ability of parents to change.

A young person who provided feedback from the exploitation cohort described a number of positives; they were very satisfied with how people dealt with their concerns and they felt that their situation had improved a lot. However, this young person noted that they were not always given information that they could understand, particularly in their review meetings. The young person stressed the importance of having a good relationship with a social worker as this is when things work best. Unfortunately, the young person was allocated a different social worker half way the intervention and they considered that things did not go as well after that. The young person did not feel listened to when they were unhappy with their foster placement and was unhappy that they could not be moved out of this placement as there was nowhere else for them to go.

A parent from the exploitation cohort provided verbal feedback stating that she had not felt listened to and felt that she had not been provided with information. The parent made a complaint and she considered that she had not been helped or provided with any additional information as a result.

Evidence of impact: feedback from the young person supported the finding from the case audit that information should be developed for young people about their meetings and that guidance should be produced for professionals about how to enable young people's active participation in meetings. The safeguarding partners tasked this to the Response and Delivery Group for inclusion in its 2021/22 work plan.

5.6 Multi-Agency Training

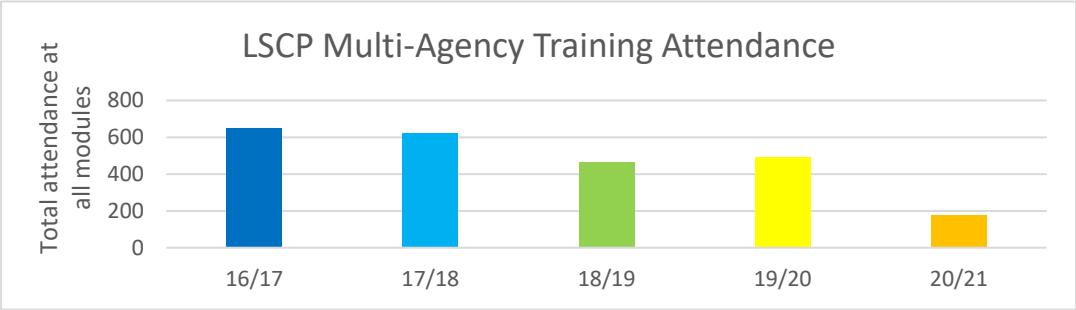
Working Together 2018 states; "*Multi-agency training will be important in supporting this collective understanding of local need. Practitioners working in both universal services and specialist services have a responsibility to identify the symptoms and triggers of abuse and neglect, to share that information and provide children with the help they need. To be effective, practitioners need to continue to develop their knowledge and skills in this area and be aware of the new and emerging threats, including online abuse, grooming, sexual exploitation and radicalisation. To enable this, the three safeguarding partners should consider what training is needed locally and how they will monitor and evaluate the effectiveness of any training they commission*." (p12-13)

The LSCP multi-agency training offer is located at: https://www.safeguardingsolihull.org.uk/lscp/lscp-training/
The range of training modules are regularly updated to reflect learning from local and national serious case reviews, child safeguarding practice reviews, domestic homicide reviews, research and case audit findings.

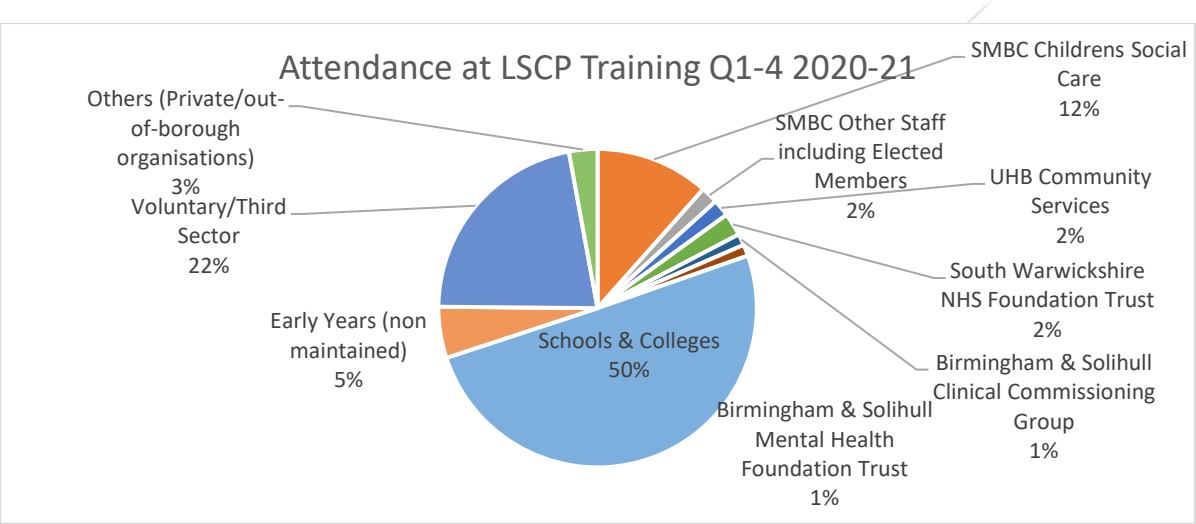
The LSCP multi-agency safeguarding workforce development strategy stipulates that as a general guide all those who regularly make child protection referrals, those who are regularly expected to attend child protection conferences and core groups, and/or those who manage or supervise practitioners who do, should receive a minimum of 3- 6 hours of multi-agency training; ideally at least 1 training module per year. This is not a fixed rule but should be intelligently used as guide to help practitioners engage in multi-agency training.

During 2020/21 Solihull LSCP was unable to deliver any face to face training courses due to the COVID-19 restrictions which were in place during the reporting period. A number of courses, where appropriate, were adapted in order for them to be delivered on virtual platforms.

Between April 2020 and March 2021, 175 practitioners and members of staff completed LSCP multi-agency training. This attendance rate is significantly lower than in previous years. Reasons for the low attendance include the inability of some partner agencies to release staff for training during an extremely challenging operating environment.



As in previous years schools and colleges made up the majority of delegates attending training. In previous years this would have been followed by Childrens Social Care however, this year has saw an increase in the number of delegates representing the Third Sector.



The LSCP Training Officer initiated the process for a training needs analysis to inform a review of the LSCP multi-agency training strategy but this was unable to be prioritised by partner agencies during the reporting period. During the reporting period some partner agencies have developed their own internal training to meet the needs of their work force during a challenging period and over time the impact of this will become apparent. It is anticipated that during 2021/22 it will be possible to evaluate the impact of the pandemic on demand and, as yet, the time scale for the resumption of multi-agency face to face training is unknown.

5.7 Summary

In October 2019 Ofsted noted that decision making within the MASH with partners is generally robust and the new arrangements which had been put in place for responding to new referrals in children's services meant that families are more likely to receive the right service at the right time, which should have led to less families requiring a statutory intervention. Arrangements for

delivering early help from the Family Support Teams in children's services had been identified as a strength in the inspection.

It has been difficult to evaluate the impact of the new arrangements during the reporting period due to the exceptional circumstances brought by the COVID-19 pandemic. Referral rates in Solihull significantly reduced, however virtually all referrals received into the MASH met the threshold for a S47 child protection investigation or a Social Work Assessment. Children were largely hidden from view during the lockdowns and they did not have access to trusted adults while they were out of school. Risks increased, especially those associated with the significant increase in domestic abuse reflected in the reasons for Child Protection Plans, and services were operating differently to align with COVID-19 restrictions which meant that some non-essential and preventative services were not available. Children continued to come into the LAC system, but some who would ordinarily have moved out of the system remained, thus increasing overall numbers of looked after children significantly.

The 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 2020/21 audit provided more assurance that practitioners generally understand thresholds and apply them appropriately. Issues of consent appear to be understood and there was evidence of good information sharing, particularly between schools and children's social care. Supervision is being provided for frontline practitioners, although there is an absence of analysis and reflection in supervision records. There is a general awareness of the LSCP Escalation Policy but an absence of evidence of positive challenge in the cases audited. Partner agencies do not routinely receive feedback on referrals made by them and the safeguarding partners noted the high volume of referrals which receive no further action. An audit of NFA referrals was undertaken by the LSCP and identified the need for the multi-agency referral form to be reviewed and updated to improve the quality of referrals coming into the MASH and to encourage the provision of feedback; this work has been commissioned from the LSCP's Response and Delivery Group and will be delivered in 2021/22 along with guidance for partner agencies on reflective supervision and positive challenge. User feedback highlighted the importance of professional continuity for young people. It also reinforced the need for information to be available for to support young people's participation in their meetings (also identified in the deep dive in respect of MACE meetings) and this has been commissioned from the LSCP's Response and Delivery Group.

The audit highlighted the issue of Health representation within the MASH to support effective information sharing and decision making. The lead safeguarding representative for Birmingham and Solihull Clinical Commissioning Group agreed to look at a means of securing resources to address any gaps and progress will be monitored during 2021/22.

Education providers in Solihull all complied with the safeguarding audits again this year and assurance has been provided that the sector is meeting requirements as set out in the revised statutory guidance. Vulnerable children were identified in accordance with Government guidelines and actively monitored during the lockdowns and the increased risk of domestic abuse was flagged. There is a high level of awareness across the partnership of the process for responding to allegations

against staff and volunteers, and good use of consultations with the LADO, and referrals have continued to be made despite the challenges associated with the COVID-19 pandemic which is reassuring.

Progress on those areas of practice identified for improvement by Ofsted in 2019 has been reported into the partnership by the Local Authority. Ofsted acknowledged that progress has continued to be made in spite of the challenges presented by the pandemic. There were difficulties in progressing the recommendations in respect of private fostering and the LSCP has agreed to support activities to raise awareness amongst partner agencies.

Some multi-agency safeguarding training modules were adapted for virtual platforms and were delivered by the LSCP during the second half of the reporting period. Attendance levels were significantly lower than in previous years and future demand will be evaluated once face to face training is able to resume. Evaluations this year have been limited but those completed continue to evidence the positive impact on knowledge and confidence levels.

6. Learning from Rapid Reviews and Local Child Safeguarding Practice Reviews (LCSPRs)

In accordance with Working Together to Safeguard Children 2018 safeguarding partners should consider undertaking a Local Child Safeguarding Practice Review (LCSPR) when it is thought that the case:

- Highlights or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified;
- Highlights or may highlight recurrent themes in the safeguarding and promotion of the welfare of children;
- Highlights or may highlight concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children;
- Is one which the Child Safeguarding Practice Review Panel has considered and concluded a local review may be more appropriate.

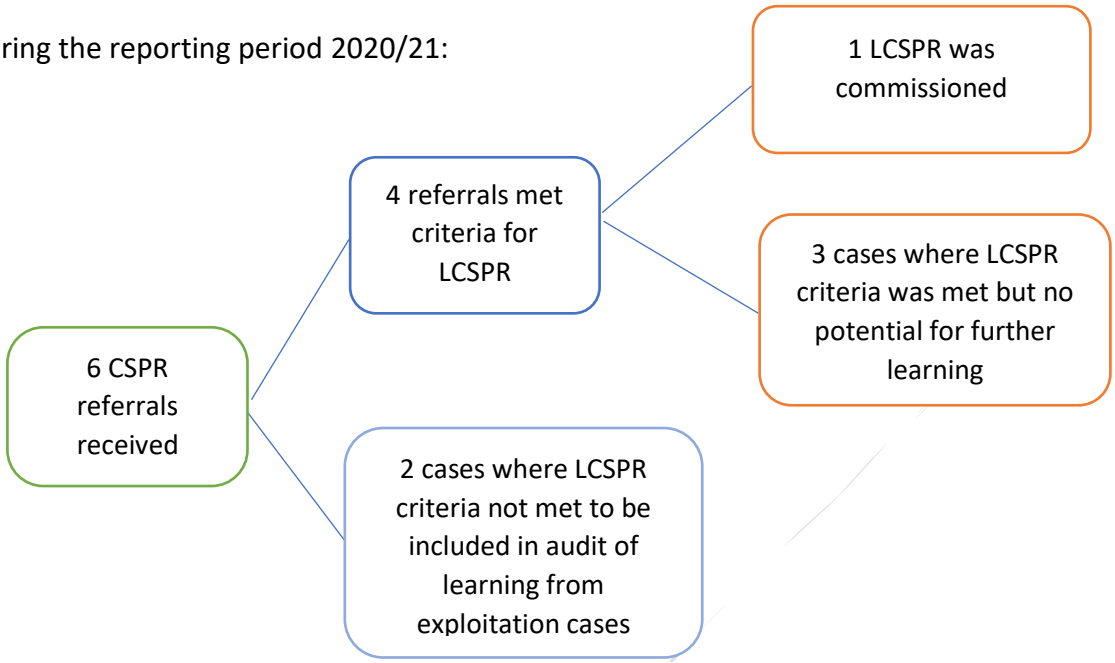
If a case meets the above criteria it is for the safeguarding partners to determine whether the commissioning of a LCSPR is the appropriate response in the circumstances.

Where a case meets criteria for a serious Incident Notification the Local Authority is required to notify Ofsted. The safeguarding partners then have 15 working days to complete a Rapid Review in order to make a decision regarding the need for any further review. Decisions are made by the Solihull CSPR sub group, chaired by the Deputy Director of Nursing and Quality for the Birmingham and Solihull Clinical Commissioning Group, and are overseen by the LSCP Independent Scrutineer

on behalf of the safeguarding partners. Decisions are then notified to and endorsed by the National Child Safeguarding Practice Review Panel.

6.1 Rapid Reviews

During the reporting period 2020/21:



Child 1

10 week old baby suffered potentially life changing injuries where abuse was suspected. Criteria was met for a Local Child Safeguarding Practice Review, however the only immediate learning identified was for Health professionals and CCG and UHB had triggered Serious Incident investigations very quickly and taken a series of actions to address individual and wider practice issues obviating the need for a LCSPR.

Child 2

A 6 year old child died as a result of a serious head injury. He was also found to have extensive bruising and unusually high sodium levels. He was not in school during lockdown restrictions and had not previously been identified as vulnerable. Police and Social Workers had had contact with him in the weeks prior to his death following concerns expressed by extended family members. A Local Child Safeguarding Practice Review was commissioned in December 2020.

Child 3

3 year old child died as a result of a serious physical assault. Child had not been attending nursery due to lockdown restrictions and had not been previously identified as vulnerable. The criteria was met for a CSPR but immediate learning was identified obviating the need for a LCSPR.

Child 4

15 year old who was the victim of a stabbing by another teenager. The criteria for a LCSPR was not met. A recommendation was made to audit local learning from previous exploitation cases to

establish whether learning had been embedded into practice and to identify any further opportunities to support effective multi-agency practice.

Child 5
15 year old who had died in a car accident. It was initially thought that his death may have been linked to concerns about exploitation although no direct link was subsequently established. The criteria for a LCSPR was not met.

Child 6
5 week old baby who died following withdrawal of life support after sustaining significant head injuries. Criteria was met for a LCSPR but immediate learning was identified obviating the need to commission a LCSPR.

Immediate learning was identified from the Rapid Reviews for individual partner agencies which were actively monitored by the Solihull CSPR Panel throughout the year.

6.2 Arthur Labinjo-Hughes

The decision of the Rapid Review was that a Local Child Safeguarding Practice Review (LCSPR) would be commissioned. An independent Lead Reviewer was contracted and Terms of Reference for the LCSPR were agreed based on the key lines of enquiry which had been identified at the Rapid Review. It was noted that this LCSPR would need to give consideration to the findings of a Domestic Homicide Review (DHR) commissioned in respect of the death of the partner of Arthur's mother which occurred while Arthur was living in her care in Birmingham, and also the findings from an investigation by the Independent Office for Police Conduct looking at contact with the family by West Midlands Police prior to Arthur's death. By June 2021 it was apparent that it would not be possible to conclude the LCSPR within the statutory 6 month time frame due to the impending criminal trial which prohibited the Lead Reviewer from speaking with family members who were to be witnesses in the criminal proceedings. At that point it was anticipated that the LCSPR would be completed and ready for publication by January 2022 (however at the time of writing the LCSPR has been suspended due to the decision by Government to commission a national review into Arthur's death).

6.3 Exploitation Learning

The learning from the two cases which did not meet the criteria for a CSPR was mapped, along with learning from previous exploitation cases and the case audit deep dive findings, against the local challenge questions set by the National Child Safeguarding Practice Review Panel in respect of criminal exploitation. This piece of work was taken through into 2021/22 for completion.

Evidence of impact: At the time of writing gaps had been identified and reported into the Exploitation Reduction Board with a decision made to add additional work streams to the work plan for the Exploitation Reduction Delivery Group.

6.4 Learning briefings for practitioners

Learning briefings in respect of two themes from Rapid Reviews were circulated to strategic leads across the partnership:

Voice of the Child: https://www.safeguardingsolihull.org.uk/lscp/wp-content/uploads/sites/3/2021/09/VOC-Briefing-FINAL-1.pdf

Professional Curiosity: https://www.safeguardingsolihull.org.uk/lscp/wp-content/uploads/sites/3/2021/10/Professional-curiosity-briefing-FINAL.pdf

Partner agencies were asked to provide assurance about how the key messages would be embedded across their respective workforce and what activity would be undertaken by the organisation to ensure that frontline practice had been informed by the learning.

Evidence of impact: Over 80% of partner agencies provided the assurance requested. Wide circulation of the briefings was achieved through electronic communications to staff and managers, staff briefings, team meetings, inclusion in organisational newsletters, publication on staff intranets, inclusion in staff supervision and reviews of single agency training content.

Examples were provided of how the key messages would be further embedded as follows:

Children's Social Work Services – incorporate learning into single agency audits
Solihull Community Housing – include in Delivery Plan Milestones for anti-social behaviour and estate management
Birmingham and Solihull Mental Health Foundation Trust – development of electronic information hub
Urban Heard (Third Sector) – update safeguarding policy
South Warwickshire Foundation Trust – undertake Safeguarding Knowledge Review

7. Understanding the Voice of the Child

The LSCP plays different roles in relation to understanding what children and young people have to say. These are summarised in the diagram below:

The LSCP seeks assurance on how well the voice of the child influences strategic service development and operational practice across the partnership; it does not directly deliver services to children and young people itself, but is concerned with how effectively partner agencies engage with children and young people to understand their lived experience to inform assessments, decision making and outcomes. In addition, the LSCP will identify opportunities for consultation with children or young people about a specific aspect of developmental work to ensure that it delivers outputs which are relevant to them and informed by their views, for example to ensure that tools to be used by practitioners are appropriate. Thirdly, the LSCP has a role to play in improving frontline practice around the voice of the child and will do so through its multi-agency safeguarding training, through inter-agency policies and procedures, and through its communications.

The multi-agency case audit sample this year was smaller than usual and contact with children and young people was limited due to the COVID-19 restrictions in place. As it was found that the voice of children was only evident in 50-60% of the cases audited it is not possible to provide assurance that this has improved on last year's findings. During 2021/22 a themed approach to VOC will be taken and partner agencies will be asked to undertake a more comprehensive audit of their practice to be used to develop single agency action plans to improve practice.

During the reporting period the LSCP could not undertake any direct consultations with young people on specific issues due to the COVID-19 restrictions in place.

During this reporting period the LSCP widely disseminated a learning briefing on Voice of the Child located at: https://www.safeguardingsolihull.org.uk/lscp/wp-content/uploads/sites/3/2021/09/VOC-Briefing-FINAL-1.pd

Evidence of impact: The briefing was sent to strategic leads across the partnership with a request for assurance about how it would be used to inform practice (see previous section for assurance on embedding key messages).

8. Responses to the Challenge set for Partners in 2019/20

By March 2020 we found ourselves moving into unknown territory in respect of the Coronavirus pandemic and the implications for the LSCP were at that time uncertain. It was almost inevitable that partnership working would look somewhat different, at least for a while, and it was unclear at that stage whether partner agencies would be able to continue to prioritise their LSCP commitments and activity in quite the same way.

In addition, we saw the large scale protests in support of the Black Lives Matter (BLM) movement following the death of George Floyd. These protests served to remind us of the institutional and structural racism which exists and the impact of this on the daily lives of black people everywhere.

Partner agencies have provided the following evidence to show how they have risen to those challenges during 2021/22:

Diversity

- **CCG**: All commissioned services follow the Quality and Equality Impact Assessment process
- **WMP**: Specific force mission established to tackle hate crime during pandemic
- **Carers Trust**: Numbers of BAME Young Carers and staff who support them reflect local demographics
- **Public Health**: A dedicated BAME refuge for female victims and their children opened in June 2021
- **SCH**: A new Equality, Diversity and Inclusion Strategy and Action Plan was developed
- **SWFT**: Established equality goals and outcomes targets and all Trust Policies require an equality impact assessment
- **UHB**: Inclusion, Diversity and Human Rights are embedded into the organisation providing the framework which protects the freedom for individuals to control their own life, prevent discrimination and set expectations for enabling fair and equal services
- **Urban Heard**: Supported young people to have a voice during the BLM campaign by creating a forum for young people to talk to the police and creating a film that was sent to the West Midlands event around young people and policing

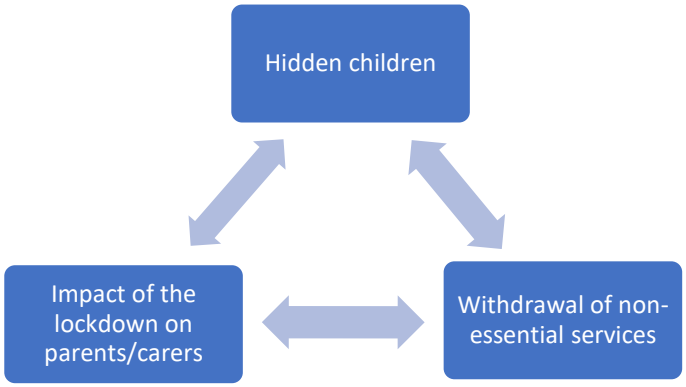
Exploitation

- **CSWS**: Development and merging of YOS, Exploitation and Missing and support in development of multi-agency strategy, pathways and procedures
- **UHB**: Established Exploitation Steering Group
- **BSMHT**: Convened all age exploitation task and finish group to implementat action plan from self-assessment
- **Probation**: Provided briefings for staff
- **Carers Trust**: Identified cases and taken appropriate action
- **SCH**: Supported development of the Strategy and direct engagement with the Solihull Exploitation Panel (ShEP)
- **SWFT**: Creation of specialist exploitation post
- **WMP**: Provided Chairs for Exploitation Reduction Board and Exploitation Reduction Delivery Group
- **CCG**: Representation on strategic groups, ShEP and in delivery of audits
- **Urban Heard**: Supported development of the Strategy

Neglect

- **CSWS**: Embedding Graded Care Profile into practice
- **UHB**: Established Early Help Steering Group to include neglect agenda
- **BSMHT**: Referenced importance of identifying neglect when working with adults through staff webinars and briefings
- **Probation**: Provided briefings for staff
- **Carers Trust**: Assess Young Carers to ensure they are not providing inappropriate care or being neglected due to being a carer
- **SCH**: Support for tenants most at risk of harm during the pandemic
- **CCG**: Involvement in review of Neglect Strategy and delivery of audits
- **SWFT**: Involvement in review of Neglect Strategy and delivery of audits
- **Urban Heard**: Involvement in review of Neglect Strategy

9. COVID-19: what it has meant for safeguarding children



- During the year partner agencies found themselves having to adapt their modes of service delivery to accommodate the Coronavirus restrictions which were in place for much of the year. For some organisations this meant the withdrawal of non-essential services in order to shift resources to respond to the needs of the pandemic. This was particularly so for Health partners, but also impacted on a range of other services normally available for children and families. (See Appendix 2 for examples of how partner agencies adapted to the needs of the pandemic.)

- The majority of children were not attending school during periods of lockdown and so were largely hidden from view. Vulnerable children were identified in accordance with government guidelines and were actively monitored by school staff and education services, but this left others, not previously identified as being at risk, without access to trusted adults during a challenging time for some families.

- Periods of lockdown have had an impact on family dynamics with an increase in domestic violence being reported during the year and, whilst referrals to Children's Social Work Services were down on previous years, a significantly higher percentage of those referrals being made met the threshold for a S47 investigation due to child protection concerns or a social work assessment due to levels of need. This translated into a swing towards children being put on child protection plans in the category of Emotional Harm (associated with domestic abuse) replacing Neglect as the predominant category of abuse.

- Courts were not operating in the same way which led to delay in dealing with less urgent care proceedings; a contributory factor in the increase in looked after children during the reporting period.

- The longer term impact on the mental health of parents is yet to be seen, however Health partners saw an increase in mental health referrals for both children and adults during the reporting period.

- For a small number of children changes in family composition during lockdown, unbeknown to professionals, led to the loss of protective adults with tragic consequences.

As safeguarding partners we acknowledge the way in which organisations have been required to adapt their ways of operating during these exceptional circumstances is to ensure that essential services have continued to be delivered safely to the most vulnerable children and their families. We understand the pressures on families, particularly during periods of lockdown, and the impact that these challenges have had on parenting capacity and the increased risks and levels of need which have resulted for some of them.

Over the coming year we will begin to understand the longer term consequences of the pandemic for families and, as we adapt to the 'new normal', we will work with partner agencies to ensure that services are able to respond robustly to emergent needs.

There is more to do to embed Solihull's response to all-age exploitation in order to see the impact for victims and to implement the new Neglect Strategy. These will continue to be priorities for the Local Safeguarding Children Partnership during 2021/22.

Appendix 1

Solihull LSCP Budget 2020/21

	Actual 19/20	Actual 20/21	Budget 21/22
	£	£	£
Pay and Overheads	176,423	166,672	192,850
Training	169	0	500
Car allowances	1,735	185	500
Telephones	392	236	400
IT Equipment and Related	6,810	3,860	15,100
General Office Expenses	6,049	2,926	1,000
Professional fees - CSPR/Other	3,962	4,200	10,000
Other fees - CDOP	13,000	0	0
Other fees - Independent Chair	21,319	5,217	12,000
Grants and Subscriptions	704	704	1,000
Internal Room Hire	3,647	0	1,500
Internal ICT	2,166	2,303	2,200
Income			
Schools Forum	-13,540	-13,540	-13,540
Childrens Services	-118,640	-118,640	-118,640
CCG	-60,300	-60,300	-60,300
Police	-12,879	-13,008	-13,010
UHB	-6,200	-6,200	-6,200
SCH	-10,000	-10,000	-10,000
National Probation Service	-477	-477	-477
Community Rehabilitation Grant	-1,500	-1,500	0
CAFCAS	-550	0	0
External/Other income	-6,580	-1,116	-1364
Carry forward	-29,426	-23,715	-62,193
Net Budget	**-23,716**	**-62,193**	**-40,884**

Gross Expenditure	**236,376**	**186,303**	**244,840**
Gross Income	**-260,092**	**-248,496**	**-285,724**
Net Shortfall /-Surplus	**-23,716**	**-62,193**	**-40,884**

Appendix 2

Examples of how partner agencies have been required to adapt during the pandemic

Birmingham and Solihull Mental Health NHS Foundation Trust

Access to/from service users was much more difficult. Crisis care continued, with impatient admissions remaining unaltered other than restrictions on visits and the use of initial isolation whilst screen for COVID was carried out. Crisis care continued to be face to face. Other community based interventions became remote either using phones of video call technology.

There was a significant surge in mental health referrals when lock down was eased and the acuity of service users was much higher than previously.

Children in Solar services valued the use of digital options, although every effort was made to keep the face to face function in place. A 24 hour help line was initiated – which is run via MIND. Kooth was also employed for younger service users. Children we knew to be open to other services were prioritised (or the adults associated with them). We put a Safeguarding professional into Solihull MASH to support the mental health identification during the pandemic (virtually) for 3 days a week and this resource subsequently became full time.

NHS England

A challenging year for all; NHS England and NHS Improvements work centred on managing the pandemic to ensure health care was delivered safely. We supported our local health and care systems and the services we directly commission to deliver the priority care required. We worked closely with our partners in the Local Authority, third sector, Public Health, the Armed Forces and supported the mobilisation of the Birmingham Nightingale Hospital at the NEC to be ready to provide care for patients. We mobilised the COVID-19 vaccination programme across the region, working with our GP, pharmacy and volunteer colleagues amongst others. More latterly, the NHS as a whole is working on recovery and restoration of routine services we are supporting provider organisations with.

South Warwickshire Foundation Trust

Throughout the Pandemic the 0-19 Family Health and Lifestyle Service has continued to provide a Universal Service for all families. Contact was maintained via telephone or various social media platforms. Face to face visits with appropriate personal protective equipment were targeted for families who required a Universal Plus or Partnership Plus level of provision. Practitioners have continued to attend Child Protection Conferences and Core Groups remotely.

West Midlands Police

Initial reduction in crime demand followed by increase in hate crime, online offences and domestic abuse.

Concerns around under reporting of hidden crimes given reduced access to vulnerable communities and young people.

Solihull Community Housing

The suspension of non-essential services during lockdown. All services and operations were delivered in accordance with the prevailing legislation and guidance e.g. arrangements were made for all staff who could work from home to do so, and face to face contact with customers curtailed.

Working with the Council, SCH developed a 'Recovery Roadmap' to plot the reinstatement of services when appropriate. An SCH Incident Recovery Team (IRT) was established. This was led by a member of the Executive Leadership Team who was also linked into the Council's Covid-19 response framework.

A Service Status Tracker was established to closely monitor the demand on services and deploy available resources in the most effective way.

Associated risks were managed through the Risk Management framework, which initially included a specific Covid-19 risk register.

Birmingham and Solihull Clinical Commissioning Group

The Designated Safeguarding Team has adapted and responded to safeguarding needs across the health economy and in multi-agency partnership working. Team members have supported acute provider services safeguarding teams in carrying out their functions. As an early response during the pandemic - acknowledging increased risks to children and adults from domestic abuse – lockdown / isolation messages were communicated to Primary Care to heighten awareness, guidance and responses for early identification in changing ways of delivering care. In addition, the CCG's attendance at MARAC commenced to provide information sharing regarding high risk victims and associated children from and to the MARAC from Primary Care.

Meetings with our acute and community health provider safeguarding Leads were increased in frequency (weekly, fortnightly, or monthly as deemed necessary), to discuss, share and offer support and escalate safeguarding issues within the health economy.

Our Safeguarding Advice line extended its business hours to reflect the opening hours of the Red Clinic GP service and to facilitate a timely safeguarding response to practitioners.

Similar to other agencies, we were provided with digital platforms early on in the pandemic to enable virtual multi-agency working throughout.

Our GP Practice Safeguarding Leads Network meetings have been shifted to a virtual platform and increased in frequency from quarterly to bi-monthly. This Forum has been utilised effectively to deliver key safeguarding messages, learning from reviews and opportunities for GP Safeguarding Leads to discuss cases.

Safeguarding Children training has been delivered on virtual platforms and IRIS (domestic abuse) training was adapted and delivered to GP practices that were awaiting the training prior to the first lockdown.

Work has commenced to roll out the ICON programme throughout the BSOL health economy to support families who care for babies to cope with crying, thus minimising abusive head trauma.

The Safeguarding Assurance Survey (SMART Survey) was deferred to Primary Care and commissioned Third Sector organisations due to the added pressures on services at that time. This has now been reinstated with plans in place for review of the pending survey returns from these services and support our colleagues as appropriate.

Probation Service

COVID-19 saw both probation providers (National Probation Service and the Community Rehabilitation Company) resort to an exceptional delivery model that meant that most contact with our caseload became remote (telephone or video) with only the highest risk offenders, or those without telephones being seen face to face. As the year went on, periodic face to face delivery was gradually extended to medium risk offenders where there were known current issues around child safeguarding and domestic abuse. Volume of new work reduced in the earlier part of the pandemic as sentencing volumes decreased due to courts also having an exceptional delivery model. That began to increase again in the course of the year but there remains some backlog.

Public Health

Shortly after lockdown in March 2020 there was a visible increase in reports of domestic abuse made to the police. By early spring 2020 this increase was being seen across the system with sharp increases in persons fleeing domestic abuse approaching homelessness services, requests for support to specialist domestic abuse provision and child safeguarding concerns.

Most services remained open but transitioned to remote working. Significant work was undertaken with practitioners to raise awareness of an increase in domestic abuse and to inform those at risk that support was still available.

We sadly have also had an unprecedented number of adult fatalities which fell within the remit of Domestic Homicide Review. At this time we are unable to comment on how much, if any of these were linked to COVID-19.

Children's Social Work Services

The Covid-19 pandemic has required the consideration and introduction of different ways of working. This has created challenges in the way services have continued to be delivered as well as the support provided to staff. As a consequence new and innovative ways of working have been developed to improve service delivery to children and families.

As part of COVID 19 the Government introduced a number of flexibilities that could be used to adapt to the more restrictive requirements of the pandemic, but at the same time maintaining a safe service for children and families. Given the statutory nature of the work in children's services, Solihull took the view that we would not instigate many of the 'flexibilities' available and continued to provide an ongoing safeguarding and support service via a blend of both physical and virtual responses. This included undertaking physical child protection and safeguarding visits but virtual visits to children looked after, given they were in a safe environment due to their care plan. Additionally, we moved to conducting all of our meetings, court hearings, panels, conferences and reviews online – a more blended approach to the delivery of our services. During Covid Childrens Services has continued to provide a safe service to children, young people and families throughout the pandemic.

Extensive work has taken place across the directorate between social care and education in monitoring and co-ordinating support to vulnerable children whilst schools were closed. This has laid useful foundations for ongoing vulnerable children tracking – an internal structure that encourages a coordinated response to children and young people with increased vulnerabilities and their school placement is at risk.

For some young people virtual visits using phone or video calling had increased their comfort in participating and communicating with their workers. This has included communication with advocates completing welfare return interviews for young people who have been missing from home or care.

Looked after children and young people were also offered virtual contact which then moved back to face to face contact in the summer following Government guidelines.

There has been partnership working across directorates to ensure that appropriate PPE is available and guidance issued to ensure consistent use of PPE. This has enabled visits to take place and children to be seen despite understandable concerns held about Covid-19 transmission by service users, carers and staff. Staff found that a number of their work tasks have taken longer than usual due to challenges with visits, seeing people and also liaising with other partners / agencies.

In addition to promoting access to the Employee Assistance Programme, we have linked in with the Council's wellbeing lead and piloted a suite of wellbeing tools that help managers have structured discussions with staff about all aspects of their wellbeing and to help devise bespoke plans to support staff as needed.

Urban Heard (Third Sector)

Urban Heard adapted immediately to provide online support through 1-1 and group sessions. We also supported through information sharing online through social media. We started to provide detached youth work from 8th June 2020 where youth workers would give out free reusable masks and hand sanitiser to young people. There was a change in demand with a lot of young people expressing that they wanted somewhere to go and were very bored.

During the lockdown we had to work with children's services twice and YOS a couple of times. We supported 3 teenage girls who became pregnant with one giving birth, one miscarriage and one termination. The latter needed a lot of support as she was sent the pills to do on her own at home. As soon as we could we started 1-1 support face to face for the most vulnerable young people. We have since secured a hall where we have opened a youth centre which will operate every week day for 12-17 year olds.

Carers Trust Solihull (Third Sector)

We were unable to meet face to face with young & young adult carers (YCYAC) but were able to deliver around 90% of our services online. YCYACs told us that the biggest impact was isolation, education and emotional welfare therefore we continued with online activities and support work and provided grants for hobbies, interest and activities at home and with family. We provided laptops and digital support and grants for materials etc. whilst home schooling and ran a return to school campaign this Summer offering grants for provision of school uniform, equipment, university packs etc. We are also running face to face group support work for emotional wellbeing 'looking after me'. Referral numbers halved from April to September 2020 then returned to normal rate thereafter. Providing online activities revealed YCYACs who couldn't access our services before due to caring and our DMG (Decision Making Group) have opted for a blended approach of support in the future - both face to face and online with streaming.

Coventry Warwickshire Partnership Trust (Respite Care)

Lyndon House – Overnight respite was offered but reduced amount of 2 nights per week, for 1 child initially but was increased to 2 managed by placing the children separately for families in high levels of need or at risk of family breakdown or where the child was at risk of admission to hospital. The number of nights offered has increased gradually as the national restrictions have eased

Outreach respite was offered to families within the home, family garden or taking the child out to access walks or the local park to allow families few hours respite during the day where the level of need was lower than for children accessing overnight respite. This service was well received and utilised by families, which enabled a level of service to be offered to the majority of families that wanted and needed support.

Wellbeing telephone contact was made with families on a 2-4 weekly basis and Risk Assessments have been updated in line with any changing family needs. The number of referrals remained at a rate as pre-Covid, alongside several enhanced support packages requesting respite at Lyndon House. This was to provide for families who are known to the service and some new families.

The service is now running at 7 nights a week but continues with reduced numbers of children resident overnight. Social distancing, good hand hygiene and wearing of PPE remains in place and a standard operating procedure is used to direct this.

Jade Unit – Brooklands Hospital

The unit continued to accept new referrals onto the unit where appropriate and self-isolation measures were put in place for the new admissions until 2 x negative Covid swabs were obtained. Children/young people resident on the unit had their temperature checked daily and this practice is continuing.

Requests were made prior to new admissions that a Covid test was carried out. Covid swabs were undertaken as appropriate.

Visiting by family members continued however this was restricted to 1 member of the family for 1 hour at a time, social distancing, good hand hygiene was encouraged and wearing of PPE was essential. Family were asked if any Covid symptoms were present or any members of the family were positive to Covid before the visit took place. The use of face masks by visitors continues however 2 members of the family are now able to visit at 1 time and the time limit on the unit is flexible. Family visits were encouraged to take place were possible (dependant on the needs of the child/young person) in the visiting room which is located off the unit to minimise risk of infection.

The unit school closed during the pandemic, however educational activities continued with the children/young people on the unit where possible.

The use of MS Teams was introduced to allow multi-disciplinary teams meetings to continue, allowing all professionals, parents, advocates (where appropriate) and the children to participate. This has proved to be very successful in getting all professional to attend and is continuing.

University Hospitals Birmingham

Our experience:

- Increased numbers of children referred due to safeguarding concerns
- Increased numbers of children presenting with complex mental health difficulties
- Increased numbers of staff who are in position of Trust subject to allegations

An increase in safeguarding referrals for children, with serious injuries in those under one year of age; increases in the reports of domestic abuse and hate and violent crime in the West Midlands region. There have been noted increases in youth violence in the City linked to exploitation and gang activity. Increases have also been noted in complex mental health presentations in children.

Developments that have assisted us address consequences of Covid-19 from a safeguarding perspective include:

- The development of the ICON offer across all partner agencies (a programme to assist parents understand and cope with infant crying)
- Development and implementation of the patient safety notice for non-mobile infants presenting with injuries at UHB
- The agreement to develop a shared safeguarding dataset across all provider NHS organisations (which is still in development and will help us identify trends in safeguarding activity)
- Flexing safeguarding provision to meet need to ensure clinical teams felt supported throughout the pandemic
- Production of guidance to assist in the management of virtual contacts with patients
- Increasing the domestic abuse offer within our organisation with the support of on-site Independent Domestic Violence Advocates
- Increasing the health presence at multi-agency domestic abuse risk assessment conferences (maternity)
- Deep Dive Review into mental health provision and flexible approaches to assist acute organisation cope with the increased mental health demand.
- The acceleration of early help provision to families

The year was characterised by unparalleled partnership working across the safeguarding system to jointly assess and respond to the risks for our population. Partnership working is heralded as an absolute necessity for improving safeguarding outcomes and to reducing inequalities and so the enhanced and accelerated partnership working established during 2020-21 will need to continue at pace for the foreseeable future.

Appendix 3

Glossary of terms

ACEs	Adverse Childhood Experiences
BSMHFT	Birmingham and Solihull Mental Health Foundation Trust
CAFCASS	Children and Families Court Advisory and Support Service
CCG	Clinical Commissioning Group
CDOP	Child Death Overview Panel
CPP	Child Protection Plan
CPRU	Child Protection Review Unit
CQC	Care Quality Commission
CSP	Community Safety Partnership
DHR	Domestic Homicide Review
EHCP	Education, Health and Care Plan
ERB	Exploitation Reduction Board
ERDG	Exploitation Reduction Delivery Group
FIB	Force Intelligence Bureau
GCP2	Graded Care Profile 2
H&WBB	Health and Wellbeing Board
ICPC	Initial Child Protection Conference
ILACS	Inspecting Local Authority Children's Services
LAC	Looked After Children
LADO	Local Authority Designated Officer
LCSPR	Local Child Safeguarding Practice Review
LGA	Local Government Association
LSCP	Local Safeguarding Children Partnership
LSOAs	Lower Super Output Areas
MAACE	Multi-Agency Adult/Child Exploitation
MACE	Multi-Agency Child Exploitation
MARAC	Multi-Agency Risk Assessment Conferences
MASH	Multi-Agency Safeguarding Hub
NFA	No Further Action
NRM	National Referral Mechanism
SAR	Safeguarding Adults Review
SCH	Solihull Community Housing
SCR	Serious Case Review
ShEP	Solihull Exploitation Panel
SIAS	Solihull Integrated Addiction Services
SSAB	Solihull Safeguarding Adults Board
SUDI	Sudden and Unexpected Death in Infancy
UHB	University Hospitals Birmingham
VOC	Voice of the Child
VT	Vulnerability Tracker
WMP	West Midlands Police