SHROPSHIRE SAFEGUARDING CHILDREN BOARD

ANNUAL REPORT

2016 - 2017

Shropshire Safeguarding Children Board annual report 2016- 2017 provides an account of the activities, development and impact of the Board and its partners in fulfilling their statutory responsibility of safeguarding and promoting the welfare of children and young people in Shropshire.

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2 FOREWORD

Welcome to Shropshire Safeguarding Children Board's annual report for 2016 - 2017. This is a public report which sets out the work of the Board and its view of the effectiveness of safeguarding arrangements across the county. The report aims to give everyone who lives and works in Shropshire a sense of how well local services and people in the community are working together to keep children safe. The report is also intended to inform the decisions made by those responsible for leading, commissioning and funding local services.

As in previous years, many of the organisations which contribute to the Board's work have continued to face significant financial pressures, which have entailed difficult decisions about allocation of resources. Where it was felt to be necessary, the Board has challenged decisions made by agencies at both strategic and operational levels. For example, West Mercia Police were challenged regarding the potential implications of their proposed Single Investigative Model for safeguarding children, and responded positively by suspending their plans to implement these new arrangements in Shropshire with a view to reviewing its effectiveness following pilots elsewhere in the force area.

Despite the pressures, the Board's partners have maintained a focus on developing arrangements and services which enable a quicker, earlier response to children and families who may need additional help. This is an area that will continue to be promoted in the year to come, with the aim of supporting families more effectively at an early stage and reducing the need for statutory intervention as difficulties become more entrenched.

Throughout the year, agencies have continued to demonstrate their commitment to safeguarding children through contributing to the multi-agency work of the Board, taking part in multi-agency auditing and challenge activities, and sharing their own data and self-assessments. The Board has also worked in support of the vision of the Children's Trust, focusing attention on areas which present the greatest risk to Shropshire's children - child sexual exploitation and going missing, neglect and domestic abuse – and working more closely with other multi-agency partnerships to ensure that the most vulnerable individuals and families are identified, supported and safeguarded.

Whilst the Board has not published any serious case reviews during the year covered by this report, we have reviewed individual cases and groups of cases to identify both good practice and areas for improvement. We have also commissioned an SCR on an Unaccompanied Asylum Seeking Child which will be published during the coming year. We will continue to monitor the impact of the learning from these cases on the quality of local practice.

We have all welcomed the increasing engagement of young people in the work of the Board, through the development of the Student LSCB. This year, the group decided to focus on neglect and sex education (especially related to sexting and sexual abuse, and their insights have been most valuable in informing the understanding of Board members of the perspectives and priorities of young people.

Another important development for the Board has been the increased focus on disabled children, who must always be kept in mind because of their additional vulnerabilities. This will continue in the coming year.

The report sets out what the Board will do during 2017-18 in order to continue strengthening arrangements for safeguarding children and developing access to early help services. This will involve working with partners both within the SSCB context, across Shropshire, and more widely across the region. The year will also see attention paid to putting in place future arrangements for safeguarding children in response to the changed legislative context that has been introduced by the Children and Social Work Act 2017, which gives greater flexibility locally whilst increasing accountability for NHS and police partners alongside the local authority.

Finally, as ever, there are staff and volunteers who day to day demonstrate their commitment to children and families through their work and dedication. We thank them all for everything they do to safeguard children and promote their wellbeing.

Sally Halls

SSCB Independent Chair

Ivan Powell

Interim SSCB Independent Chair

3 INTRODUCTION

Shropshire's Safeguarding Children Board (SSCB) is a statutory body established under the Children Act 2004. It is independently chaired (as required by statute) and consists of senior representatives of all the principle stakeholders working together to safeguard children and young people in the county. Its statutory objectives are:

(a) to coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and

(b) to ensure the effectiveness of what is done by each such person or body for those purposes.

Working Together to Safeguard Children 2015 requires the Independent Chair to publish an annual report on the effectiveness of arrangements to safeguard and promote the welfare of children and young people in the local area. The guidance states that the report 'should provide a rigorous and transparent assessment of the performance and effectiveness of local services. It should identify areas of weakness, the causes of those weaknesses and the action being taken to address them as well as other proposals for action. The report should include lessons from reviews undertaken within the reporting period.'

This annual report for the SSCB covers the period between April 2016 and March 2017 and evaluates the work and impact of the Board whilst identifying future challenges and priority areas of work for the period 2017– 2018.

Chapter 1 sets out the contents of the report.

Chapters 2 and 3 include a foreword from the Independent Chair and an introduction to the annual report.

Chapter 4 sets some context and includes a strategic overview of safeguarding within Shropshire, including local demographics, implementation of the Children and Young People's Plan, challenges faced by partners and information about the SSCB.

Chapter 5 focusses on the SSCB's priority areas of work and progress made against these during 2016-2017 set against the SSCB's strategic objectives.

Chapter 6 outlines other activities and functions of the SSCB including the development of policies and procedures, safeguarding disabled children, private fostering, case reviews (including the findings of a recent Learning Review), multi-agency training, the work of the Child Death Overview Panel, managing allegations against professionals and participating in the planning of services.

Chapter 7 analyses the effectiveness of multi-agency safeguarding arrangements through SSCB's quality assurance processes.

Chapter 8 details the ways in which SSCB engages with children and young people including the work of the Student LSCB.

Chapter 9 provides a conclusion and a look to the future of multi-agency safeguarding arrangements and what implications this may have for the SSCB and partner agencies in 2017-2018.

Appendix A is a summary of partner agency assurance reports that have been presented to SSCB throughout 2016-2017.

The report is ratified by the SSCB and is presented in final version to the Chief Executive of the local authority, the Leader of the Council, the local Police and Crime Commissioner (PCC) and the chair of the Health and Wellbeing Board. In addition the report will also be presented to Shropshire Council Young People's Scrutiny Committee, Shropshire Children's Trust and the Chief Constable of West Mercia Police.

4 CONTEXT AND STRATEGIC OVERVIEW

4.1 CHILDREN IN SHROPSHIRE

Shropshire is one of England's most rural and sparsely populated counties with a large geographic area of 1,235 square miles. Situated in the West Midlands, bordering Wales to the west and Cheshire to the north, the area has a population of 311,373 (ONS, mid-year estimates 2016). Shropshire's population is largely of White British ethnic origin. The number of residents from minority ethnic groups is low; comprising 4.6% of the population (this includes white other, gypsy/traveler and Irish). 40.1% of Shropshire's population live in the main market towns of Shrewsbury, Oswestry, Whitchurch, Market Drayton, Ludlow and Bridgnorth. (Census 2011)

Shropshire has approximately 63,000 children and young people under the age of 19 years. This is 20.2% of the total population (ONS, mid-year estimates 2016). The proportion entitled to free school meals is 8.8% of primary and 8.1% of secondary pupils, which is below the average for both national and statistically similar local authority areas. Children and young people from minority ethnic groups account for approximately 6.1% of the 0-19 population, compared with the English average of 24.2%. (Census 2011). In 2017, the percentage of children whose first language is not English was 3.7% of primary and 2.8% of secondary pupils, which is significantly lower than national statistics and lower than statistically similar local authority areas.

Shropshire has 152 state funded schools: 98 primary schools, 4 infant schools, 4 junior schools, 6 secondary schools, and 2 special schools. These are local authority maintained schools. There are also 42 local authority maintained nurseries. There are 38 Academy Schools consisting of 22 primary, 13 secondary, 1 special, 1 all through and 1 free school (as at July 2017).

According to the Income Deprivation Affecting Children Index 2015 [IDACI], Shropshire had approximately 13% of children (aged 0-15 years old)

considered to be living in income deprived families, low compared to national figures. However, this statistic masks pockets of deprivation where 9 areas are amongst the 20% most deprived nationally in terms of the IDACI. It is estimated that 1,195 children living within these 9 areas (around 38% of dependent children aged 0-15 within the 9 areas) are classed as living in families which are income deprived.

A particular characteristic of Shropshire is the large numbers of looked after children placed with private care providers by other local authorities. This number is estimated at around 500 at any one time, although the local authority is not always notified when young people move out of area. Whilst these children remain the responsibility of the placing authority this does have a significant impact on a number of local services, particularly police, health and mental health services.

4.2 IMPLEMENTING THE CHILDREN AND YOUNG PEOPLE'S PLAN

The vision of the Children's Trust, set out in Shropshire's Children, Young People and Families Plan, 2016, is that:

> *The Children's Trust wants all children and young people to be happy, healthy and safe and to reach their full potential, supported in a family environment, by their families, friends and the wider community.*

This year has seen the Children's Trust focus on 4 key themes, work has included:

- **Family including hidden harm** working closely with other Partnership Boards on the refresh of the Domestic Abuse Strategy and ensuring children receive the support they need if they are affected by domestic abuse.

- **Transition planning and arrangements,** with the development of a new Multi-Agency Transition Policy and Pathway due to be launched in September 2017.

- **Emotional / Mental Health and Wellbeing,** work to embed the Adverse Childhood Experiences (ACE) and routine enquiry approach across all partnership agencies and strengthen links with the Shropshire Mental Health Partnership Board.

- **Strengthening Families through Early Help,** with a refresh of the Early Help Partnership Board that will see partners working together on a new vision for Early Help in Shropshire.

The Children's Trust has most recently begun a piece of work supporting parents and professionals to ensure children are prepared for school by encouraging the development of their cognitive, fine and gross motor skills.

4.3 CHALLENGES FACED BY PARTNERS

Public sector organisations continue to face the dual challenges of managing with reducing resources whilst facing increased demand for their services. SSCB members have recognised this and are determined to work collectively to minimize any unintended consequences for children and young people – and for partners - when making difficult decisions about the future of services.

Partner agencies have demonstrated commitment to the work of the SSCB by ensuring agency representation and contributions to the work of the sub-groups of the Board, including multi-agency audit activity, and by keeping the

Board informed of any plans for service re-design through the SSCB Safeguarding Impact Assessment. This has enabled the SSCB to be assured that safeguarding and outcomes for children have been considered in service redesign and that any risks have been mitigated against.

In this challenging climate, partners have worked hard to develop a range of effective early help services which can support children and their families at an earlier stage, reducing demand for the more specialist and expensive services. The joint working of the Pentagon of Partnerships[1] is already beginning to make an impact and this is evidenced further in Chapter 6.8.

4.4 SHROPSHIRE'S SAFEGUARDING CHILDREN BOARD

SSCB is a multi-agency partnership that is jointly funded by its partners. The core budget for 2016-2017 was £208,840. A breakdown of this, showing contributors and expenditure is available on the SSCB website, together with further details about Shropshire's LSCB arrangements, including governance and accountability, membership and attendance.

Following five successful years as SSCB Independent Chair Sally Halls stepped down in December 2016 and Ivan Powell was appointed as the new interim Independent Chair.

The SSCB carries out much of its work through a number of subgroups and task and finish groups, supported by the SSCB Business Unit. Details of these are available on the SSCB website. All sub-groups terms of reference and work plans have been reviewed in 2016 to ensure they remain fit for purpose and their work progresses the SSCB Business Plan.

Subgroups are well supported by a wide range of agencies, including schools, colleges and voluntary sector organisations as well as the larger statutory organisations who also contribute to the main Board.

There are also a number of reference groups related to the SSCB which contribute significantly to progressing the safeguarding agenda in Shropshire. These include:

- the health safeguarding governance group, which brings together safeguarding leads from across all the NHS providers working in Shropshire and beyond its borders;
- the private providers' forum, which promotes safeguarding of looked after children placed within Shropshire from elsewhere;
- the schools safeguarding group, which provides a close link with schools across all phases, from early years to further education.

The SSCB Governance Group continued to meet in early 2016. The group was made up of partners from the local authority, health, the Police and also including the SSCB Independent Chair and the SSCB Business Manager. The Governance Group considered the SSCB budget, risk register and any partnership wide issues that had been escalated for action by the Board. During 2016 this group was superseded by the SSCB Strategic Group which has been established to develop and oversee the new local safeguarding arrangements under the Children and Social Work Act 2017 and the review of the SSCB Business Unit. See Chapter 9 for further details.

5 PROGRESS ON SSCB PRIORITIES

The SSCB Strategic Plan 2015-2018 set the SSCB's objectives following assessment of the effectiveness of the SSCB and its partners, consideration of

[1] Pentagon of Partnership consists of SSCB, Health & Wellbeing Board, Children's Trust, Keeping Adults Safe in Shropshire Board & Safer Stronger Communities Partnership

information and evidence, and reflecting areas of weakness and challenge set out in the previous year's annual report. The SSCB Strategic Plan identifies four strategic objectives:

Strategic objective 1

Ensure quality safeguarding across agencies

Strategic objective 2

Assess the safety of all children

Strategic objective 3

Embed early help

Strategic objective 4

Identify children most at risk across all agencies

The SSCB has also set out its intentions for 2016-2018 in a business plan which is published on the SSCB website. The business plan compliments the SSCB Strategic Plan and sets out a number of areas of activity in relation to the SSCB priorities, which are:

SSCB Priorities:

- **Child Sexual Exploitation and children who go missing**
- **Neglect**
- **Domestic Abuse**

Progress against objectives and priorities is monitored by the Board and reviewed annually.

5.1 CHILD SEXUAL EXPLOITATION (CSE) AND CHILDREN WHO GO MISSING

What we know:

During 2016-2017 95 CSE referrals were considered by the CSE panel, representing a slight drop in referrals based on 2015 – 2016 figures. Of the 95 cases heard, 56 were new referrals, the rest comprised of re-referrals or reviews of cases.

Children's Social Care continued to receive risk identification assessments from private care providers as part of their notification of the placement of out of county looked after children into Shropshire, but this figure too, had dropped based on the previous year.

It could be assumed that the higher level of referrals received in 2015-2016 was due to raising awareness in schools through the theatre production Chelsea's Choice. This demonstrates the need to continually raise awareness of the risks of CSE to children and young people, professionals, parents/carers and the local community.

Data has shown that the picture of schools referring concerns of CSE is still patchy across the county. Some schools have not referred any cases, although there is information indicating there are risk issues with some young people in those schools (for example truancy and/or substance misuse). Multi-agency training records also show that some schools have very few or no staff who have attended CSE training.

The majority of referrals in 2016-2017 were for females and were made by schools, social workers, private care homes and the police. Referrals from health agencies remained low.

The CSE profile for Shropshire indicates that the most common type of exploitation involves young women aged 13 – 15 years being exploited online or by male peers or young adult males. The local profile suggests there may be an under-identification of male victims.

In terms of geographical spread most referrals come from the north of the county, followed by central Shropshire, with few referrals from the south. The SSCB is confident that overall the understanding of CSE has improved, but there are still areas of the county where referral rates are low and this issue is being considered by the Board.

The breakdown of categories of intervention following cases being presented at CSE panel is as follows:

Early Help – 37

Child in Need – 19

Child Protection Plan - 16

Shropshire Looked After Child– 7

Other Local Authority Looked After Child – 13

These figures and categories fluctuate as children move through different levels of support post panel.

The highest number of interventions for CSE cases are managed at Early Help which suggests that practitioners are recognizing the indicators of CSE at an early stage and are making appropriate and timely referrals.

A large number of children looked after by other local authorities are placed in Shropshire; some in private care homes providing therapeutic services for sexually exploited children. As of 31st March 2016 there were 12 homes in the county specializing in the provision of services for children who are identified as being at risk of CSE.

What action we have taken:

Leadership and governance

In 2016 the SSCB, through joint partnership funding, commissioned a comprehensive review of agencies response to CSE in Shropshire. The purpose of the review was to inform SSCB on what more needed to be done to maximise strategic links and address any gaps in CSE service provision locally.

The review identified the following positive developments:

- Significant activity has been coordinated by SSCB across a range of functions including training, communications and the development of an infrastructure that promotes information sharing in respect of CSE.
- Dedicated resources have been secured within the Local Authority and Police.
- An award winning Sex and Relationships Education curriculum is on offer to nearly all Shropshire children.
- Significant work has taken place to engage with private care providers, many of whom are caring for children placed in Shropshire by other Local Authorities. This has resulted in tangible outcomes for individual children e.g. every child in residential care has a trigger plan.

Developments as a result of the review have included:

- Local data was used to inform a revised CSE Strategy and action plan which is being monitored by the CSE sub-group.
- The CSE pathway, assessment tool kit and practitioner guidance was revised to ensure clarity of role and responsibilities of Children's Social Care and partner agencies in relation to victims of CSE.
- Revised terms of reference for both the CSE sub-group and the CSE Panel.
- The CSE Panel is now much more strategic, as opposed to case focused, enabling the panel to pick up on trends, themes and links, as well as supporting prevention and disruption.
- Individual cases are now managed through the case management processes within the local authority.
- The revised Thresholds document references CSE and has been re-launched via briefing sessions.
- An intelligence form has been developed to ensure vital information is shared with the Police and CSE Panel.

Prevention and early identification

A CSE scorecard has been developed to measure performance. This focuses on a range of matters including the identification of agencies that are making low levels of, or no CSE referrals at all.

This has enabled a number of actions to be undertaken to address this, including:

- Training analysis has taken place to highlight which schools have staff CSE trained (and numbers) and any who do not. Information is shared with the schools safeguarding group to promote the training.
- The CSE co-coordinator has linked with the schools safeguarding group and schools safeguarding leads for opportunities to present in schools to raise awareness.

A new website, Tell Someone, has been developed across West Mercia by the police and regional LSCBs to raise awareness of CSE amongst professionals, parents and carers and children and young people.

http://www.tell-someone.org/

Young Solutions were commissioned in 2016 to roll out a programme to raise awareness of CSE within the commercial sector to embed the work of the local 'Say Something if You See Something' campaign which was launched in 2015. Young Solutions have worked with Shropshire Council's Licensing Team to deliver raising awareness training to 50 members of staff.

85% of primary schools, all secondary schools and 2 independent schools deliver the Respect Yourself programme through Personal, Social and Health Education (PSHE). This includes the topics of keeping safe, healthy relationships and CSE.

Work is ongoing to develop a programme aimed at young men to address behavior and attitudes that underpin sexual abuse/exploitation.

Multi-agency briefing sessions attended by over 300 practitioners have increased knowledge and awareness of the Brook Traffic Light Toolkit, an assessment tool used to identify sexually harmful behavior.

Locality meetings are being held in 'hot spot' areas and also in those areas where awareness needs to improve to bring relevant agencies together to discuss any CSE concerns.

In one area a high risk case was identified, and it was noted that there had been a number of risk factors for some time, other concerns and connections were identified as a result. The Locality meeting aimed to raise awareness and knowledge about identifying and referring concerns.

Protection and support

The Care Home Team was set-up in the summer of 2015 with two goals. To reduce inappropriate demand from care homes and to ensure children in care were not unnecessarily criminalised. Both of these goals were met, with a reduction in inappropriate calls (total calls), a 32.6% reduction in missing persons from Care Homes (quarter on quarter) and a 57.3% reduction in offences against Children in Care where a child/young person was the offender.

The Care Home Team was originally going to be a twelve month project, however it quickly became apparent that there was a long term need for a full time team. The Team now comprises of two Police officers who manage the risk presented from homes. The two officers work closely with the Police CSE Coordinator and Shropshire Council's CSE co-ordinator, regularly sharing information and raising concerns.

There has been increased progress in return home interviews with 313 interviews being completed for 2016 – 2017 with almost all children having been offered a return interview during this period. Interviews being carried out within timescale remained a challenge, particularly at peak times, but continues to be a priority.

The quality of return interviews has improved with good engagement by children being demonstrated.

During this period it was agreed that the Parenting and Contact Team (PACT) team members would carry out return interviews on behalf of the child's social worker and this appears to be something young people are happy to engage with as evidenced by some of their interviews.

Empower, a two day 'keep safe' programme for young people at risk of CSE, continues to run with sessions taking place every six to eight weeks. The sessions can be hard hitting and evaluations have indicated a greater understanding of risks following the sessions.

CSE awareness raising has been included in the local parenting support programme and due to launch in September 2017.

Offering enduring support and intervention to young people who have experienced CSE continues to be a challenge, as there isn't a dedicated service as such and existing services are not readily geared towards the longer term intervention that enquiries and studies have found to be necessary. This is an area for development in 2017-2018 and is being prioritized by the CSE sub-group.

Pursue and prosecute

12 Child Abduction Warning Notices (CAWNs) were issued by West Mercia Police in Shropshire in 2016-2017.

In addition to the issuing of CAWNs West Mercia Police have developed some learning resources on human trafficking and the National Referral Mechanism to raise awareness of the issues, with a referral form under development. The SSCB will produce a learning and improvement briefing once the full learning is identified from a current SCR and is planning to host a multi-agency event on unaccompanied asylum seeking children and human trafficking. Police consider the use of intermediaries in court for all CSE cases.

What SSCB will do next:

SSCB will need to harness the capacity from across its constituent partner agencies to deliver the revised CSE action plan and through its existing governance processes hold partner agencies to account for their contribution to the collective work to tackle CSE in Shropshire. More specifically SSCB will:

- Continue to raise awareness of CSE, particularly in areas of the county where there are lower rates of referrals.
- Monitor and analyse performance against the revised CSE scorecard.
- Formalise reporting arrangements from the CSE Panel to the sub group.
- Support the development of and seek assurance that a mechanism for gaining the views of children who have been sexually exploited on their experiences of interventions/ support services.
- Review the capacity and approach used to provide enduring support to sexually exploited children.
- Deliver a PSHE briefing, to include CSE, to all Independent Schools in preparation for PSHE becoming statutory from September 2019.

NEGLECT

What we know

As an outcome of a Serious Case Review published in November 2015 the SSCB identified the need for a sharper focus on childhood neglect, following work carried out on issues of compromised parenting.

Performance data also indicated that there has been a steady increase over time in relation to children subject to child protection plans under the category of neglect, standing at 59% of children with a child protection plan at year end 2016-2017, (a 2% rise on the previous year).

Neglect remains the highest category of need for those children subject of a plan across all timescales with 18% subject of a plan for over 9 months.

Currently SSCB is unable to collect data in relation to number of children with an early help plan where neglect is the predominant safeguarding risk. This is an area for development for 2017-2018 and is a feature of the revised Early Help strategy.

Neglect multi-agency audit

In May 2016 the Quality Assurance and Performance sub-group undertook a multi-agency audit of neglect cases. A small sample of cases was selected from

those on a child protection plan, child in need plan and those in receipt of early help support. The audit found that:

- Existing neglect assessment tools were not being used across all agencies to inform referrals or within social work assessments.
- There appeared to be a lack of confidence and knowledge among some practitioners in contributing to the progression of child protection plans through the core group process.
- It was found that some child protection plans were not 'SMART' enough and not sufficiently focused on outcomes for the child.
- Not enough consideration was given to historical information. There was evidence that chronologies were inconsistently used.

What action we have taken

Between July to September 2016, three multi-agency briefing sessions took place focused on sharing the learning from the Serious Case Review on Children A & B, (published in November 2015). A sample of the evaluation forms completed by practitioners that attended showed evidence of learning.

In September 2016, SSCB considered the revised Neglect Strategy and proposals for the implementation of Graded Care Profile 2, (GCP2). The Board developed a set of assurance questions in relation to Neglect in order to inform the Neglect dataset and to assist the SSCB Executive in monitoring the effectiveness of the Neglect Strategy. The assurance questions were as follows:

- How well do we understand the nature and scale of neglect in Shropshire?
- Do we recognise if there are any underlying themes either geographical or issue based in Shropshire?
- How well do we identify neglect and respond early?
- How do we know we're making a difference?
- How well used is the GCP2 assessment across agencies?
- How is the neglect strategy and toolkit embedded in agencies that don't predominantly work with children?
- How many referrers have completed GCP2 and what action has resulted?

In November 2016 SSCB held its biannual conference on the theme of childhood neglect attended by 130 multi-agency delegates. The conference launched the Neglect Strategy and delivered workshops on the commissioned NSPCC "Graded Care Profile 2" which focuses specifically on the lived experience of the child and the impact on their safety, well-being and development.

Between November 2016 and March 2017, 137 practitioners attended the full GCP2 training to become accredited users. 93 delegates in total attended GCP2 briefings. An online GCP2 tool has also been developed that will enable practitioners to complete and score their assessments more easily.

"I talked to other professionals in other areas of a young person's life which enabled me to build up a bigger picture. This gave more information that I was not aware of".

"By using the [GCP2] profile with the family, the family could see what they needed to address. They started to make changes straight away as I was still carrying out the monitoring. This had a big impact on the child, who now had clean dry bedding to sleep on"

The Case Conference & Core Group training has been revised and strengthened, with positive feedback from learners:

"It has helped to build my confidence in these situations. Although I have always been willing to speak out in these meetings, I now have more confidence because I better understand the procedure."

"It has helped me to look at the start again syndrome and the impact that this has on young people suffering from Neglectful parenting"
Health Shropshire Community Trust

"Feedback to colleagues about the importance of their role as core group members."
LA Maintained School

There has been an increase in the scrutiny of core group working with multi-agency and single agency audits taking place – see page 27 for findings from the multi-agency audit. Developments have included the expectation that practitioners working with families must produce a chronology which must be available at all planning and review meetings across the safeguarding system and this has been set out within the neglect strategy.

Work has taken place throughout 2016-2017 relating to the length of time children and young people were subject to child protection plans. Focused work is being undertaken on children who are subject to a child protection plan for 9 months or more to consider whether the case should progress into Public Law Outline process or care proceedings.

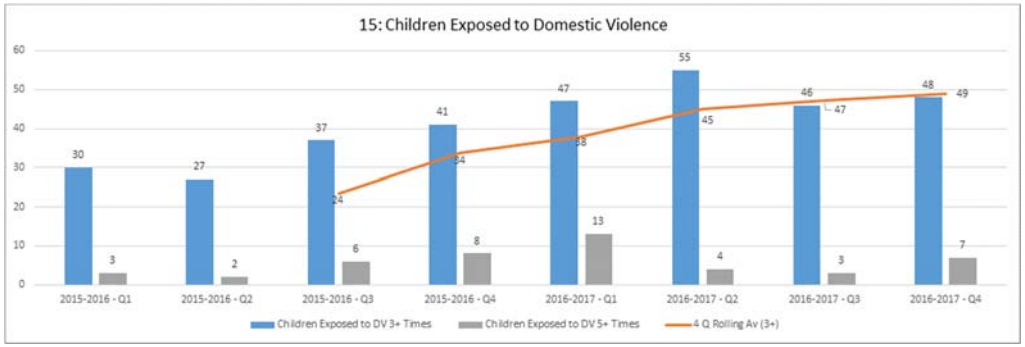
What SSCB will do next:

- Review the effectiveness of the neglect strategy through performance data and a multi-agency audit planned for September 2017.
- Develop an understanding of the prevalent categories of neglect in Shropshire.
- Ensure all children subject to child protection plans have a GCP2 assessment.
- Ensure effective use of chronologies.
- Improve multi-agency working to progress plans.
- Identify themes and patterns to better understand the effectiveness of managing neglect across the system, including Early Help, Step Up and Step Down and Child Protection.

DOMESTIC ABUSE

What we know

The Board's previous focus on issues of compromised parenting also identified a need for a sharper focus on domestic abuse. Over the past 5 years there has been a steady increase in the numbers of children exposed to repeat incidents of domestic abuse.



From April 2016 to December 2016, there were 1,602 records of domestic abuse crimes recorded (crimes with a Home Office code and classification), the rate of reports for Shropshire as a whole during that period was 5.23 reports/1,000 residents.

In the twelve months to December 2016, Multi-Agency Risk Assessment Conferences, (MARAC), recorded 282 cases; 107 (38%) of these cases were recorded as 'repeat cases'.

- 155 of these cases were referred by the Police Service,
- 20 by the IDVA service,
- 6 by children's social care,
- 43 by primary care services,[2]
- 4 by secondary care services,
- 29 by housing services,
- 1 by mental health services,
- 7 by probation services,
- 12 by voluntary services and
- 2 referrals from 'other' services.

It appears, from the data available (from the period April to December 2016), that the total number of recorded incidents has risen again in 2016. Considering the current trend, we may expect the total number of reported incidents in the 12 months period to the end of March 2017 to be in the region of 3,800 (the 12 months of 2015 saw approximately 3,200 reports).

Domestic Abuse multi-agency audit

A case sample was selected from a list of children repeatedly exposed to domestic abuse. The audit found:

- Good evidence of multi-agency working, information sharing and attendance at meetings.
- Improved single assessment pathway within Adult Mental Health is in place that considers impact of parental mental health on the child.
- There is good shared understanding across agencies when Domestic Abuse is an issue.
- The majority of cases had been considered at MARAC and information shared appropriately with all agencies, with the exception of GPs.

[2] Health colleagues are working on a process to improve our understanding of where within health referrals are being made and this will be reported on in the SSCB Annual Report 2017-2018.

- Good use of CAADA DASH risk assessment by police which is shared with partner agencies.

- Evidence that the appropriate support services are being identified in plans and accessed by families.

A further multi-agency audit on MARAC cases identified the following:

Information sharing was generally good across agencies and professionals knew children, their families and their story.

Good practice identified included:

- Safeguarding Women with Additional Needs, (SWAN), meetings held on a monthly basis by community midwifes, where women considered to be vulnerable are discussed and information shared. There is representation from a variety of agencies at the meeting.
- Timeliness of the Freedom Programme being utilised.
- Evidence of health representatives involved at strategy meetings.
- Tenacity of drug intervention workers and their willingness to work on anger management problems in the current absence of a voluntary perpetrators programme.
- Good challenge from a Child Protection Conference Chair regarding issues on a case.
- Good examples of MAPPA information being shared with a school.
- Evidence of assessments being carried out with families.

It was also recognised that Shropshire did not have a 'Domestic Violence Court' as exists in other areas where cases of this nature are heard together, and allow for professionals such as the IDVA's to attend and advocate for the victims.

What action we have taken:

Children's Social Care have improved the step down process for all children stepping down from child protection to Child in Need for a minimum of twelve weeks, before step down to Early Help. A six week period for handover of a case from CIN to Early Help has been implemented to ensure that step down plans are robust.

Shropshire Recovery Partnership have raised awareness amongst social workers on how and when to make a referral to their service.

Regular domestic abuse triage meetings now take place in COMPASS and notifications are sent to schools to alert them to domestic abuse incidents where children have been present in the household.

The SSCB dataset has been revised and will be an area of on-going development alongside the collation of domestic abuse data to monitor the effectiveness of the revised domestic abuse strategy.

Challenge and scrutiny

The SSCB was of the view that the revised all-age Domestic Abuse Strategy 2017-2020 would need to include a more robust and comprehensive approach to the safeguarding of children affected by domestic abuse.

Based upon information and findings the SSCB provided a challenge and recommendation report to the Community Safety Partnership in January 2017. The report is summarized below:

Suggested challenge and scrutiny questions:

1. Do we understand the scale, distribution and nature of domestic abuse in Shropshire?

2. Do we have sufficient data in relation to victims, perpetrators (including young people), and particularly the impact on children and the wider family to inform the Domestic Abuse Strategy.

3. Have we promoted a system and community wide understanding of domestic abuse and its impact (including on children)? What needs to be done to promote longer term prevention?

4. Are we able to evidence the effectiveness and impact of CSP funded training programmes for staff and victims?

5. Is the response across the public protection system to incidents of domestic abuse timely, robust and consistent? And are there agencies to refer people to?

6. Are children affected by domestic violence identified and effectively safeguarded?

7. How can we be assured that MARAC is effective and lessons are learned from the information shared?

8. Are the MAPPA and MARAC arrangements robust, transparent, effective and reported on regularly?

9. With regard to Domestic abuse services, are we satisfied that there are sufficient and co-ordinated services for victims of Domestic Abuse; Perpetrators (statutory and voluntary); children and other family members who may be affected by domestic abuse.

10. Does the current infrastructure and the reporting lines provide effective leadership and governance for the local response to Domestic Abuse?

What SSCB will do next:

- Continue to contribute to the development of the revised domestic abuse strategy.

- Work is under way in relation to fully implementing the Barnardos Domestic Violence Risk Assessment Matrix, to support assessment of risk in relation to domestic abuse and the impact on children. A referral pathway for children who are affected by domestic abuse is being developed along with practitioner guidance.

- Implement the recommendations from the recent multi-agency audit on cases presented to MARAC.

- Continue to refine the SSCB domestic abuse dataset to feed into the partnership dataset in order to better understand the impact domestic abuse has on children and to monitor the effectiveness of the revised strategy.

What SSCB hopes to see in 2017-2018:

- Clarity around governance arrangements for leading the domestic abuse agenda across the partnership.

- Implementation of a multi-agency all age domestic abuse strategy.

- A fully operational voluntary perpetrators programme.

- An increase in referrals to MARAC.

- Effective use of evidence based assessment tools.

- Improved provision of services for children and young people affected by domestic abuse, influenced by the views of children and young people.

- More sophisticated performance monitoring to measure outcomes in relation to domestic abuse and its impact on children.

6 OTHER ACTIVITIES AND FUNCTIONS OF SSCB

LSCBs have a number of statutory functions in addition to their objectives of:

- *Co-ordinating what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area, and*

- *ensuring the effectiveness of what is done by each such person or body for those purposes.*

This section of the report refers to wider significant areas of safeguarding children in addition to the priority areas for 2016/17.

6.1 DEVELOPING POLICIES AND PROCEDURES

It is a statutory function of the Local Safeguarding Children Board to publish multi-agency policies and procedures which set out the action to be taken by practitioners when there are concerns about the safety or welfare of a child, and the policies in relation to a number of practice areas, such as training and safe recruitment.

One of the most significant achievements for SSCB and its Policy and Procedures sub-group this year has been the successful implementation of the West Midlands Safeguarding Procedures Project.

This year the Board took the decision to join a consortium of nine LSCBs across the West Midlands to develop and commission a shared set of inter-agency procedures, to procure an independent provider to host the procedures via a website and collaboratively launched the project. The first phase of the project was funded by the DfE Innovation Fund and a Regional Safeguarding Procedures Group (RSPG) has been formally established to oversee the project including the procurement of a provider. The initiative has provided policy consistency across Boards in the region, economies of scale (significantly reducing the cost of providing multi-agency procedures), and accessed current regional expertise on policy development.

In January 2017 Phew Design Ltd was formally commissioned by Sandwell Council on behalf of the consortium following a robust procurement process. The new procedures went live on 31 March 2017.

Level A (core statutory) procedures were agreed across the 9 LSCBs, Level B procedures were agreed across the region and Level C procedures are those local to each individual LSCB (e.g. referral pathways).

The SSCB Policies and Procedure sub-group oversaw the development of the project from the Shropshire perspective, assisted with the development and ratified several procedures to be adopted by the region. SSCB was kept informed of the progress of the project at every stage in the development of the new procedures.

SSCB has recently developed additional Level C procedures including a multi-agency referral form (MARF), a child protection conference report form and revised its thresholds guidance. The SSCB Policy and Procedures sub-group will continue to monitor this area of work on behalf of SSCB, including making use of intelligence via analytical data about accessibility and demand.

The Regional Safeguarding Procedures Group (RSPG) continues to meet regularly with SSCB representation. RSPG has a rolling programme in place to refresh and update the West Midlands procedures.

6.2 SAFEGUARDING DISABLED CHILDREN

Following a review of arrangements for safeguarding disabled children in 2015-2016 the SSCB set out a number of improvements in practice that it expected to see in 2016-2017 as follows:

- Local Authority to have developed a comprehensive register of disabled children.
- The SSCB Training Strategy to reflect the needs of disabled children.
- To see disabled children represented in multi-agency audit samples.

An independent review of the existing register was carried out in 2016. The following recommendations will be submitted to the SEND 0-25 Strategic Board in July 2017:

To turn the existing All-in register into the new Children with Disabilities (CWD) register, by

- Merging useful information of the previous CWD register into the All-in register
- Expanding the remit of the existing All-in register to include all families who wish to register on it.

All SSCB training takes account of all children with additional vulnerabilities including the needs of disabled children.

Where possible, disabled children have been included in the multi-agency case file audits, dependent on the theme and available case sample.

6.3 PRIVATE FOSTERING

During 2016-2017 Shropshire Council reported on private fostering arrangements during the previous year. The report provided assurance that the 7 National Minimum Standards for Private Fostering are being met. Numbers of private fostering arrangements in Shropshire are still low (13 arrangements during the year) and detailed areas for further development include:

- Raising awareness across agencies about the duty to report
- Gaining feedback from children/young people who are privately fostered
- Promoting single agency training on private fostering
- Promote understanding and awareness of private fostering across schools.

6.4 CASE REVIEWS

The SSCB carries out case reviews when it is felt that a case meets the criteria for either a Serious Case Review (SCR) or it is deemed that lessons can be learnt about the ways in which agencies work together to safeguard the child.

A number of different models are used for case reviews including the SCIE Learning Together approach, Root Cause Analysis (RCA), hybrid models and deep dive audits.

SSCB considered the learning from a Domestic Homicide Review undertaken by the Community Safety Partnership. The case centered around domestic abuse and historic concerns when the child of the family was known to Children's Social Care. As a result of the review SSCB has revised and re-launched its escalation policy.

In 2016-2017 SSCB sought advice from the National Panel and then commissioned an SCR on an Unaccompanied Asylum Seeking Child. The learning from this SCR will be reported in the 2017-2018 annual report. A

learning review utilising a Root Cause Analysis methodology was completed in this year and the learning is summarized below.

6.4.1 RCA LEARNING

SSCB undertook an RCA which focused on the care arrangements for a young person with complex mental health issues, self-harming behavior and suicidal ideation. The review looked at the robustness of care planning and information sharing between a number of different health provisions and the interface with Children's Social Care.

Learning and considerations for practice:

- Intervention was more often reactive and not linked to any care plan based on comprehensive assessment.
- "Someone else will be doing it syndrome." The case that was reviewed lacked a clear understanding of who/ which agency was taking the lead. As the report concluded this is essential for "clear oversight of plans, that plans are monitored and agreed and all safeguarding issues and plans are regularly reviewed to keep children safe".

Improvements to practice as a result of the RCA include:

- A procedure and guidance around the application of section 117 of the Metal Health Act 1983, regarding multi agency planning of after care.
- The development of the use of CETR (Care, Education and Treatment Review).
- RAID (Rapid Assessment, Intervention and Progression) services in hospitals to support care for 16-18 year olds earlier.

6.4.2 PROGRESS AGAINST SCR ACTION PLAN FOR CHILDREN A & B:

SSCB continues to embed learning and evidence its impact in relation to the SCR for Children A & B, published in November 2015. This has included:

- Briefings on the learning from the SCR, attended by 80 practitioners and managers.
- Revision of the SSCB Neglect Strategy and introduction of the Graded Care Profile 2 – see Neglect section on page 12.
- Biannual SSCB Conference on the theme of Childhood Neglect, 130 practitioners and managers attended.
- Improvements have been made to strategy discussions/meetings to ensure Health colleagues are represented.
- Improvements in the scrutiny and effectiveness of core groups in progressing child protection plans, through case conference observations and regular auditing of core groups.
- SSCB sighted on risk pertaining to service re-design within agencies following the introduction of the SSCB Safeguarding Impact Assessment.

The use of the Safeguarding Impact Assessment Form has enabled the SSCB to provide challenge to West Mercia Police regarding their proposed re-organisation. As a result the Single Investigative model has been put on hold within Shropshire whilst assurances are sought from pilots in other LSCB areas.

6.5 MULTI-AGENCY TRAINING

In total from April 2016 to March 2017 the SSCB has delivered 62 multi-agency Universal and Targeted training sessions to 1103 learners. In addition e-learning modules were taken up by 389 learners.

Training Pool membership continues to be highly valued and as of April 2017 there were 67 trainers in SSCB Multi-agency Training Pool. However numbers are constantly fluctuating with changes in the workforce and this represents a decrease of 23 trainers since last year.
The use of SSCB Peer Training Observations has been encouraged for professional and personal development and feedback from trainers has included:

"I found this helpful to direct thinking before the training and it enabled me to focus my thinking around observing delivery. Also supported our thinking post training, in identifying what went well and areas to focus on more next time." Shropshire Council

"We found it really useful to gain insight into how we were perceived, our style and how the training comes across." Housing Officers

"I found the form very useful for my own development." Independent business

More agencies are reporting increased single agency safeguarding training activity in line with the SSCB Training Pathway, with 10,776 practitioners being trained.

To further ensure effectiveness of the single agency training delivered SSCB will be requesting that agencies include examples of qualitative data taken from learners evaluations.

Training evaluations demonstrate that SSCB is providing good quality training which is equipping the workforce with the right skills and knowledge to carry out their roles. This is evidenced further by triangulating with performance data which shows that appropriate referrals are being made and that thresholds are better understood.

The Developing Practice modules on the categories of abuse Emotional, Sexual, Physical Abuse and Neglect will be combined in a new module Protecting Children, Managing the Challenge which will be reported on in 2017/18.

Skills Training on Risk Management (STORM) which focusses on managing the risk of suicide continues to be delivered and now also includes Self-Harm Mitigation. Through partnership working with Public Health, SSCB has received funding from the CaMHS Transformation Fund to deliver 9 sessions to 91 learners with a further 28 learners attending self-harm mitigation update sessions.

Impact evaluations are completed three months after attending training to evidence the impact training has had on practice. The response rate has risen this year to 67%.

Of learners who submitted impact evaluations:

- 96% said that the training they attended was effective in meeting their expectations and needs.
- 95% said that the training was effective in increasing their confidence in the subject matter.

What SSCB will do next:

- Review the Training Strategy

- Monitor the effectiveness of GCP 2 training

- Deliver and evaluate Specialist Learning events to include:
  - Multi-agency CSE Strategy Briefings
  - Magistrates conference on Domestic Abuse
  - Public Protection Learning Event for Licensed Premises
  - New Training Module – Protecting Children, Managing the Challenge.
  - Consolidate SSCB Train the Trainer module into 2 days to reflect professional's capacity to attend.

The full SSCB Multi-agency Training Report can be found on the SSCB website.

6.6 CHILD DEATH OVERVIEW PANEL

SSCB's Child Death Overview Panel is conducted jointly with Telford and Wrekin LSCB. It facilitates multi-agency reviews to understand the causes of all child deaths and learn lessons to prevent future deaths and safeguard and promote children's welfare.

The CDOP considers the death of each child, and is required to complete a national proforma regarding its findings for each child. The proforma includes factors relating to the child and family, and service provision; categorisation of the cause of death; a judgment regarding whether there were modifiable factors; learning points and recommendations; immediate follow up actions for the family and whether the case should be referred to the SSCB Learning and Improvement sub-group for consideration of a Serious Case Review or Learning Review.

There were 21 child deaths reported in Shropshire in 2016-17. This is a 50% increase on last year's figures.

Developments during 2016-2017 have included:

- Regional CDOP group has been re-established.
- 47 practitioners/foster carers attended a Safer Sleep event in February 2017.
- The LeDeR process is followed by CDOP for deaths of children aged 4-18 years old with a learning disability.
- Dedicated neonatal CDOP Panels are attended by a Consultant Neonatologist.

Future development of Child Death Overview Panels

It has now been 8 years since CDOP Panels were first formed and the Wood Review included a review of CDOP Panels as well as LSCBs.

Key points in the Wood Review relating to CDOP:

- Child death reviews should continue to be hosted within local multi-agency arrangements but CDOPs should be hosted within the NHS, and that ownership of the arrangements for supporting CDOPs should move from the Department for Education to the Department of Health.
- National child death database should be set up as soon as possible
- Child deaths need to be reviewed over a larger population size
- Consideration to be given to establishing a national-regional model for child death overview panels (CDOPs)
- Transfer national oversight of CDOPs from the DfE to DoH, whilst maintaining links with necessary child protection agencies

These recommendations have been welcomed by the CDOP Panel and together with the anticipated publication of the updated Kennedy Report in the autumn

of 2016, will provide the opportunity to review the responsibilities and function of the CDOP Panels, locally and regionally/nationally.

6.7 MANAGING ALLEGATIONS AGAINST PROFESSIONALS

"LSCBs have responsibility for ensuring there are effective inter-agency procedures in place for dealing with allegations against people who work with children, and monitoring and evaluating the effectiveness of those procedures"

Working Together to Safeguard Children, 2015

The SSCB receives an annual report from the Local Authority Designated Officer (LADO) which this year evidenced that the number of LADO contacts has shown a steady increase (8%) from the previous year.

The majority of referrals relate to private care providers (44%), with education settings being the second largest referral group (28%). Referrals from other sectors are all less than 7% of the total referrals.

No referrals have currently been received from the police. This is an internal issue within their reporting and complaints procedures and is being addressed with West Mercia Police.

There has again been a significant rise in the number of police investigations which have taken place as the result of a LADO referral (25% on last year's figure). The introduction of the Compass team in Shropshire, has enabled timely and targeted information sharing to take place.

Outcomes

The majority of cases dealt with have an unsubstantiated outcome (61%). Despite this, safer working practice issues are often identified during the process of an investigation.

Almost 30% of referrals are substantiated. This is a larger percentage than in previous years. Around half of substantiated allegations have resulted in dismissal with only 35% leading to a DBS referral where it is felt there is evidence to indicate that a person is not suitable to work with children in the future.

Cases are being dealt with within the timescales outlined in Working Together 2015, with over 80% of cases being resolved within one month and 90% being resolved within 3 months.

The West Midlands LADO network convened a LADO conference in 2017, part funded by SSCB.

Areas for improvement include:

Data Collation

There is a significant issue regarding referrals which relate to serving police officers. No referrals have been made by the police about their own employees. There is a reluctance to share personal information about their own employees, due to personal safety, which prevents checks being undertaken in LADO cases. This is being addressed with West Mercia Police Professionals Standards Department.

Private Providers

The number of referrals involving private care providers remains very high. There is evidence that some private care managers lack the confidence to apply the thresholds guidance and manage cases internally. Positive working relationships do exist with private care providers and work is ongoing to address this area.

Agency staff

There are difficulties in managing safeguarding issues when there are no formal disciplinary processes in place and there remain significant loopholes in recruitment processes.

Timescales

Data needs to be used to challenge particular sectors regarding timely responses.

Taxis

There is a need to strengthen the safeguarding processes between Passenger Transport and Licensing.

6.8 PARTICIPATING IN THE PLANNING OF SERVICES

The SSCB works with other multi-agency partnerships working in Shropshire to improve outcomes for Shropshire's communities. The partnerships which interface most closely with the Safeguarding Children Board are described below.

The Health and Wellbeing Board is responsible for the development and delivery of the Health and Wellbeing Strategy. Established and hosted by local authorities, Health and Wellbeing Boards bring together the NHS, public health, adult social care and children's services, including elected representatives and Local Healthwatch, to plan how best to meet the needs of their local population and tackle local inequalities in health including early help for families http://www.shropshiretogether.org.uk/

Shropshire's Children's Trust leads the elements of the Health and Wellbeing Strategy focused on children. It commissions services for children and families, including early help services.

Organisations which comprise the **Safer Stronger Communities Partnership** work together to protect their local communities from crime and to help people feel safer. They work out how to deal with local issues like antisocial behaviour, domestic abuse, drug or alcohol misuse and reoffending. They annually assess local crime priorities and consult partners and the local community about how to deal with them.

The overarching purpose of the **Keeping Adults Safe in Shropshire Board** is to help and safeguard adults with care and support needs. It leads adult safeguarding arrangements across its locality and oversees and coordinates the effectiveness of the safeguarding work of its member and partner agencies. There are a number of areas of overlap with the SSCB, both in relation to the transition of vulnerable young people to adulthood, and also in respect of adults with care and support needs who are parents and carers of children.

These five partnerships make up what is known locally as the **Pentagon of Partnerships.** Chairs and Business Managers of the five partnerships meet once per quarter to ensure that priorities and work programmes are aligned across each of the Partnership Boards, to ensure effectiveness and efficiency whilst also reducing duplication.

Pentagon of Partnerships - Domestic Abuse:

In March 2016 the Pentagon of Partnerships held a domestic abuse conference to inform the revision of the New Safer Shropshire Multi-Agency Domestic Strategy 2017-2020. The event looked at the findings of the Domestic Abuse needs assessment, considered local cases and the findings from Shropshire's Domestic Homicide Review.

Pentagon of Partnerships - Mental Health:

Work is ongoing to progress the Mental Health Needs Assessment which identifies the trends, patterns, service provision and qualitative feedback through engagement with people who have experienced mental health illness in Shropshire. This will be completed in early 2018.

In the meantime the Mental Health Partnership Board has developed a 12 month action plan to progress the Mental Health agenda prior to the development of a multi-agency, all-age Mental Health Strategy informed by the Mental Health Needs Assessment.

7 EFFECTIVENESS OF MULTI-AGENCY SAFEGUARDING ARRANGEMENTS

The SSCB draws on evidence from a number of sources to evaluate the effectiveness of the safeguarding system throughout the child's journey. These include reviewing data, receiving assurance reports from agencies, viewing external reports from inspectors, peer reviews, etc... carrying out audits, and reviewing cases. Increasingly, the Board seeks the feedback from the children and families who use its services to inform its assessments.

AUDIT FRAMEWORK

A framework for audit has been developed to build a cumulative picture of practice, share good practice and plan for further improvement where needed. The overall aim of the audit programme is to ensure that agencies' safeguarding work is effective and of high quality, demonstrates continuous improvement and results in consistently good outcomes for children.

The framework sets out three tiers of activity – oversight and analysis, practice, and compliance. The associated tools enable a better capture of this information:

Oversight and Analysis

- Multi-agency audit;
- Deep dive;
- Audit is undertaken by relevant Quality Assurance & Performance subgroup members and frontline practitioners, every quarter on a themed basis.

Practice

- This involves evaluating how effectively services are embedding safeguarding practices and integrated working into the delivery of safeguarding children;
- Outcome focused;
- Multi-agency findings and learning are reported to QAP and to the SSCB Executive through agency assurance reports.

Compliance

- Compliance is interwoven across all of the tiers of the quality assurance and audit framework;
- Section 11 audits - Section 11 of the Children Act (2004) imposes a duty on specified agencies to ensure that their safeguarding work complies with the requirements laid out in the statutory guidance "Making arrangements to safeguard and promote the welfare of children".

The list of key performance indicators to be considered for inclusion on the SSCB scorecard has been reviewed and a 'dashboard' developed of key performance information which is presented at each Board meeting, supported by an exception report highlighting key areas for the attention of partners.

Performance information is included that reflects:

- SSCB's priorities for 2015 – 2018;

- The Children's Safeguarding Performance Information Framework (DfE, 2015);
- Framework and Evaluation Schedule for the inspections of services for children in need of help and protection, children looked after and care leavers. Reviews of Local Safeguarding Children Boards (Ofsted, 2014/17);
- Proposals from the West Midlands Improvement and Efficiency Board;
- Partnership working activity

SECTION 11 AUDIT

This year SSCB has focused on quality assurance of the Section 11 audit returns, (including Section 175/157 audits from Education), that were reported to SSCB in February 2016.

A peer challenge and reflection session took place for statutory partners in January 2017. The session focused on:

- The quality of the audits completed
- Reflection on the section 11 audit process
- A small number of the elements of the audit exploring:
    - Evidence provided to justify comments and ratings
    - Seeking further evidence through the peer challenge session
    - Identify examples where evidence is good, and where it is not so good, to support learning for future audits.

The quality assurance session looked at three questions from the completed section 11 audits:

- How clearly are your responsibilities towards children communicated to staff?
- How effectively does service development take account of the need to safeguard and promote welfare of children and is informed, where appropriate, by the views of children and families?
- How effective are your arrangements for Information sharing?

Findings from the quality assurance exercise led to the following recommendations:

- Safeguarding Children Impact Assessments should be carried out whenever agencies are considering changes in services, policies, process, practice etc.
- Agencies should consider whether it is appropriate to have child friendly complaints/ compliments processes.
- Consideration to be given to how/whether it is appropriate to involve young people in service user/critical friend type panels.

What SSCB will do next:

- There is enough evidence to suggest that the traditional Section 11 audit is not universally completed well enough to be of full value, and actions are not robust enough. The proposed electronic audit tool will enable flexibility of use. For example only auditing certain sections at any one time.
- When providing assurance reporting agencies should consider how they can provide good evidence to support their self-assessment.
- Consideration will be given to Assurance Reporting in another format (i.e. agencies not completing both a Section 11 audit and an Assurance Report).

Regional development work:

The West Midlands Regional LSCB Chairs commissioned a regional task and finish group to develop a consistent approach to Section 11 audits across the West Midlands.

Phase 1 of the project considered regional and local good practice across the section 11 tools and guidance set out by Working Together 2015. The audit tool has been revised so that it is consistent with the approach of other LSCBs in the West Midlands region to provide comparative analysis and potential regional themes and to aid those partner agencies that span more than one LSCB. The new audit tool details specific standards and grade descriptors and focuses on the seven safeguarding arrangements that organisations should have in place as per Working Together 2015 guidance.

Phase 2 of the project to consider an IT solution to support partners to collect and evaluate the data and produce an action plan for those areas requiring development.

SSCB has purchased an online auditing tool to facilitate the ease of completion and analysis of the Section 11 audits, freeing up capacity to focus on quality assurance. The Quality Assurance and Performance sub-group have agreed to pilot 3 standards of the new Section 11 audit tool in 2017 -2018 to ensure that there is also capacity for effective quality assurance of those standards, which are:

- Policies and procedures – to assess the effectiveness of the new West Midlands Safeguarding Procedures and how agencies are using them and disseminating procedures to staff.

- Information sharing, communication and confidentiality – to triangulate evidence from multi-agency audits to demonstrate that information sharing is working well in Shropshire.

- Listening to children and young people – to gather further evidence of agency's commitments to ascertaining the views of children and young people and using this to design their services and ensure they are child focused

QUALITY ASSURANCE AND PERFORMANCE DASHBOARD

The Quality Assurance and Performance Dashboard enables the LSCB to be sighted on performance information by exception with regular reporting of a core dataset and themed performance information. Interrogation of the data allows the LSCB to identify points in the system that may require improvement or further exploration and often leads to the commissioning of assurance reports, single or multi-agency audits. The Quality Assurance and Performance sub-group has recently revised measures and created scorecards for each of the SSCB priority areas.

Information provided through this method concerning the Child's Journey through the system includes the following (N.B. All England comparisons for 2016 in green, rates per 10k in brackets):

- 554 Early Help Family Assessments were completed
- As of end of March 2017, 540 families were being supported at a targeted Early Help level
- 1416 referrals were received by Children's Social Care 238.8 compared to a national rate of 532.2 (2016). 0.9% resulted in no further action compared to a national rate of 9.9% (2016)
- 65% Social Work Assessments were completed within 45 days, compared to 60.6% in 2015/16. This is lower than the national rate of 83.4% (2016)

- The rate of 'Section 47' child protection investigations has increased from 107.9 per 10,000 in 2015/16 to 111.6 in 2016/17 compared to national rate of 147.5 (2016)
- 90.2% of initial child protection conferences were held within 15 working days (77.5%)
- 240 children were subject of a child protection plan at end March 17, (40.5), compared to a national rate of 43.1 (2016)
- 1.3% of child protection plans lasted for 2 years or more at end March 17 compared to a national rate of 2.1% (2016)
- 10.5% of children were subject of a child protection plan for a second or subsequent time within 2 years – an increase on the previous year's figure of 4.5% but similar to rates in previous years
- There were 291 looked after children an increase of 3.9% on the previous year's figure. The rate per 10,000 children was (49.1), compared to national rate of 60 (2016)
- 53.8 per 10,000 offences against children were reported – a rise from 44 per 10,000 the previous year.
- 49 children had been exposed to domestic abuse 3+ times and 7 children exposed to domestic abuse 5+ times as of end of March 2017.
- 56 new CSE referrals and 39 repeat referrals or reviews of cases heard at CSE Panel. (a 30% decrease in referrals compared to 2015-2016)

SSCB has recognized that Early Help data is not currently available by category of abuse or by SSCB priority area. This is an area for development in 2017-2018 to ensure that SSCB can measure effectiveness across all of its priority areas and all categories of abuse throughout the whole system. The Early Help Service is currently in the process of developing a revised performance framework and the SSCB Executive Group advised on the need to understand the impact of early help in outcomes for children around the SSCB priorities.

MULTI-AGENCY CASE FILE AUDITS

In addition to the multi-agency case file audits on the priority areas of the SSCB the following two multi-agency audits have also taken place:

Core Groups

The SSCB QAP Sub-Group conducted a multi-agency audit in November 2016 with specific emphasis on multi-agency effectiveness across core group activity. The overall purpose of the audit was to consider compliance with multi-agency procedures in relation to partnership working and information sharing linked to the planning process for children and young people, as identified as an area for improvement within the SCR published in November 2015.

The recommendations from the audit were as follows:

1. All minutes of core group meetings to reflect the core group agenda and the headings given.

2. To ensure that at each core group meeting membership, attendance, progress against the child protection plan are discussed, considered and recorded, including how the plan is supporting outcomes for children.

3. Core group minutes to clearly state who holds parental responsibility for the child.

Since the audit progress has been made in respect of the effectiveness of core group working. Children's Social Care have also introduced a new step down process whereby parents and professionals feedback is sought when a child ceases to be on a child protection plan.

Child Mental Health Wellbeing Audit

A multi-agency audit was undertaken on children with emotional and mental health needs as a result of an increasing number of child deaths due to deliberate self-inflicted harm. The case sample was chosen from cases that were open to Child and Adolescent Mental Health Services, (CAMHs), whereby the young person had previously attempted suicide or had self-harmed.

The results indicated good multi agency working and effective use of ECINS. The report also demonstrated the schools very positive support for children with mental health issues and that some schools had even employed counsellors to support children's key workers.

There were some challenges noted around communication between agencies especially schools (not being made aware of safety plans) and information not been shared with Designated Leads in schools following A&E admissions.

Recommendations from the audit included:

1. Consideration to be given to a protocol for sharing discharge notifications with school designated safeguarding leads, in a proportionate way, following A&E attendance with self-harm/suicidal ideation.

2. All safety plans for young people must be shared with multi-agency partners who have a role in safeguarding the child to ensure that all professionals are aware of and are supporting the plan in accordance with the SSCB Self-harm and Suicide Prevention Care Pathways to enable a co-ordinated Early Help response.

3. To raise awareness of the young person's screening tool Substance Misuse and Risk Taking Early Referral (SMARTER), in particular the need to complete it for any young person where substance misuse is identified as a risk factor through the use of other assessment tools, even if this is does not appear to be the predominant risk.

The audit also highlighted a lack of referrals to the Shropshire Recovery Partnership (SRP) from CAMHs and Health Services. Due to the decline in referrals an assurance report will be requested from SRP to look at the issue of children attending A&E following substance misuse in more detail.

AGENCY ASSURANCE REPORTS

Partner agencies are required to produce an annual assurance report to the SSCB to evidence compliance, inform the SSCB of any learning from inspections, case reviews and audits and report on how outcomes have improved for children and young people. This allows the SSCB to challenge the arrangements, identify areas for improvement, monitor that work and then seek further assurance about sustained change. Agency assurance reports are presented to the SSCB Executive with a summary report being tabled at the full Board.

A summary of these assurance reports, together with other relevant information, is included in Appendix A.

CHALLENGE LOG

The SSCB administers a challenge log of all challenges posed to partner agencies and their response. This allows for tracking of issues that are pertinent to the Board and areas of particular risk.

During the course of the year the SSCB has presented a number of challenges to partner agencies and their responses are outlined below.

SSCB has further challenged the **Safer Stronger Communities Partnership** regarding the lack of a voluntary perpetrators programme which was again highlighted through a multi-agency audit on domestic abuse.

The Safer Stronger Communities Partnership reported back that in November 2016 the County Domestic Abuse Forum reviewed a proposal for the 'Strength to Change' training in working with perpetrators with a view to seek funding for the programme. The Shropshire Countywide Domestic Abuse Forum has been striving to bring about a cultural change in partners' response to domestic abuse through information, meetings, discussions and the 'Working with perpetrators' conference.

This was followed up with correspondence to the partnership which included intelligence that the SSCB had identified to inform the revision of the all age multi-agency Domestic Abuse Strategy 2017-2020. See domestic abuse section on page 15 for further details.

Shropshire Council were presented with a challenge from SSCB when two Health Visitors were removed from COMPASS on the basis that they could not access their electronic systems. SSCB was concerned that this would impact on the effectiveness of the domestic abuse triage and information sharing which was enhancing decision making. Following discussion with the Lead Commissioner in Public Health the issue was resolved with an IT solution being provided.

The SSCB Executive considered an assurance report from MAPPA which highlighted the risk whereby there is a culture in Children's Services to close cases at the point where an offender is sentenced to custody. This was of particular concern as some families choose to take children on prison visits and this is not always appropriate.

Children's Social Care acknowledged that on occasions it is appropriate that ongoing work is undertaken with a family even when the offender is sentenced to custody. Children's Social Care have not been made aware of any cases where it was felt that a child was being placed at risk by attending prison visits prior to the assurance report from MAPPA. No cases had been raised or formally escalated via the SSCB escalation policy. A briefing has been issued to social workers regarding consideration of the appropriateness of prison visits and to ensure that clear guidance is provided to the parent or carer.

West Mercia and Warwickshire Police were challenged regarding the potential implications of their proposed Single Investigative Model. This was following the agreement of the SSCB Executive with the concerns raised from the perspective of the LADO. These included:

- Established, trusting relationships between Protecting Vulnerable People (PVP) colleagues and the LADO would be lost.
- The current PVP model offers continuity within cases and assists in the identification of patterns.
- Expertise of PVP colleagues supports a sensitive response to safeguarding issues and to vulnerable children with complex needs.
- LADO issues would often not be seen as a priority within a generic CID case load.
- Resolution of cases would take longer, due to competing demands and shift patterns, having a detrimental impact not only on victims but also employees who may remain suspended for significant periods of time.

West Mercia and Warwickshire Police responded by suspending their plans to implement the Single Investigative Model in Shropshire with a view to reviewing the effectiveness of the proposed model following pilots elsewhere in the force area.

8 ENGAGEMENT OF CHILDREN AND YOUNG PEOPLE

Student LSCB

Developing the means of listening and responding to the voices of children and young people has been a particular commitment across the partnership.

The Student LSCB which comprises of members from the various further education colleges in Shropshire provides a mechanism for the voice of children and young people to be heard by SSCB. This includes evaluation of the work of the Board as well as having an influence on decision making.

The group delivered the SSCB Development Session for the Board in June 2016. This was an opportunity for the students to introduce themselves to the Board and explain their chosen priorities and what they planned to do over the coming year.

In 2016-2017 the group decided to focus on neglect and sex education (especially related to sexting and sexual abuse).

The students are looking at using the Harrow video on neglect for some development with young people in colleges and schools. Two of the students also attended the SSCB Neglect Conference in 2016.

The students reported to the Board that they were aware that young people would like to be taught more than basic sex education, for example same sex relationships, as well as how issues can affect their emotional health.

The Board members agreed that if the PSHE curriculum was not saying the right things at the right time, then it will not achieve the desired outcomes.

In order to take their work on this area forward they are working in conjunction with the Public Health Curriculum Advisor and have agreed to:

1. Encourage support in their colleges for the 'It's My Right' campaign (for PSHE to be made statutory in schools). The idea is to work with Tutorial leads to ensure that the campaign petition is considered and signed by the students in their settings. They will also contact PSHE leads in schools to ask them to consider encouraging students to sign.
2. Ascertain whether the PSHE leads in schools are Senior Managers and whether they report to governors and to encourage this good practice where it is not taking place.
3. Complete an audit of the 2016 Young Person's Charter with PSHE leads, to see if they are in agreement with the priorities of young people in Shropshire.
4. Contribute to the National Policy Briefing session in Shropshire in 2017.
5. Contribute to discussions with 16-19 PSHE leads on the guidance provided in schools and colleges in Shropshire and work with professionals on development in this area.
6. Develop a tutorial session for 16-19 year old students for delivery across the county.

8.1 HOW AGENCIES HAVE ENGAGED WITH CHILDREN AND YOUNG PEOPLE

The following agencies highlighted their engagement with children and young people in their agency assurance reports as follows:

Youth Justice Service

The Youth Justice Service works directly with young people in conflict with the law. A Viewpoint survey of 76 service users conducted in 2015/16 showed that:-

- 88% felt the YJS had made them less likely to offend
- 93% felt they had been treated fairly most or all of the time
- 97% felt the service given to them was good or very good

- 88% felt YJS took their views seriously

Shropshire Council

Improvements have been made in hearing the experience of the child and parent. There has been an overall reduction in complaints during 2016-2017 with approximately 61 complaints and 21 compliments received.

Children's Social Care are in the process of establishing a Service User Board to coordinate, oversee how they engage service users, and learn from their feedback.

In response to Children's Commissioner's Takeover Challenge, Shropshire Council hosted its first "Take Over Day" in October 2016. The Takeover Day Challenge was a fun, successful and exciting opportunity which saw Shropshire Council opening their doors to children and young people to take over adult roles. It put children and young people alongside decision-making positions and encouraged us to hear their views.

Looked After Children (LAC) Reviews

There continues to be a high level of participation by young people in their LAC reviews and Independent Reviewing Officer's (IROs) report that around 70-80% of children and young people aged over four years actively attend and participate in their review meetings and IROs in Shropshire promote this happening.

Children and young people are also invited to complete a consultation document prior to their review. The small number of children and young people who did this reported a number of positives over the course of the year as below in relation to the care planning arrangements for them and also areas for follow up:

- They are happy in their placement
- They get on with their social worker
- They see their social worker often enough
- They are listened to in their placement
- Children and young people report being involved in activities and are healthy
- Want to see their parents more often
- Children and young people report a number of positives around school and education

Children's participation can take place at several levels e.g. through personal attendance in an effective and meaningful manner, holding meetings in 2 parts, through completion of consultation documents, through separate meetings or conversations with IRO's and the use of an advocacy service.

Care Leavers Forum and New Belongings

New Belongings was instigated by the Care Leavers' Foundation and involves a team of care leavers and others working with councils to improve services for young people in care.

- 5 young care leavers attended the initial New Belonging's training and 2 Shropshire New belongings Ambassadors attended the New Belongings national conference.
- In May 2016 the New Belonging's Ambassadors delivered their 'Have your say' workshop event and have sent out 100 questionnaires to young care leavers with 19 completed returns.
- In August 2016 New Belonging's ambassadors met and spent the day with the Care Council Crew to develop links and get their views on leaving care.

The New Belongings Ambassadors gave a presentation to Corporate Parenting Panel in December 2016 on their work so far and the outcomes of consultation.

The issues identified ranged from better opportunities needed to help transition from care to independence, access to quicker support when things go wrong, employment/training/apprenticeship opportunities, an improved pledge to care leavers, and access to a drop in service.

Voice and Engagement

In 2016 the police piloted a Citizen Programme aimed at Shropshire Looked After Children between the ages of 11-14 years old. The young people involved work towards an award and had input on a range of subjects including road safety, first aid and healthy relationships.

LAC Celebration Event

In consultation with young people the event was moved to the Buttermarket for a more "party style" evening. All children had glow in the dark bangles on arrival and the food was jumbo hot dog, chips and salsa.

The entertainment was provided by Shropshire looked after children who had taken part in the summer band building programme. This is provided through the Virtual school Arts Offer in conjunction with The Hive.

In January 2017 a survey was launched to gain the views and experiences of Children in Care (age 4-18) which was commissioned through the Bright Spots project (a partnership between Coram Voice and Bristol University). They developed the *Your life, your care survey* - A tool, grounded in research and comparable to national data sets, to explore children's care experience and well-being based on what they say is important.

A Question Time event was held in February 2017 which has resulted in the Corporate Parenting panel planning a workshop to progress the issues that had been identified; exploring a training flat, drop in facilities for care leavers, bus and leisure passes.

The Advocacy and Independent Visiting Service reported to the Corporate Parenting Panel throughout the year. This reporting has included a powerful account from a young person of the importance and difference made by having an Independent Visitor.

Early Help

A child journey audit of 16 cases found that with regards to the child voice being present throughout early help support:

- 6% of cases were outstanding
- 38% of cases were good
- 38% of cases require improvement
- 19% of cases were inadequate

The audit findings commented that the voice of the child is generally well represented and thoughtful and reflective practice is evident. There is excellent inference of pre-verbal children and older children often engaging well with workers. A range of tools are used to help elicit wishes, feelings and views to understand experience better, however, it is not always clear how this translates to plans or how it is responded to and is not consistent practice.

A number of children and young people have provided feedback on Early Help support they have received and have made the following comments:

"Without the support I received from you I can't imagine where I would be with regards to the relationship I have with my mum, the way I manage certain situations and the overall view I have of myself. You've helped me realise how to deal with a lot of very different things and I appreciate every bit of time you spent listening to me and all the advice you gave. You always made me feel equal and respected" (Targeted Youth Support)

[Targeted youth support worker] has supported me through times when I have felt I couldn't cope with any situation and managed to get me through it. I feel so much better about myself and the way I see things and I couldn't of done it without [him]" (Targeted Youth Support)

'Made some emotional but effective progress. Just having an outside voice has moved things along and made us more aware of each other's feelings.' (Enhance)

'Our lives have changed so much. We are busy living not dying. We speak rather than shout, we love rather than fight, we kiss and make up. We respect each other' (EnHance)

9 CONCLUSION AND LOOKING FORWARD

Evidence suggests that Shropshire agencies are generally effective in keeping children safe across Shropshire, and that more children and families are receiving help at an earlier stage. We have seen a significant reduction in the number of referrals to Children's Social Care as a result of ensuring that children and families receive early help to meet their needs. We have also seen a reduction in the number of repeat referrals which evidences robust decision making and effective step down processes. Overall, there is also a reduction in children within the child protection system. However, numbers of looked after children have increased by 3.9%, partly due to the emerging challenges of accommodating unaccompanied asylum seeking children. Further development in strengthening families through early help services should assist with keeping children safe and improving their wellbeing without recourse to child protection and looked after processes.

The SSCB has worked hard to ensure that agencies work effectively together to keep children safe. Evidence presented suggests that this has generally been successful, with particularly positive impacts in key areas such as early help, neglect and CSE.

The SSCB monitors progress in achieving its strategic objectives against its Business Plan, subgroup work plans and learning review action plans. This is evidenced through performance data and findings from audit activity. Progress is regularly reviewed in Board meetings in order to identify where further improvements can be made.

The SSCB has provided many challenges to other partnerships/Boards and has sought assurances regarding the part they play in the safeguarding system. This has led to improvements within practice, multi-agency awareness raising and more effective multi-agency working throughout the system.

Performance measurement has demonstrated improvements in practice as a result of multi-agency audits and learning. Evidencing impact has been a challenge this year due to new ways of working, for example the introduction of family assessments, introduction of the GCP2 and revised processes and pathways in respect of responding to CSE. Plans are in place to monitor performance in these areas and evidence of impact will be reported in next year's annual report.

An identified area for improvement and challenge to partner agencies is improved data collection and analysis. For SSCB to be able to evidence impact effectively multi-agency data must be made available and be supported by a narrative from partner agencies. Meaningful data can then be interrogated with confidence and will provide the SSCB with robust performance data that can be used alongside audit findings and other learning in order to highlight good practice and identify areas for improvement.

Through its work with the Pentagon of Partnerships, the SSCB has made a significant impact by joint working on cross-cutting themes. By aligning resources, and avoiding duplication this approach will undoubtedly have a significant impact on improving practice and improving outcomes for young people and their families into the future.

Developing a consistent approach to hearing the voice of children and young people, parents/carers and professionals continues to be an area for development in 2017-2018. Good foundations have been put in place with the

development of a Student LSCB and developments are underway to routinely capture young people's views of CSE support services. In order to deliver effective safeguarding measures SSCB needs to continue to use this feedback effectively to influence service delivery and provide challenge to partners.

In terms of quality assurance the Board has strengthened its processes and is beginning to triangulate data with other partnership boards, incorporating service user feedback and audit findings. This will provide robust evidence of impact regarding the effectiveness of safeguarding systems and practice in Shropshire. Quality assurance reporting aligned to the journey of the child will build on SSCB's revised dataset to ensure that SSCB is able to evidence that children and young people receive the right service at the right time and evidence of impact against the Board's priorities can be effectively demonstrated.

In addition, in order to be truly effective, the SSCB has increasingly to work across boundaries with colleagues from other partnerships within Shropshire, and with other LSCB and LA areas. There is a much greater focus now on regionalised working and SSCB is engaged in a number of regional projects across the West Midlands as well as continuing to collaborate on pieces of work with the other three LSCBs within West Mercia.

The SSCB has long maintained a focus on looked after children placed within Shropshire from elsewhere. New challenges associated with unaccompanied asylum seeking children demand that this is further developed. Much work has been done between the Police and the Local Authority, including foster carers, which has resulted in improved practice and reduced safeguarding concerns for this population of young people.

With many partner agencies undergoing re-organisation the impact on reducing budgets to support safeguarding is considerable. The SSCB is having to make efficiency savings as a result of reduced contributions from partner agencies. For 2016-2017 this resulted in a review of the provision of multi-agency training to ensure that SSCB is not delivering a training offer beyond its means whilst still ensuring effectiveness.

The Board has begun to respond to findings from the Wood review of LSCBs and the new legislation of the Children and Social Work Act 2017. The SSCB Strategic Governance Group has begun to consider new local safeguarding arrangements, primarily with a review of the effectiveness of the SSCB Business Unit. The review has sought to streamline processes within both the LSCB and Adults Safeguarding Board Business Units by joining both units to maximize efficiencies and create more joined up working across safeguarding issues. As part of these developments a joint development day is planned with the Adult's Safeguarding Board for autumn 2017. A revised governance structure and meeting schedule for the SSCB will be implemented and further consideration will be given to new ways of working across the partnership to implement local safeguarding arrangements.

Effective working across partnerships will continue locally and will become increasingly more important, as will working collectively with other LSCBs on a regional basis in order to do things better together.

10 MESSAGE FROM THE INDEPENDENT CHAIR

In December 2016 Sally Halls stepped down as the Independent Chair of Shropshire's Safeguarding Children's Board and I took over. I wanted to take this opportunity to place on record the collective thanks of the board to Sally for her significant commitment and leadership throughout her tenure as the Independent Chair.

Ivan Powell

Interim SSCB Independent Chair

Appendix A: A summary of agency assurance reports

Public Protection

Public protection services in Shropshire are delivered by West Mercia Police, the National Probation Service, Warwickshire and West Mercia Community Rehabilitation Company, and West Mercia Youth Justice Service. All of these organisations work across a number of local authority and Local Safeguarding Children's Board (LSCB) areas, which has an impact on their capacity and resourcing.

West Mercia Police

West Mercia Police have reported the progress made in response to the 2015 PEEL inspection of vulnerability by HMIC, which found a number of areas required improvement. In relation to children missing, this has resulted in the removal of the 'low risk' and 'absent' categories for children, which is welcome. Implementation of the 'pathfinder model' is on hold in Shropshire and Telford & Wrekin following risks identified in other areas.

Improvements to national crime recording processes and measurement of outcomes has ensured that West Mercia Police are able to better understand the issues facing children and young people in Shropshire.

West Mercia Police was asked to share the findings of the forthcoming audit on the effectiveness of CSE provision in West Mercia and Warwickshire with the CSE subgroup and also to provide information to the Executive meeting in February 2017 regarding access by Shropshire young people to Sexual Assault Referral Centre services, in light of the decision to close down the facility in Wellington.

National Probation Service (NPS)

NPS reported on its responsibility and activity to safeguard children in Shropshire, including the findings of the most recent audit (undertaken in July 2015). This found most work to be of high quality. In addition, there has been a significant improvement in the timeliness of response by Children's Services to requests for information which contributes to safer decision-making in relation to risks posed by offenders. The identified area of risk concerns the inconsistency of PPRC (person posing a risk to children) responses, and work is underway to address and remedy this. Representation by NPS at the Quality Assurance and Performance sub-group has been addressed and a further NPS audit of safeguarding activity taking place in November 2016 will be reported on in due course.

Community Rehabilitation Company (CRC)

The CRC assurance report stated that good communication between NPS and CRC and with children's services have meant that complex challenges have not impacted too significantly on safeguarding in Shropshire, and work on the challenges has led to improvements. CRC staff attend the triage process at Compass.

As well as the financial challenges faced by CRC, audits have identified some areas for improvement and further development:

- Any significant events or changes in circumstances should result in further assessment or review.
- When domestic abuse perpetrators start new relationships, the offender manager needs to review the case to evidence if there are any new risk and actions.

The CRC reported that improved communication and information sharing between NPS and CRC, prompt allocation of cases and good quality assurance processes has enabled offender managers to manage and have oversight of

cases where children are at risk. Most cases audited which had child protection and safeguarding issues are of sufficient quality, but further work is required in developing a risk management and sentence plan. The service will undertake further audits in the future to evidence changes from these findings.

Youth Justice Service (YJS)

A new assessment and planning framework, Asset Plus is being rolled out nationally. The YJS reported that a central assessment and planning element in the framework is safety (safeguarding) and wellbeing. The YJS also implemented a new case management system; Staff have had extensive training and ongoing coaching on the new systems, and quality assurance processes and tools have been developed alongside the new framework.

There are a significant number of looked after young people on YJS caseloads, with a significant number of children from OLA. The YJS are supporting the Police Looked after Children decision making forum and are taking a lead in a protocol to reduce the offending by and criminalisation of looked after children. There has also been an increase of young people referred to the service for the first time.

The YJS have identified a number of areas for deep dive analysis: looked after children; harmful sexual behaviour; first time entrants to the youth justice system; young offender education; training and employment issues, re-offending.

From reviews carried out in the last 12 months, areas of good practice included:

- Young person appropriately diverted from Court
- YOS attending a multi-agency meeting (TAC) prior to the YJS intervention programme
- Young person consulted, views taken in to account
- Timely referral to substance misuse service.
- Learning points included:
  - Standard template should be used for recording all contacts
  - Assessment updates should be dated
  - Sharing plans and decisions with other agencies, to improve shared plans for managing risks.
  - Information should be sought from all possible agencies and sources when carrying out assessments.
  - Management oversight to be better recorded.

The areas of risk / challenge were noted as follows:

- Potential future budget pressures in 2017-18
- Increasing caseloads from July 2016
- Increasing numbers/rates of first time entrants across West Mercia
- High proportion of other authorities LAC requiring intensive intervention.

The areas for improvement are:

- Implementation of a revised performance and quality assurance framework
- Understanding the drivers behind the differential rates of FTEs across West Mercia
- Evaluation of the pilot bureau

Multi-Agency Public Protection Arrangements (MAPPA)

The most recent inspection of MAPPA by HMIC (published in October 2015) highlighted that some risk management plans were still not good enough and that the quality of MAPPA minutes was inconsistent. These are being addressed. The increased spread of referrals following the training arising from a recent discretionary SCR was welcomed, and the challenge of the large number of children placed within Shropshire from elsewhere noted.

A particular area of risk for West Mercia was the practice of closing cases in Children's Services when an offender is sentenced to custody. Requests are made at panel for some of those cases not to be closed as some families choose to take children on prison visits and this is not always appropriate. These concerns have been addressed and are reported on page 29.

SSCB was also asked to endorse the request for greater representation from Shropshire partner agencies to attend and contribute to the work of the MAPPA Performance and Standards subgroup.

Children's Social Care (CSC)

Children's Social Care reported the following outcomes of improvement against key performance indicators:

- More advice and support being provided through Early Help staff in Compass. There has been an increase of 28% of Initial Contacts progressing to Early Help in 2016-2017 from 2481 at Q4 2015-2016 to 3316 in Q4 in 2016-2017. This evidences the promotion of an Early Help Service where it is appropriate to do so, which provides a more proportionate response to partners and families in the offer of Early Help.

- A related 29.5% decrease in referrals being received in Q4 2016-2017 compared Q4 2015-2016, as well as an increase in the percentage of referrals moving to Social Work Assessment from 85% in March 2016 up to 98.8% in March 2017 which represents a more consistent application of the threshold document and ensures provision of the right service at the right time for families.

- Robust decision-making and effective step down arrangements means repeat referrals have dropped from 18.8% March 2016 down to 15.4 % March 2017 and is lower than the England and statistical neighbour averages.

- Improved joint decision making in Compass to agreed and shared thresholds has resulted in an increase in the number of Joint police/social care S47 enquires following strategy discussion, as a result of an audit and co-location. Joint investigations increased from 26.3% in March 2016 to 29.2% in March 2017.

- Improved timeliness of assessments has been achieved in Q4 2017. There have been serious delays in Social Work Assessments being completed in the maximum 45 day timescale, during the course of 2016-2017. In March 2016 60.6% of assessments had been completed in time, in comparison to 88.2 in April 2015. By May 2016, performance had dropped to 33.9%. This has been a key area of focus and at the end of Q4 64.3% of assessments have been completed within timescales, which is a cumulative figure.

- Number of Children Subject to Child Protection. Child protection numbers have been higher than England rates with the highest point in year being December 2015 when the figure stood at 46.3 per 10,000 reducing to 39.8 at March 2016.

- During the course of 2016- 2017, CSC have worked hard to progress effective child protection planning for all children. As at 31st March 2017, 240 children were subject of a Child Protection Plan. This is a reduction from 272 at 1st April 2016. There is also evidence that the quality of interventions is improving.

- Sustained outcomes for children through effective CP/Targeted Early Help interventions. We have seen an increase in the number of children subject to a second or subsequent plan, standing at 23.6%. This has already been an area of focus and CSC are now seeing a reduction in children subject to a child protection plan overall, as cases are now

stepping down for a period of Child in Need (CIN) planning before stepping down to CIN.

- Number of children in care. The number of children in the care of the Local Authority had fallen from 313 in March 2015 to 285 in March 2016 and was down to 279 in January 2017. However, at the end of March 2017 the figure stood at 290 children in the care of the local authority. This sudden increase was in part due to 10 unaccompanied minors arriving in Shropshire unexpectedly in March 2017.

- Appropriate action taken to safeguard There has been an increase for those in care who are subject to an interim care order or care order; 64% March 2016, up to 66% in March 2017.

- Number of Children in Need. Overall during the course of 2016-2017 numbers have remained stable, increasing from 238 open CIN cases to 240, as more children have been appropriately stepped down from a child protection plan to a child in need plan. There has also been a reduction in the number of CIN cases open for 9 months or more, reducing from 70% in June 2015 to 15% in March 2017.

- Improvement in hearing the experience of the child and parent. There has been an overall reduction in complaints in 2016-2017 with approximately 61 complaints and 21 compliments received. Learning from these complaints is shared with staff on a quarterly basis.

"We are working hard to improve the timeliness of our responses and in ensuring that children and families are receiving the right level of help at the right time. This has resulted in an increase in children and families receiving Early Help interventions and less referrals into Children's Social Care. Where it is appropriate for cases to step down to Early Help from Children's Social Care only a small percentage are returning as a repeat referral. This indicates that children are receiving the right level of intervention. We are focused on all open children receiving the level of services that reflect their needs and children are in the right part of the service. We remain focused on the quality of our social work practice and on ensuring that we are progressing plans and ensuring that we are proactively case managing all open cases to ensure there is no drift and delay within the system and that recording is timely and of good quality."

Independent Reviewing Officers (IRO):

The IRO assurance report for 2016-2017 is due to be received by the SSCB Executive in October 2017 and will be reported in the SSCB Annual Report 2017-2018.

Early Help

The Early Help Assurance Report for 2016-2017 highlighted the following:

Accessibility of Early Help consultations

- 77% of practitioners felt that early help social workers were accessible
- 44% of practitioners felt that CAHMS Primary Mental Health workers were accessible
- 86% felt that Targeted Youth Support workers were accessible

Over 70% of practitioners agreed that the support and systems provided by Strengthening Families through Early Help allowed them to promote the welfare of and safeguard children.

Outcomes for the family

65 (12%) of the 551 Family Webstar and Assessments had been reviewed by the end of April 2017.

At their last Webstar score review, overall:

- 67% of families had made improvement against their initial Webstar scores
- 17% had got worse
- 17% had stayed the same.

The greatest impact of early help support is on improvements in emotional mental health (56% of families improved) and parenting (53% of families improved).

The outcome where the least positive impact was seen was Housing (15% of families got worse).

Targeted early help outcomes

From September 2016 to March 2017, 70% (167) of early help targeted services cases closed with an outcome of "outcomes achieved" recorded.

3% closed due to escalation of needs to require social work involvement.

EnHance data shows that at closure 70% of families reported that they thought the support they had received had been fully effective with a further 21% of families saying that they thought the support had been partially effective. The most prevalent improvements are in behaviour and peer relationships in school, increased parental confidence and better communication and family relationships.

Sustained progress

From April 2016 to March 2017, 7% of social care referrals were recorded as having an early help intervention in the last 6 months.

Quality of early help assessments

The Targeted Early Help Case audit (50 cases) found that:

- 18% of cases (9) were good
- 70% of cases (35) required improvement
- 12% of cases (6) were inadequate

With regards to the quality of assessment the Targeted Early Help Case audit found that:

- 38% (19) assessments were good
- 50% (25) assessments required improvement
- 12% (6) assessments were inadequate

74% of assessments were considered timely, having been submitted at the time of referral, but there was little evidence of any assessments being added to as the intervention with a family progressed.

52% of assessments evidenced that the families had been appropriately involved in the assessment; the majority of cases appear to have been written in consultation with the mother.

Quality of planning and review

The targeted early help case audit (50 cases) found that:

44% of plans addressed all the needs identified within the assessment.

62% of cases had plans which were SMART.

56% of cases had plans which demonstrated multi-agency working.

50% of cases had carried out a review of the plan and 48% of these had recorded any impact or progress on the revised plan.

The Health Economy

An assurance report for 2015-2016 from the Health Economy was received by the Board during 2016-2017. Due to a change in the reporting schedule the Health Economy assurance report for 2016-2017 will not be received by the SSCB Executive until October 2017 and will be reported in the SSCB Annual Report for 2017-2018.

Education

The Education Assurance Report was full and comprehensive, covering Ofsted grading of schools; How education delivers its safeguarding objectives for schools; Findings from auditing; ongoing safeguarding support 2017-18; Training; Children missing education; Elective home education; Schools Safeguarding Group; representation at SSCB meetings; hate crime reporting; school attendance; exclusions.

Young people had contributed to the report; their voices had been included in the Section 9 and Section 11 audits, in fast track meetings, and in the 'All about me' section of the Education Health and Care Planning process. There were 31 permanent exclusions from education in 2016-2017. Locally there have been some issues around communication between some academy schools and the local authority, but not all. A protocol is being devised for academy schools.

A direct consultation report with schools with regards to concerns raised around safeguarding process will be presented to Children's Social Care and outcomes reported to the SSCB Executive.

With regards to the Elected Home Educated children, there are continuing concerns regarding the safeguarding of vulnerable children and young people, as they are invisible to agencies. Parents do not need to engage with the LA when home educating their children.

Schools undertake Section 9 and Section 157/175 audits on a rolling programme and outcomes are reported to the SSCB Executive.

Energize STW (Shropshire & Telford & Wrekin County Sports Partnership)

An assurance report was requested following recent concerns about historical child abuse in football, and to assure the board regarding safeguarding children in sport.

Recommendations and areas for consideration were:

- Safeguarding young talented athletes
- Supporting parents – through parent in sport week, which is due to be held in autumn 2017.

Energize STW run some safeguarding events; amend safeguarding policies within sport and share knowledge and best practice within sport.

Club Mark accreditation is a continuous measure, due to sports clubs having to renew every 2 years. The Club Matters website holds information relating to which clubs have achieved the Clubmark locally and is free to check.

Energize STW reported that it delivers its safeguarding objectives for children through:

- Sports safeguarding courses being delivered (78 individuals trained).
- Increased confidence of staff in delivering safeguarding cross the programmes. Incident reporting has increased (there have been staff surveys to measure confidence).
- Quality assurance checks of over 100 local deliverers safeguarding plans, to ensure they meet the funding standard.

- Energize will also be launching new Safeguarding Strategy and Safeguarding Vulnerable Adults Strategy, and revised guidance around recruitment in sport.

SSCB
Shropshire's Safeguarding Children Board
Child Protection
Keeping Children Safe From Harm

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