Annual Report 2014-15

Birmingham Safeguarding Children Board

Contents

Executive summary

This report does not have an Executive Summary, as this is set out in a separate Executive Summary Report, published at the same time but available as a short summary report that can "stand alone" or be used with this full report. It covers the whole of the full report and contains the same key messages, data and analysis. The contents include an introduction, and a section which sets the context and provides a strategic overview of safeguarding in the city in 2014-15. It addresses the effectiveness of safeguarding practice in the city and the effectiveness of the Safeguarding Children Board. It also covers all the statutory requirements of the annual report. Most importantly it contains the same analysis, summary and challenges as are set out in this full report.

Foreword

I am happy to present my third Birmingham Safeguarding Children Board Annual Report (2014-15) for publication. The report gives a full description and robust analysis of the activity of the Board collectively over that year.

As Chair of the Board from October 2011 the report covers my fourth year in the role, setting out the effectiveness of the Board itself and the effectiveness of the work of Board partners in safeguarding children and promoting their welfare in the city. The report presents a positive picture of progress over that year in most aspects of the Board's work. There is clear evidence that as a result of the hard work put in by the local authority, and all other partners to the Board, especially the NHS (in all its organisational forms) and West Midlands Police, children are safer in Birmingham, and the most vulnerable are getting a better response. In addition there is a lot of good work happening across the city, undertaken by front line professionals from every agency who are quietly 'getting on with the job' and doing above and beyond what is necessary to meet individual children's needs which should be recognised and celebrated. This is imperative if the children and young people of the city are to get the services they deserve, achieve their potential, remain safe and become fully rounded and responsible adults. I also continue to believe we owe it to the children of the city and their families and communities to be as open, honest and transparent as possible about our progress, our effectiveness and our inadequacies.

The report covers the first year of "Getting to Great", the Board's new Strategic Plan 2014-17 (Appendix 1). We have made steady progress across all our priorities and we can see the differences we are making for children and young people, their families and for the staff working with them. The new model for establishing how staff should respond to need, ('Right Services, Right Time'), and the Multi-Agency Safeguarding Hub (MASH) are both excellent examples of the changes we are making as is our much enhanced performance and quality assurance work. There is of course much more still to do. We are ambitious for the city's children. They deserve the best and we are central to helping the city's services be the best in the country rather than some of the worst. We need to build on the progress in 2014-15, increase pace, and taking action that is, if necessary, radical and innovative. The challenges ahead undoubtedly remain very great. In particular we need to support the great work underway to coordinate, extend and develop early help in the city, rapidly improve our responses to child sexual exploitation and address the issues for children who are missing from home, school, care and those children not receiving or accessing normal universal health, education or early years services. In addition we need to find much simpler ways to do things, different ways to become more effective on less money, to share our resources and do more together rather than separately. Most importantly we need to not only build the confidence of children, young people, their families and their communities that we can make them safer, we need to ensure that those children, young people, families and communities shape what we do, and challenge us to do better.

Jane Held
Independent Chair
Birmingham Safeguarding Children Board
2015

Part 1 – The effectiveness of safeguarding in Birmingham

1. Context and key facts about Birmingham

Birmingham, is the largest unitary authority in Europe with a population of 1,085,400 is one of the youngest, with approximately 280,000 0-17 year olds (312,000 0-19). It is one of the most diverse cities in the UK with almost 50% of the population from a Black and Minority Ethnic (BME) community. As a major regional city it has areas of considerable wealth and areas of great deprivation. 47.7% of the population is under 30 (nationally this averages at 36.8%) and 32.4% of children in the city are children living in poverty (nationally 20.1%). Infant mortality is 7.2 per 1,000 lives against a national average of 4.3. 23.4% of 10-11 year olds are obese (nationally this stands at 18.9%. 10% of babies born in Birmingham weigh less than 2.5kg compared with 7.5% in England as a whole. Six wards have child poverty levels that are better than the national average. The remaining 34 wards have poverty levels worse than the national average. However, 14 of these are better than Birmingham's average. In the worst ward child poverty levels reach 46.5%. The scale and size of Birmingham's challenges and the high proportion of children and families living in poverty creates significant creates significant difficulties in meeting the high levels of need for additional support. The annual Birmingham child wellbeing survey indicates that there are declining rates of physical health in children in the city and ongoing high levels of significant behaviour problems and emotional ill health. About 82% of children and young people report feeling safe at home, about 50% feel safe at school and about 45% feel safe in their neighbourhoods. The Birmingham Child Poverty Commission is working to understand how best to change the pattern and the impact of poverty in the city and is due to report in 2016.

In terms of complexity of services in December 2014 there were 441 schools in the city, comprising a mix of academies, free schools, and maintained schools. Of the total school population 34,088 have special educational needs. There are 73 children's centres (of three different types) and the 20 youth settings, based in areas of high levels of multiple indices of deprivation. 12,618 different young people aged 11-25 received a service and 64% of them were from BME backgrounds. The Youth Offending Service provided more than 8,833 programmes during the year. There are 3 Clinical Commissioning Groups (CCGs) in the city with 268 GP practices, with 1,096 GPs. The city is served by these plus five child development centres five Accident and Emergency Units and nine NHS trust hospitals. There are 10 BCC children's homes in the city. The Board estimates that the total workforce in daily contact with children and young people just in the statutory sector is above 85,000.

As a consequence outcomes for children and young people are very mixed. By the end of March 2015, 2,614 16-19 year olds were not in education, employment or training (NEET) (6.9%), there were 1,976 children in care and 1,251 children the subject of a child protection plan. 93.8% of care leavers were in suitable accommodation at the end of February 2015 and 67 out of 157 care leavers were NEET (figure 21).

The BSCB commissioned a full analysis of what life is like for most children in the city from the Department of Public Health in the council. The full report, "Understanding the needs of children and young people in Birmingham" is attached at appendix 3. The report provides a rich source of information from the data used to assess need.

Ethnicity, faith and diversity

In 2014-15, ethnicity, faith and diversity became a more dominant element of the work of the Board and of all its partners. Two major issues, one of which (Trojan Horse as it is known) sparked significant national and governmental attention, create concerns about how well children and young people from the wide and diverse range of communities in the city were safeguarded and getting their needs met and their wellbeing promoted. Whilst both these areas of concern were challenging, (i.e. The so-called "Trojan Horse" matter and the issues raised by national concern about radicalisation, travel to Syria, and the impact of this on the Prevent and Channel programmes) the impact has been investment into better meeting the needs of the communities affected, improved support to schools and significant improvements in awareness of the issues.

It Takes a City to Raise a Child

Commissioned and funded by Birmingham City Council, The Birmingham Commission for Children was run by The Children's Society. The Commission examined what life should be like for children and young people in Birmingham in ten years' time and how the city council and other organisations might go about making their vision for Birmingham's young

people a reality. The Commission listened to children's voices in a number of different ways.

Working with the Innovation Unit, they also heard the voices of communities in Sparkbrook and Longridge. The Commission took evidence from four different sources:

- Outputs from focus groups and a city-wide survey of children and young people undertaken by The Children's Society
- Detailed ethnographic work with families and communities in Longbridge and Sparkbrook by the Innovation Unit
- Seven public sessions with 41 representatives from statutory, voluntary and community organisations working with children and young people across the city
- Written submissions sent in response to an open call for views, and documents or publications provided by the contributors.

All of the voices of children in the city, the in-depth work with communities and the outcome of the Commission meetings were fed into the report, "It Takes a City to Raise a Child" published in October 2014.

Key messages from children and young people were that:

- Relationships are the most important thing in the lives of children and young people, especially relationships with their families.
- Children and young people from every group, and from every part of Birmingham, want to feel safer in the city. They feel they lack safe, affordable spaces and activities that allow them to be with friends and family.
- Children and young people want to have a say in the issues that matter to them, they want their voices to be heard and acted upon.
- Children were positive about school and valued the opportunities that education gave them.
- Young people wanted knowledge and skills that were useful for getting a job and being a good citizen. They valued their community and their sense of place.
- Children and young people wanted a positive story to be told about Birmingham and young people's achievements.

Key messages from families and communities were that:

- Families with young children were often in 'survival mode' and lacked the time, energy and resources for reflective parenting. Parenting skills and support need to be considered alongside improving the resources available to families.
- Families, in particular single parent families, were often socially isolated, and this tended to be driven by fear – of crime, of difference, and of judgment.
- Trusted and confidence-building relationships were the way out of this social isolation.
- All the families had aspirations, for some that meant work, while for others it meant focusing on bringing up their children. Effective services work both to understand where parents are, and where they want to be.
- As children got older, parents found it harder to help with schoolwork and many parents found it challenging to support teenage children with their education.
- Young people wanted more spaces in which to socialise outside school.
- Religious spaces and institutions were safe places and could be used more.

The Commission report made a range of recommendations for the Council, working with its partners, as follows:

1. Embed children and young people's voice into decision-making through the council's 10 district structure
2. Bring people together at a neighbourhood level to improve children's access to, and their perception of safety in, local parks and open spaces
3. Harness the city's assets to give enriching experiences to children through their school curriculum, and genuine skills and experience to prepare for work
4. Tell a positive story about Birmingham's children and young people
5. Harness community resources to support the community's children and families
6. Lead in the development of an early help strategy, which shows how council, NHS and voluntary sector partners will work together to ensure vulnerable children, families and young people get the extra support they need.

It also set out a "suggested entitlement" for children and young people in the city which has not, as yet been adopted.

These recommendations were broadly accepted by the City Council and have informed the work undertaken on developing an Early Help Strategy and in the production of the City Council's Improvement Plan for Early Help and Children's Social Care 2015-2017. The Council Leader also included the issues identified as part of his strategic priorities for a fair, prosperous and democratic Birmingham.

In 2015-16 the BSCB Board will monitor progress generally by the council and its partners against these recommendations as well as against our formal performance data set and other scrutiny activity.

Participation, communication and engagement work across the city

The Board's collective work with partners in terms of listening to, engaging with and responding to children and young people's views, wishes, and experiences in 2014-15 continued to be limited. Despite this we became increasingly aware of the range, depth and breadth of work that was being done by different agencies across the city. In November 2014 work commenced to map agencies methods of engagement with children and young people. Once this work is completed in 2015-16, it will provide the Board with a fuller picture of the excellent work undertaken by the city to engage children and young people whilst providing the Board with a platform to engage children and young people in its work.

In November 2014 the Board were invited to and attended a youth conference called 'Protect Yourself'. All secondary schools in the Birmingham area were invited to send two pupils from year nine and above to the conference which was intended to gather young people's opinions on how agencies could appropriately meet the needs of young people and see what responses the city needed to make. The Board utilised the opportunity to capture the 'voice of the child' in relation to their perception around safety within the area they live. Out of the 13 key issues identified in relation to what makes young people feel unsafe; groups were highlighted as the highest concern. However, although the findings captured were from a relative small target audience, they clearly reinforce the key themes identified in the City Council's Child Wellbeing Survey 2013-14 (which was unfortunately discontinued in 2014-15) and forms part of the information collected to capture the 'voice of the child'.

In March 2015 the City Council, working with INLOGOV held the last of its series of "Think Tank" events and focussed on the voice of the child, the report of the Birmingham Commission and work across the city. The event addressed the question of "What is our commitment to listening to, hearing and acting on the voices of children and young people. Overall it was clear that during 2014-15 the collective amount of energy going into involving children and young people was significant, and it has in some limited cases had a strong impact on service provision. The major example of this was the excellent work done by Birmingham South Central Clinical Commissioning Group in relation to the development of and tender for the new Birth to 25s Mental Health Service. This engagement saw young people being involved in designing services, the selection criteria, writing questions for suppliers, attended the bidder events and then evaluating the bids.

The outcome from the event was agreement by all participant partners (all of whom are members of BSCB as well) to sign up to seven principles for engagement with and providing services to children, young people, and their families:

- We need to design services which respond to the public (as opposed to public services)
- Do nothing without us (design and deliver nothing without involving children and young people)
- Always act (never do nothing)
- Engage in an ongoing relationship (every contact counts and every contact is an opportunity)
- Embrace technology and new methodologies
- Listen, listen, listen!
- Recognise the opportunity of the experience for young participants ("giving back", "belonging" and "it's your city")

The conclusions from the event echoed the views of and key messages from children and young people in 2014-15. This message is that whatever is being undertaken needs to make a difference, that children and young people should benefit as individuals and that we as agencies embrace new ideas and be open to different views. These key messages will be taken into consideration when engaging children and young people in 2015-16 in the work of the Board.

Partner agencies engaged in a wide variety of ways with children and young people over the year. Some

key examples of work that has been undertaken around young people and participation within the Youth Service include:

#Youthengage: Shaping The Future Together was an engagement event for young people that looked at bringing young people together to discuss the issues that affect them. It was also about identifying priorities that would help BCC shape the future way that services would be delivered. A regional child sexual exploitation conference for young people took place in March and focused on raising awareness around CSE for young people. It helped shape the regional campaign. This event was organised by the Youth Service in partnership with West Midlands Police, Uprising and BCC. In addition the Youth Service have four Youth Commissioners who were elected by their peers to work as part (of a wider team to) with the Police and Crime Commissioner , police officers and key decision makers. Their role is to be the voice of young people through actively engaging and consulting with other young people in their local communities and ensuring their concerns and priorities are used to influence the planning and priority setting of the PCC.

West Midlands Police have begun the cultural changes needed to re-orientate officers as they deal with children and young people. Training inputs around the voice of the child have been delivered as result of a learning package entitled 'Improving Our Service to Children'. This was disseminated across West Midlands Police in March 2015. In addition, the Birmingham MASH ran a series of training events for staff to attend in both March and July 2015. Partnerships, Neighbourhood Teams and PCSOs attended from across Birmingham. In May 2015, awareness work took place around details of the Young Witness Initiative. Further awareness work around Early Help and Right Service, Right Time will be delivered in October 2015.

The NHS often struggles to engage with young people when it comes to mental health, but the development of digital tools at Birmingham and Solihull Mental Health Trust (BSMHFT) brings them practical advice and support and has put young people at the heart of service design and delivery. Through its Youthspace.me website BSMHFT has a track record of using digital channels to engage young people. Over the latter part of 2014-15 BSMHFT developed a suite of mobile phone apps co-designed by clinicians and young people affected by mental illness.

The first of these is 'Silver Linings', which encourages young people to self-manage psychosis and engage with their treatment to increase the chances of recovery. Silver Linings is about engaging them using a medium they are familiar with, empowering them on the road to recovery by better understanding and managing their illness. It works by users signing in, creating an avatar and answering a series of personalised questions about topics like their medication, mood, diet and wellbeing. It also involves 'gamification' which provides rewards the user for achieving goals set in the app in a similar way to video or computer games. The young person can keep a diary to track their medication, mood, wellbeing and build coping strategies. A smart algorithm is used so the app can provide feedback and advice, and track changes over time. By engaging patients in understanding what is triggering psychotic events and reminding them to take medication or attend appointments, Silver Linings can help symptomatic recovery. It is also designed so that young people can set goals to improve their self-esteem, helping with personal recovery. Through use of the app, treatment is extended away from the clinical setting, allowing the young person access to important advice and guidance from anywhere. The app also gives clinicians access, with the young person's permission, to data on the individual's mood and associated causes, helping them to have a fuller picture and tailor treatment accordingly. Silver Linings is being used by young people and will be followed by two more apps, 'Focus ADHD' and 'Building Resilience'.

It would be fair to say however that the Board did not progress its first key priority as far as it wished. The work is continuing into 2015-16.

The key challenge is to find ways of harnessing the energy and activity across the city in involving children and young people and build on that to inform, influence and set direction for the Board, as well as to find ways to directly engage with children and young people in the work of the Board.

A challenge for the City Council through the Place Directorate is to work with children, young people, communities and partner agencies to significantly reduce the expressed sense of being unsafe in public spaces articulated so strongly by the children and young people of the city.

2. Services and systems in Birmingham

Birmingham, change, churn and challenge

The whole of 2014-15 was (as was 2013-14) characterised by substantial change, in many of the statutory partner agencies, and, in particular West Midlands Police, the Probation service and the City Council, with the resultant churn in staff, services and stability of practice, and the challenges arising from such churn. Much of what happened during the first half of the year was imposed from outside Birmingham itself, with significant Central Government and Inspectorate activity taking place, often all at once. This meant that it was extremely difficult for partners to steer a steady course and build on the areas for improvement identified by the council and BSCB in 2013-14, and the additional and new requirements identified by Ofsted in their report. By the end of 2014-15 the City Council and its partners were dealing with the requirements set by Lord Warner, as the External Commissioner for Children's Services Improvement, Sir Mike Tomlinson Education Commissioner, and his Deputy Commissioner, Colin Diamond, all commissioned by the Department For Education, and those set for the whole of the City Council by Sir Robert Kerslake, commissioned by the Department for Communities and Local Government.

All of these external commissioners have required challenging, if necessary, improvement programmes which have stretched capacity and at times caused a degree of confusion, particularly for partners. They have also diffused focus at times and have made it challenging for BSCB in holding to account partners who are facing multiple agendas. They have also exposed just how complex safeguarding is across the system, and how challenging it is to deliver whole system improvement. Many of the partnership arrangements across the city have also been negatively affected in the short term, although by the end of 2014-15 a degree of coherence was beginning to appear especially in relation to Children's Services. As a consequence the BSCB has not been able to exercise as robust an external challenge function as it would have wanted to, and has relied more on the outcome of the challenges led by others

The impact of the External Commissioners for children's services, for education and for the council

Lord Warner was appointed by the Government as an External Commissioner to oversee the improvement programme following the Ofsted Inspection of March 2014. Over 2014-15 he reviewed the progress of the local authority in delivering its improvement plan, on a monthly basis. Whilst his focus was on the local authority he also reviewed and commented on the work of the BSCB and of partners. He expressed appropriate and accurate concerns about the BSCB's effectiveness in his second public report but did not require any specific actions of the Board. However, he asked some challenging and penetrating questions about whether an LSCB is necessarily the beast mechanism for delivering robust external and independent scrutiny and challenge of the so called "safeguarding system". This has led to considerable debate about the best way to achieve such scrutiny and challenge, reflecting debate at national as well as local level. His work did create a very strong impetus for improvement in the City Council, and specifically in children's services. Lord Warner withdrew at the end of the year, stating on 30 March 2015 that there had been "significant improvements" but more was needed. He concluded that children and young people were safer than they were in March 2014 but they were "not as safe as they could be". He also noted that the police, the NHS and the council were all working much better together.

The Director of Children's Services Report to the Education and Vulnerable Children Overview and Scrutiny Committee of 10 June 2015 summarised the progress made over the year 2014-15, set out a high level summary of risks and the actions being taken to continue to progress the improvement. It concluded that overall the improvement programme for children's social care and safeguarding was amber (70%-100% completion of all actions due by April 2015). This report was not presented to BSCB but the data utilised to support the report was congruent with that collected by the Board. This report indicated that five of the six risks identified by the Commissioner at the beginning of the year had been addressed successfully, although they required ongoing monitoring. (Appendix 4).

The report shows that the Children's Services Department made satisfactory progress with identifying and responding to unmet need and risk to children, in sorting its internal governance systems, in improving its partnership relationships, in achieving senior management stability and in increasing the adequacy of resources. A strong system of internal assurance to and including the Council Leader and Chief Executive was in place. Progress in terms of improving workforce capacity and capability was however limited. Although plans were in place to address this in 2015-16.

The work being led by BSCB in improving its relationship with schools was given significant additional emphasis during the year following the three separate independent inquiries into the so called "Trojan Horse" letters. However how this "fitted" with the externally driven work led by the second External Commissioner, Sir Mike Tomlinson and his Deputy Colin Diamond was unclear, and caused some significant confusion for schools, especially given the increased focus on the Birmingham Education Partnership (BEP). The Board funded a specific programme of work with BEP to evaluate how best to support schools with their safeguarding responsibilities but the direction of travel became unclear until the publication of the education and schools improvement plan.

The responsibilities of BSCB in providing external scrutiny and challenge to schools was not initially understood or recognised by the Commissioner's Team and the Board had to work hard to ensure it was involved. This was resolved by the time the plan was published in December 2014. The new Education Improvement Plan has three strands, of which the first is "Getting the basics right: ensuring that robust systems to underpin effective safeguarding and governance of schools are in place". This underpins what BSCB expects of schools and is very important in driving improved relationships as well as practice. However, there remained significant risks which were not fully resolved by the end of the year in relation to the commissioning of BEP to provide the majority of the support required by schools, whilst retaining the post of Safeguarding in Schools Officer (established midway through 2014-15) within the Council. By the year end much of the plan in relation to safeguarding training and improved support was completed and the data received by BSCB corroborates the improvement.

The framework established by Lord Warner, and expanded to include Sir Mike Tomlinson's work for continuing to report and scrutinise progress has been retained and regular reports to Overview and Scrutiny will be provided. BSCB has accordingly reduced its focus in 2015-16 on the detail of what is being done by Children's Services and extended its focus towards more of what partners are doing. In addition the analysis of what is still to be done has supported the development of the Early Help and Safeguarding Improvement Plan 2015-16, which sets a very clear agenda for the year and which reflects the same areas of concern as those of BSCB.

The report of the third External Commissioner, Sir Bob Kerslake, resulted in the appointment of an External Council Improvement Board. This has led to the development of a full Council Improvement Plan which has had an indirect impact on some of the Board's work, through increased levels of change of challenge corporately. By the end of March 2015 it had had a limited direct impact on the safeguarding of children and promotion of their welfare. The risks are more likely to be identified and worked with in 2015-16. However the existence of the Commission did lead to a degree of stasis and confusion in relation to the partnership landscape and related issues, particularly in light of the Kerslake Report's findings on Birmingham's partnership working. It was significant that the BSCB challenges in relation to developing stronger, clearer and more mutually robust and accountable relationships with key partnership bodies were not delivered over the year. In the circumstances there was no appetite to enter into the debate on the part of other partnerships.

The Board's challenge of developing stronger, clearer and more mutually robust and accountable relationships with key partnership bodies remains a challenge in 2015-16. This is dependent on the Council's progress in developing new frameworks for partnership working, as well as on partner organisations committing to the new frameworks as part of their own strategic and operational planning.

Partnership landscape and issues

The previous partnership infrastructure in relation to Children's Services was dismantled at the beginning of 2014-15 and a new structure was not put back in place to replace it. Instead of the Children's Trust partnership the Council led a series of multi-agency topic based "think tanks" over the year. This meant that for the whole of 2014-15 BSCB was the only partnership forum for children's services in their entirety across the city. This increased the risk of, and at times real experience of BSCB continuing to act as a "proxy" for service design, delivery, and operational detail. The decision made by BSCB to stop the operational effectiveness group, whilst correct in principle, meant a vacuum occurred as a new partnership arrangement was not developed or established over the year. That said, two effective and focused council led programme boards, the MASH Board and the Early Help Board, included a range of partners and BSCB was represented on both. In addition the multi-agency outcomes from these two boards were reported to and signed off by BSCB in the absence of any other "full system" body. It did lead to confusion at times. However, as the year progressed, Lord Warner's views, plus strong debate at BSCB, partially simulated by the Governance Review, as well as challenges from individual partners led, by March 2015 to a clear recognition by the Council as the lead agency, of the need to address the

problem of partnership and governance confusion, and to develop a new partnership landscape and architecture for the city in relation to children and young people.

This coincided with the City Council's decision to review all its partnership arrangements, but by the end of March 2015 exactly how those two strands of work fitted together was still not clear. However, partnership relationships with the Community Safety Partnership and Adult Safeguarding Board remained informal, built on the shared agreements made in 2012/13 about which partnership body should lead on which cross cutting issue and informed by the increasingly close working drive through the MASH initiative.

In 2015 the challenge for the lead agency, Birmingham City Council, with every partner will be to design and implement a new partnership framework for multi-agency co-operation, co-ordination, and commissioning of services to meet children's needs. This will influence the "Future Birmingham" process as a result of the Kerslake Review.

The challenge for the Board will be to fully cease to act as a proxy for partnership working, to create meaningful relationships with the new models for partnership, including the Birmingham Education Partnership (BEP), to inform and influence their work and hold them to account.

Organisational change across partnership

As well as the impact of the improvement programmes and agendas the Council did not have a stable permanent senior leadership team for children's services throughout the year. However, the impact of this was minimised through the presence of strong interim leaders. In addition, the City Council was not the only organisation where there was significant change and organisational churn. The most significant changes were to the Probation Service and West Midlands Police. However, Heart of England NHS Foundation Trust also experienced significant changes after it was made subject to an improvement programme, new senior leadership took over at the Birmingham and Solihull Mental Health NHS Trust, and NHS England underwent a second stage of reorganisation. All of these changes had an immediate impact on the BSCB Board in terms of changing membership. The Board was appraised of the changes appropriately and the impact was less challenging than it would have been, as the governance review facilitated good discussion about the safeguarding functions and accountabilities of organisations through a period of change. In addition in relation to the NHS "system" the Board was assured by the data provided by the Clinical Commissioning Groups that the risks associated with change and recommissioning activity were being monitored and would be drawn to the Board's attention if necessary.

The reconfiguration of the National Probation Service has, however, provided some real challenges over the year, particularly for the leaders of the two new organisations. It is to the credit of both organisations that their leaders have demonstrated a strong and very real commitment to the Board and to safeguarding practice and minimised the risks that such a major change can create, particularly when the focus of the organisation is on adults. Similarly it was a very tough year for West Midlands Police as they undertook a major transformation programme to better position themselves to meet their safeguarding responsibilities. Local commitment was again very strong, and an openness to challenge, debate and discussions facilitated good assurance that risks were being mitigated – often through sheer hard work and dedication from individuals as well as some outstanding leadership.

Organisation change and its impact remained on the BSCB Risk Register over the whole year and action taken to adjust the mitigation each time the Risk Register was reviewed.

Joint commissioning activity and priorities

Another area where the absence of clarity about roles, responsibilities, functions and accountabilities across partnership arrangements related to joint commissioning activity and priorities (0-25 service; drugs and alcohol services; school nursing). Whilst an LSCB has no direct responsibility for joint commissioning activity, a good LSCB can influence what happens, what is a priority, and what should change through its regular performance reports and quality assurance activity. In 2014-15 re-commissioning of relevant children's services was led by the joint commissioning Sub-Group of the Health and Wellbeing Board (HWB) In Birmingham for the third year running the Board had limited direct influence and was not consulted sufficiently well in identifying priorities or developing new commissioning programmes. The risks were to a degree mitigated by all the other scrutiny, challenge, review and quality assurance activity taking place, and by the fact that the BSCB Vice Chair was Chair of the Children's Joint Commissioning Sub-Group.

The BSCB endorsed the re-commissioning of the new services. Although, the Board have only marginally influenced the decision making process, however the re-commissioning reflects the Board's concerns and priorities. Over the year BSCB's

influence and engagement increased as the Board became more robust in scrutinising and challenging consultation exercises and taking reports on proposals and consultations, draft specifications and tender processes. Assurance was sought about the safeguarding elements of the major re-commissioning of 0-25 mental health services and given and by the end of the year the tender was let to an innovative new provider partnership. The transition risks are being monitored by the HWB but BSCB is maintaining a watching brief. The letting of the new drugs and alcohol provider tender was not debated at the Board, but learning from an ongoing SCR has influenced the Board's oversight of the delivery of the new model and regular requests for assurance from the new provider. By the end of the year BSCB was fully engaged in the work to re-commission school nursing provision, and is involved directly in discussions about the work beginning on a new joint early years service (including health visiting).

The work of the Joint Commissioning group was in fact extremely positive over the year. The Children's Joint Commissioning Board oversaw a significant amount of work on behalf of the key partners during 2014-15. The following outlines the progress made in these areas and achievements during the year:

1. Early Help:
    a. Early Years has been the focus of activity assessing the most appropriate way to move to outcome based commissioning of early years services within the available budget to procure these services. In June 2015 a proposal was put to Cabinet to bring together local authority funding and commission an integrated early years service, bring together elements of educational entitlement, social care and wellbeing and public health 0-5 services. Consultation on a new integrated early years service will begin in October 2015

2. Vulnerable Young People
    a. The 0 to 25 mental health service procurement was completed during 2014-15 and the new provider Forward Thinking Birmingham announced. Work on mobilising the new service is now in progress. It is on schedule to deliver a new service by October 2015 as planned.
    b. A speech, language and communications strategy has been produced and a conference undertaken to disseminate its findings. The long waiting times for targeted and specialist speech and language treatment have been considerably reduced and the service is now hitting the 18 weeks referral to treatment timescale.

3. Looked After Children
    a. The complex care process for children placed out of the area was further developed and the intention to establish a pooled arrangement is being worked up.
    b. Processes to deliver education, health and care plans as part of the SEND reforms are now in place with a local offer published on the local authority web page and regular all agency panels resulting of this work.

Priorities agreed to take forward during 2015-16 include:

1. Early Help – implement the recommendations contained within the Early Help strategy.
2. Safeguarding/MASH – build on the work to date and deliver a fully functioning MASH including ensuring CSE is part of the new arrangements and that the HUBS are operating effectively.
3. SEND – Continue to deliver on the requirements of the guidance in this area including the development of a more coordinated funding arrangement as contained within the Sect 75 agreement
4. 0 – 25 – mobilise the new service and implement the evaluation process as planned and work closely with other stakeholders including schools to deliver on recent guidance to create a whole system approach to emotional wellbeing
5. Work to engage the schools through the Birmingham Education Partnership and initially through the Ladywood Pathfinder project.
6. Children in care – reduce the numbers of children in care and increase the proportion placed with families in order to promote better outcomes and deliver improved value.

All of these will assist in improving the whole safeguarding and wider welfare system positively and reflect the areas of need agreed as a priority across the partners on the BSCB Board as well as the Joint Commissioning Sub-Group.

3. Safeguarding Children and promoting their welfare in the City

The Annual Performance Report – how effective are we?

The Board agreed a new and comprehensive Performance and Quality Assurance Framework "Improving Safeguarding Standards and Assuring the Quality of our Service Delivery in Birmingham" (appendix 5) in March 2014. This was refreshed in February 2015 and updated to reflect a wider range of datasets. The whole approach is based on the principles of "outcomes based accountability" using trend data to understand how progress is being made and "the curve turned" towards the required position or target, and breaking our analysis of what we do into three domains: 'how much are we doing?; 'how well are we doing it?'; and 'what difference are we making (to children's lives)?'. The third domain was changed to "what did we learn and change as a result" following discussion.

The Board was able to report against all three Board priorities at each Board and Executive Meeting over the year, although there were some changes over that period to the key data sets and overall dashboard as the Performance and Quality Assurance Sub-Group improved the range contribution and depth of its work. As a consequence the Board was able to take a full Annual Performance Report (Appendix 6) for the first time in four years. The annual performance report examined each BSCB Priority in terms of our three dimensions. The relevant sections of this report are set out under each priority area below. Overall it was clear from that report that there had been steady improvement over 2014-15 in all priority areas, which was having a real impact on safeguarding more children and young people better and more quickly. Whilst there was a huge amount still to do, the work undertaken by partners supported and challenged by BSCB was demonstrably making children safer in the city.

Priority 1 – Voice of the Child

How much have we done?

The Early Help Brokerage Support Team on 7 October 2014 held a youth conference called 'Protect Yourself'. In line with the theme of the conference the following questions were posed: a) what makes you feel unsafe when you're outside in your neighbourhood or at school, and b) What could be done to make you feel safer. Out of the 13 key issues identified in relation to what makes young people feel unsafe; groups were highlighted as the highest concern (22%) with strangers and inadequate street lighting being cited as the next main concern (13%). In respect of what would make young people feel safer; 33% identified that there should be an increased Police Officer presence on the streets before and after school, with 17% of the young people stating that more CCTV would make them feel safer. However, although the findings are captured from a relatively small target audience, they clearly reinforce the key themes identified in the Child Wellbeing Survey 2013-14 and forms part of the information collated to capture the 'voice of the child'. In addition, as part of the quality assurance process established by the Board through the performance and quality assurance Sub-Group all audits now include at least a question or a section on the voice of the child.

How well have we done it?

The audit work on Initial child Protection conferences (ICPC) in October identified as its main concern that the Voice of the Child is not being heard. Recommendations were made in the report to include more work on the Voice of the Child in BSCB training.

The audit identified in four out of the five cases that the Voice of the Child was not clearly present and that opportunities for partners other than social workers to talk to young people were not always taken. Another area of concern was the identification of cultural background /ethnicity of the child and family on the CareFirst forms including the A1 form which is the initial point at which a referral is recorded on the system. The lack of ethnicity here was perpetuated through other forms within CareFirst. Consequently issues around honour based violence, forced marriage, FGM could be missed. The recommendations from the ICPC audit will be followed up later in 2015, to assess progress against the recommendations.

The audits of re-referrals and child protection for 2015 also include a question/section on the voice of the child. Currently 97% of Looked After Children participate in their reviews.

What did we learn and change as a result?

The audit work on ICPC has already been incorporated into the training provided to child protection chairs and further work is ongoing with them to ensure the Voice of The Child is clear in the conference.

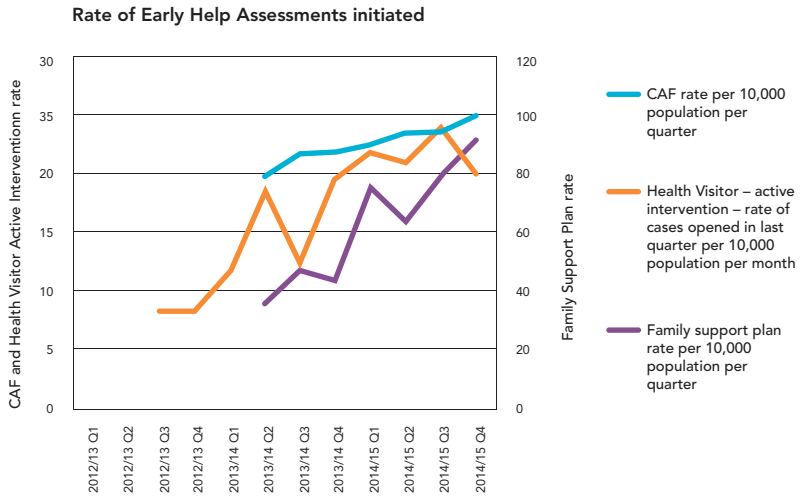
Priority 2 – Early Help

How much have we done?

A priority action for the Board last year was to develop a definition for Early Help and to develop an early help strategy. The definition was approved at the

Board meeting on 13 May 2014 and the strategy was approved on 31 March 2015. As part of the work on early help it was agreed in the performance and quality assurance sub-group to use the fCAf (family Common Assessment Framework), family support plans and health visitor active interventions as a proxy measure for early help. Figure 1 below shows a clear increase in the early support work being carried out by all agencies with fCAF and health visitors' active interventions. The increase in health visitor active interventions may be as a result of the increase in the number of health visitors which is seen in the staffing data later this has resulted in an overall drop in caseload for health visitors.

Figure 1



How well have we done it?

Birmingham has now come to the end of phase 1 of the Think Family Programme. Despite extremely strong performance over the final year, delays at the beginning of the programme meant that the final target for families where outcomes have been achieved was missed by a narrow margin (figure 2). Nevertheless entry into the expanded Troubled Families phase 2 has been secured and DCLG is extremely satisfied with the progress that has been made in the city.

Figure 2

Key Targets	Actual	Target
Identified Think Family cases	7,449 families	4,180 families
Families worked with	6,200 families	4,180 families
Families where outcomes have been achieved (families "turned around")	3,984 families	4,180 families

What did we learn and change as a result?

A major long term national evaluation exercise is under way covering both phases of the programme and for which Birmingham has already supplied a large amount of data, although findings from this will not be available for some time. Locally there are indications of the effectiveness of the whole family approach, although this is an area which would definitely benefit from further analysis. It is intended to carry this out once more analytical capacity is created within the Think Family Team.

Over the last three years the programme has achieved:

- 424 families where adults have found sustained employment
- 2,320 families where children have improved school attendance
- 752 families where youth offending has ceased or significantly reduced
- 844 families where anti-social behaviour has ceased

(note families may have achieved more than one outcome).

Priority 3 Safe Systems

How much we do?

As part of Safe systems Performance and Quality Assurance have reviewed data from all agencies and the following data (figures 3, 4, 5 and 6) has been provided by Health and Police to assist in identifying areas of concern:-

Hospital Data

Figure 3

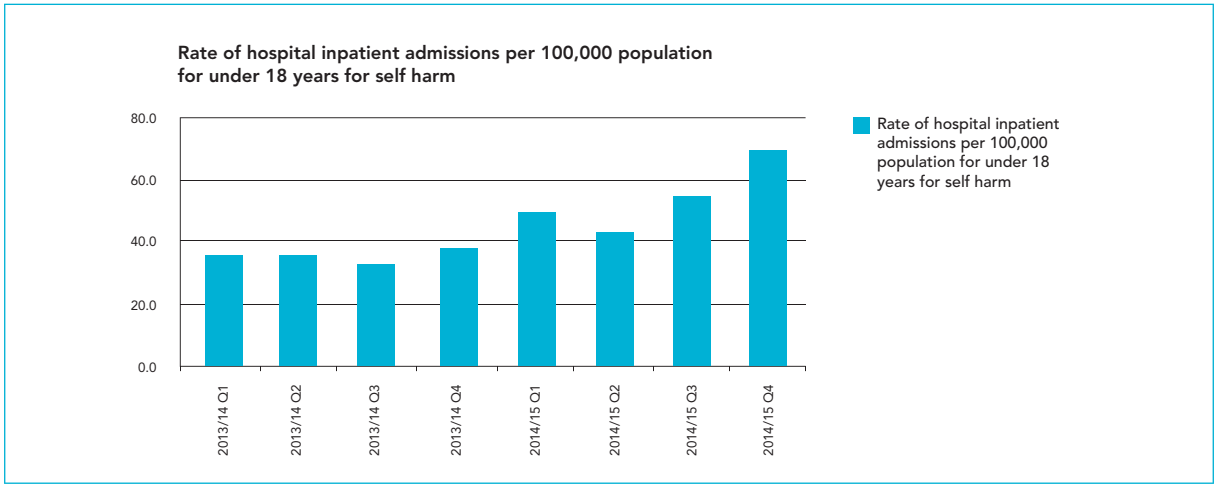


Figure 4

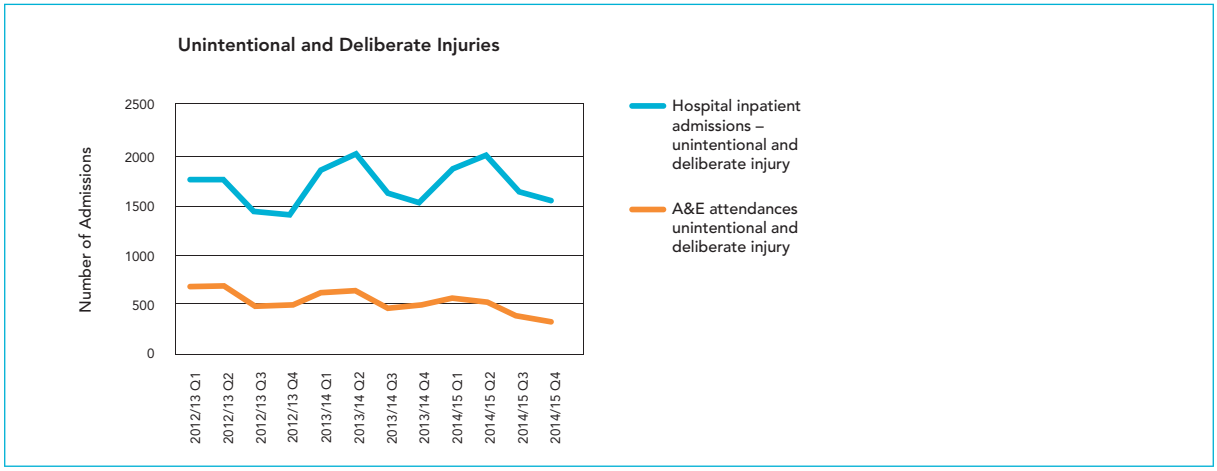
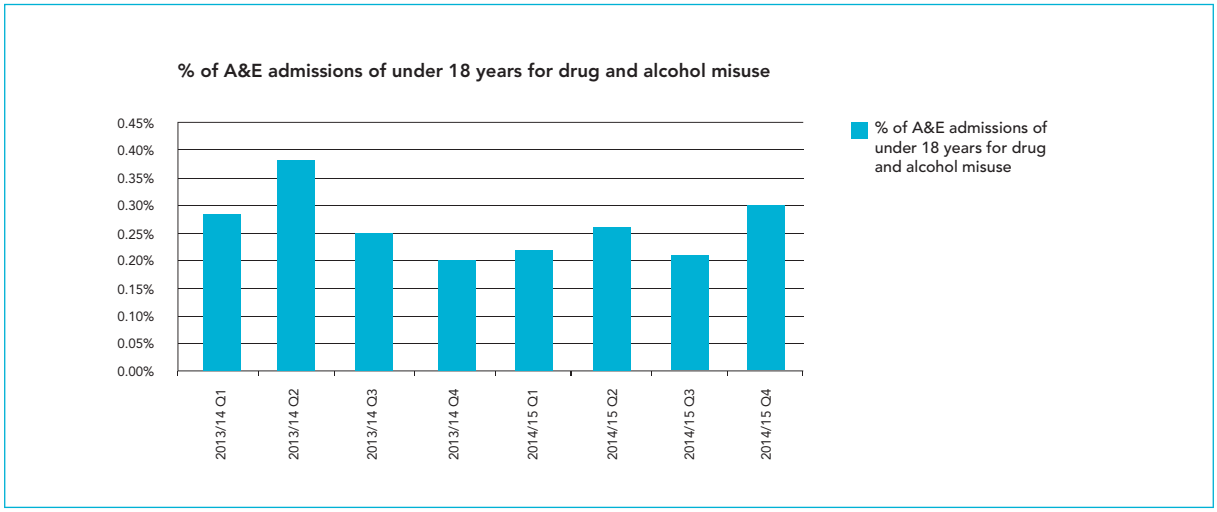
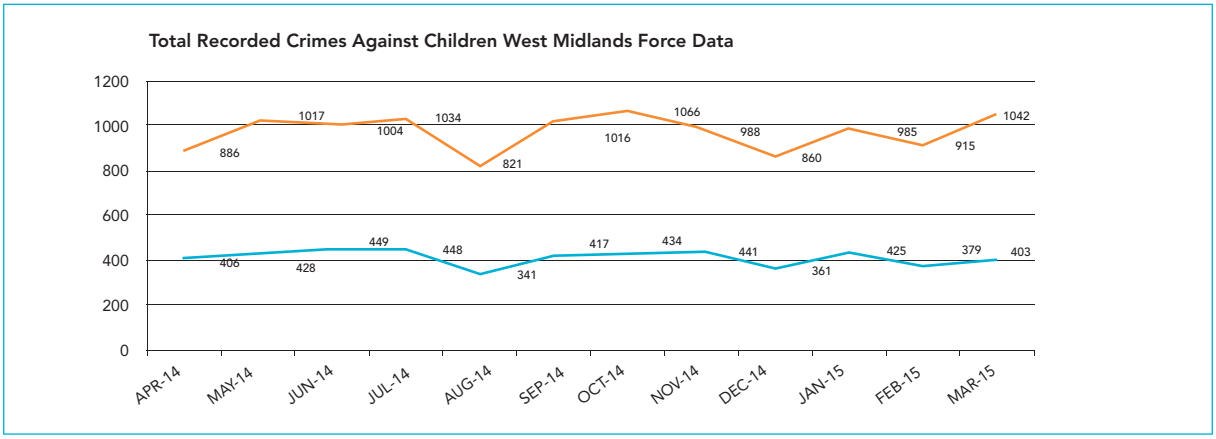


Figure 5



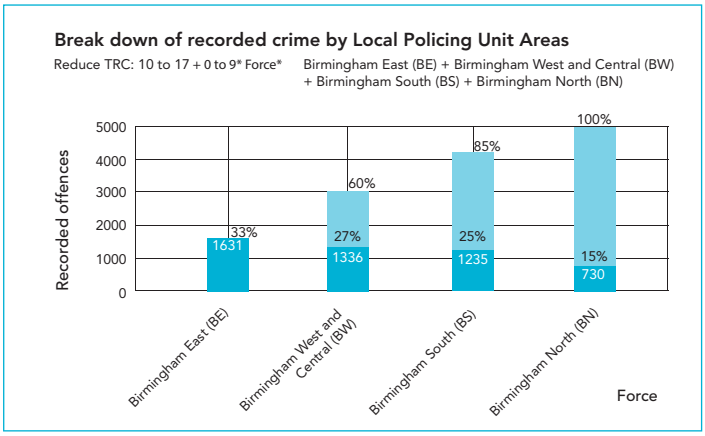
West Midlands Police data

Figure 6



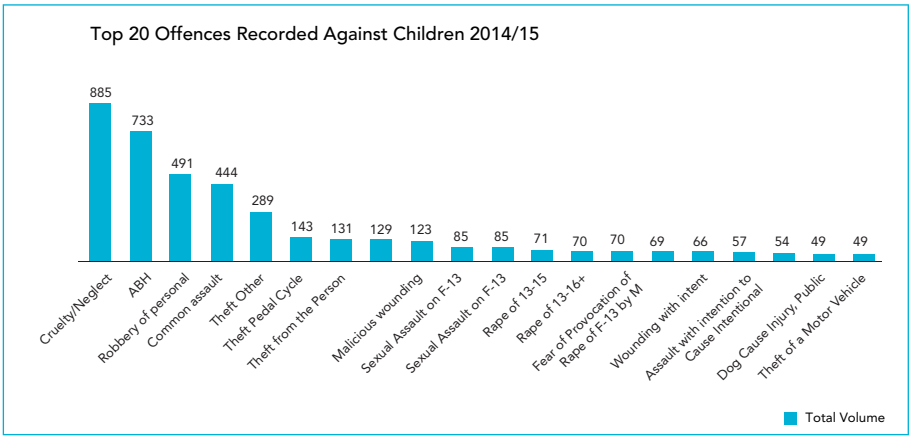
- The orange line in figure 6 shows the total number of "recorded" crimes against children force wide – the blue line shows the number of "recorded" crimes for the four Birmingham LPUs – this is for ALL offences not just those committed by parents/carers.
- Clearly the volume of recorded crime against children in Birmingham has remained stable over the year compared to the increase shown for the force wide figures.
- The two noticeable "dips" in the statistics in August and December are most likely attributable to school holidays when the number of referrals reduces significantly.
- The volume of crimes against children in Birmingham on average is 42% of the force total volume.

Figure 7



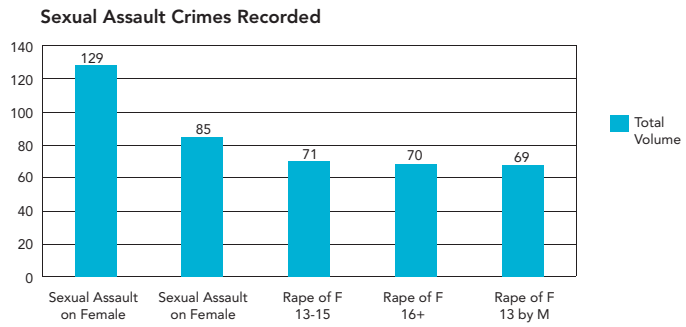
- Figure 7 shows the total number of recorded crimes against children in Birmingham separated into the geographical areas – the total being 4,932 crimes recorded, force wide the figure is 11,634.
- This shows that statistically Birmingham East (BE) has the highest number of recorded crime and Birmingham North (BN) the lowest.

Figure 8



- Figure 8 details the top 20 offences against children in the Birmingham area.
- Clearly 60% are for child cruelty/ neglect which would suggest the majority of offences are committed by a parent or someone in care and control of the child.

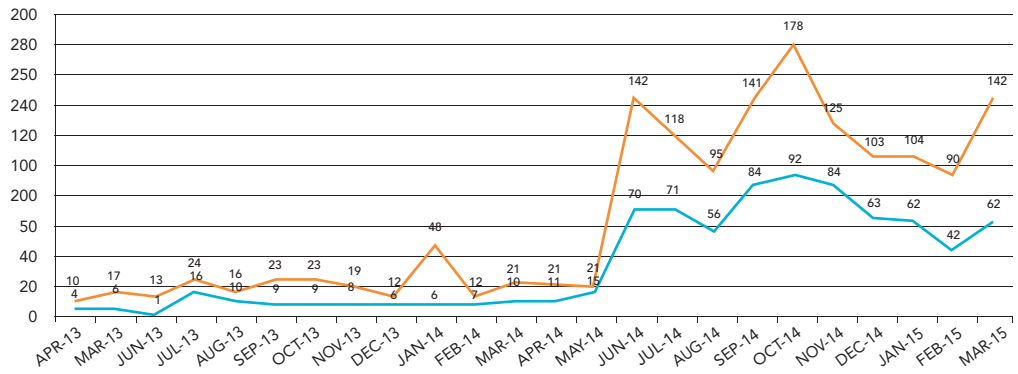
Figure 9



- Figure 9 shows that sexual offences then account for the vast majority of the remainder. The graph below identifies the sexual offences listed in the top 20 there are a number of other sexual offences which do not feature in the top 20.

Volume of CSE Reports for the West Midlands

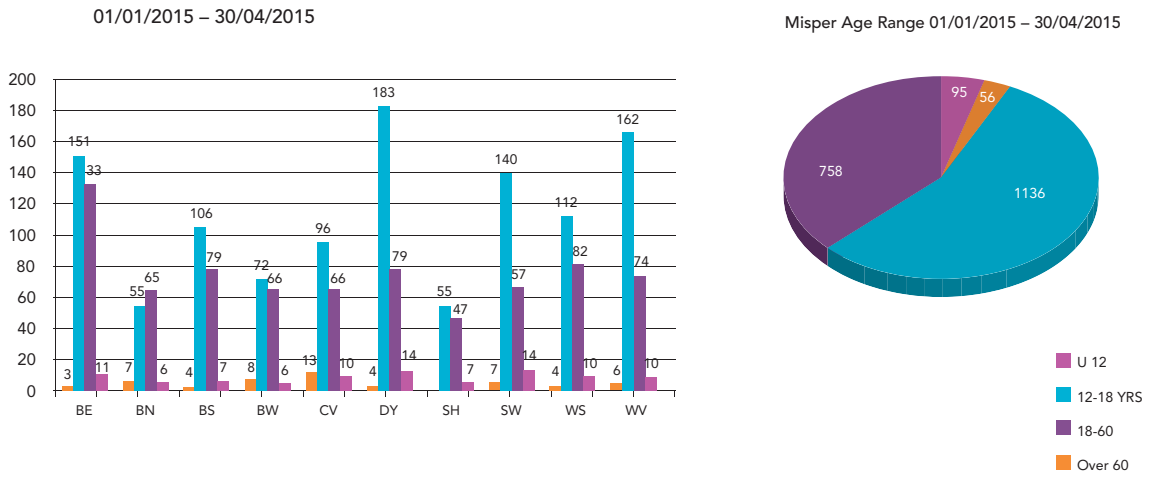
Figure 10



- The orange line in figure 10 shows the total number of referrals with a CSE "Special Interest Marker" force wide – the blue line shows the number for the Birmingham LPUs.
- The data is over two years to show the substantial increase in the number of referrals from May 2014 onwards.
- Figure 11 shows a four month snapshot of missing persons data by age and local policing unit area. During this period 386 children under the age of 18 years were reported missing.

Missing Persons

Figure 11



Crime Outcomes

Figure 12

Outcome Type	% of Total Volume	Total Volume
Outcome 16 - Named suspect identified: Evidential difficulties prevent further action (no victim support)	34.77	467
Outcome 15 - Named suspect identified: Victim supports police action but evidential difficulties prevent further action	28.00	376
Outcome 1 - Charge or Summons	13.63	183
Outcome 3 - Caution - Adult (inc Conditional Caution)	10.28	138
Outcome 18 - Investigationcomplete: No suspect identified	6.33	85
Outcome 8 - Community Resolution	3.05	41
Outcome 14 - Evidential difficulties victim based - named suspect not identifed	2.23	30
Outcome 10 - Police decision - Formal action against the offender is not in the public interest	0.52	7
NC1 - Non Crime Closure	0.37	5
Outcome 5 - The offender has died (all offences)	0.30	4
Outcome 9 - Prosecution not in the public interest (CPS) (All offences)	0.22	3
Outcome 2 - Caution - Youth (inc Conditional Caution)	0.15	2
Outcome 11 - Prosecution prevented - named suspect is below the age of criminal responsibility	0.07	1
Outcome 13 - Prosecution prevented - Named suspect identified but victim or key witness is dead or too ill to give evidence	0.07	1

- The volume of outcomes 15 and 16 show the difficulty faced in terms of successful prosecutions.
- The orange highlighted rows are deemed "Positive Outcomes" in relation to Home Office Crime Standards.

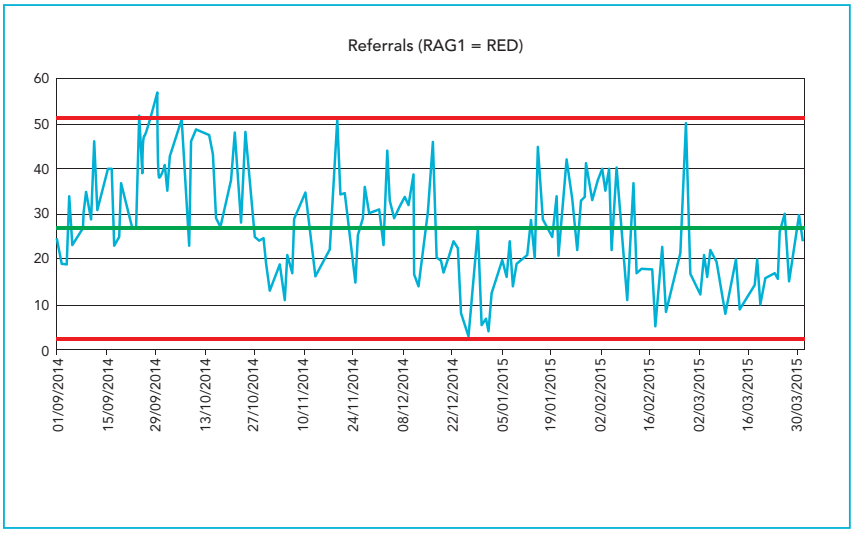
Multi Agency Safeguarding Hub

During 2014-15 the Birmingham Multi-Agency Safeguarding Hub (MASH) began operating on 28 July 2014. MASH is a fully integrated and co-located multi-agency team based in the centre of Birmingham. The team focuses on receiving referrals for children believed to be at risk of significant harm, including domestic violence. MASH was agreed as the strategic multi-agency response to reaching and meeting high levels of unidentified risk as articulated by Ofsted, Le Grand, Kerslake and Lord Warner.

Each agency within the MASH has access to their own systems and shares information as appropriate with key partners. This enables partners to gain a much more timely and comprehensive understanding of the current situation, together with any relevant historical information. The team jointly discusses and assesses the risk and needs of the child and agrees what action needs to be taken. MASH works because the partners are sitting together, sharing information and taking joint action.

MASH is embedded within the Birmingham 'Right Service, Right Time' model. The key determination within Right Service, Right Time is that MASH responds to all children with additional needs and complex/significant needs.

Figure 13

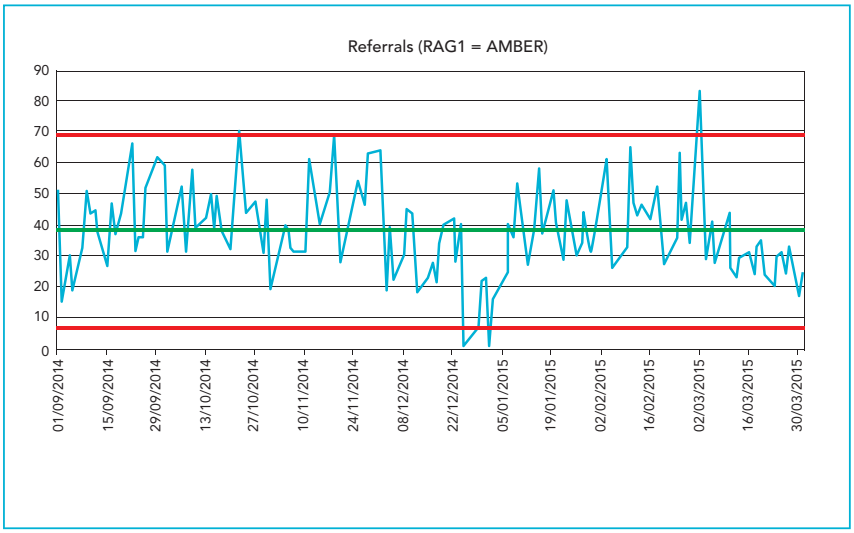


The data shown in the tables below demonstrates how referrals have been received by MASH each week between 1 September 2014 and 31 March 2015.

Figure 13 shows referrals rated red.

- The actual number of referrals received (blue line)
- The average number of referrals received (green line)
- The upper and lower expected normal behaviour limits (red lines)

Figure 14

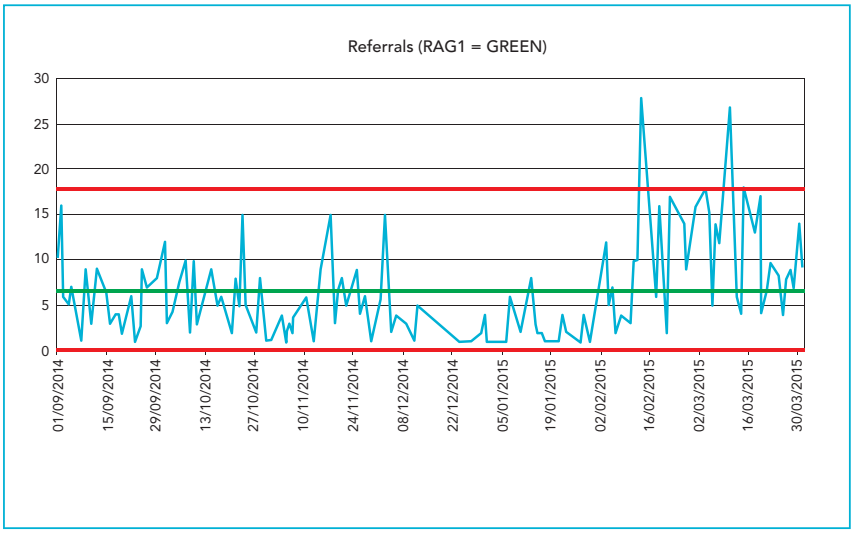


Figures 13, 14 and 15 demonstrates how referrals have been received by MASH each week between 1 September 2014 and 31 March 2015.

Figures 14 and 15 provide detail for referrals rated amber and green.

- The actual number of referrals received (blue line)
- The average number of referrals received (green line)
- The upper and lower expected normal behaviour limits (red lines)

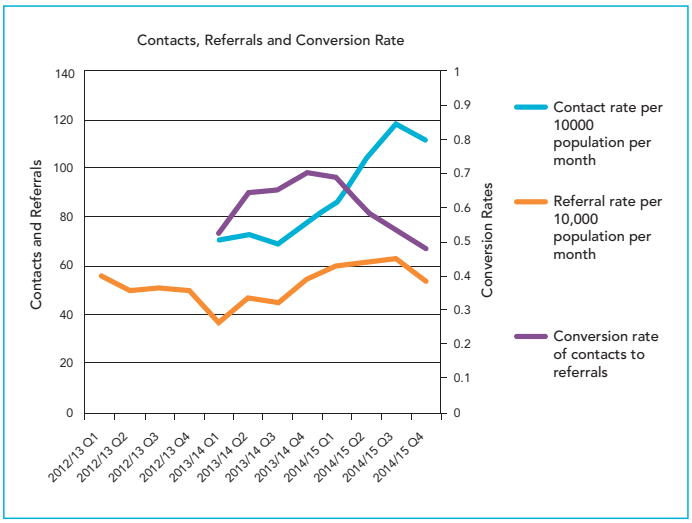
Figure 15



Referrals

Following the introduction of MASH there was a significant increase in the number of contacts, (see figure 16), however this not only coincides with the start of MASH on 28 July 2015 but also 1 August was the point at which police started sending in information regarding domestic violence, which accounts for an additional 1,100 contacts approximately per month. These contacts do not usually become referrals as the majority are referred to other agencies. Hence the conversion from contact to referral rate appears to have dropped over this period.

Figure 16



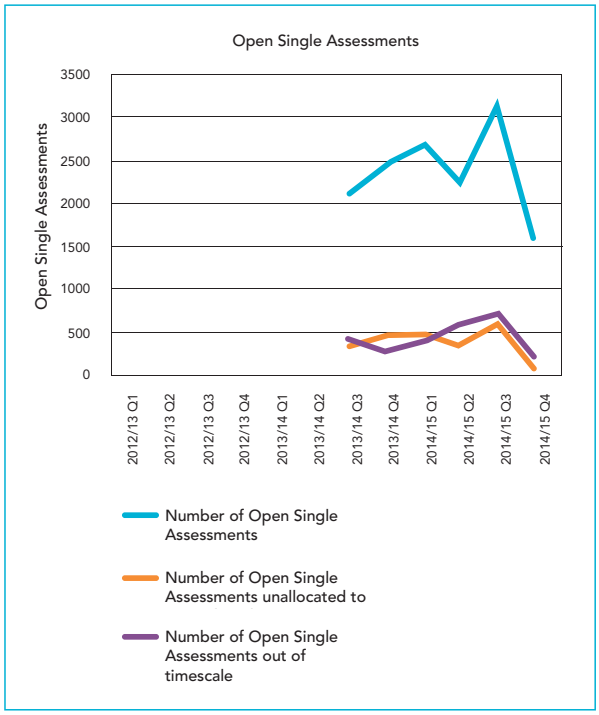
Referrals

At the start of last year the Board identified an issue with the number of single assessments not allocated to a social worker. At 31 March 2014 there were 457 unallocated single assessments, during the year this went up to 763 on 1 July 2014. Areas of children's social care developed a triage system for managing the unallocated single assessments. The directorate carried out some focused work in the south of the city which had the biggest number of unallocated single assessments. As at 31 March 2015 there were 68 unallocated single assessments (see figure 17).

From 1 April the directorate has established teams in all three areas to manage referrals that are rated "amber" in the MASH which are then referred to the area. The area then decides whether an assessment is required and the nature of the assessment. This has resulted in fewer single assessments being initiated. Whilst performance has dipped slightly (appropriate) reduced demand will result in improved timescales and more importantly improved quality in working with the family.

All single assessments should be completed within 45 days. Those over 45 days are out of time, as at 31 March 2015, 223 single assessments were out of time, this has dropped from 517 as at 4 March 2015.

Figure 17

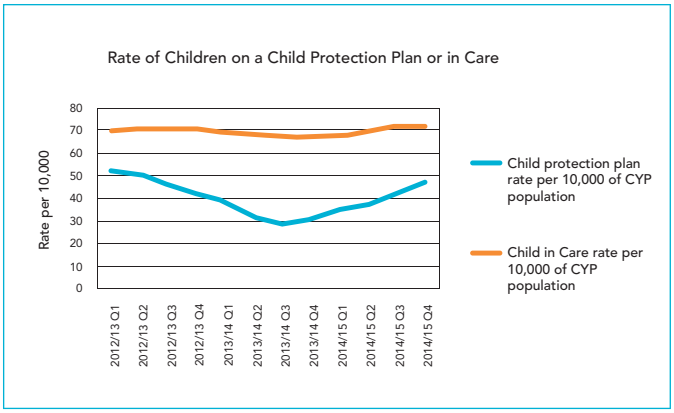


Vulnerable Children - Child Protection and Looked After Children

In March 2014 a new child protection conference process was introduced known as "Strengthening Families". This new approach involves the chair being sent reports from agencies prior to the conference to provide the chair with an overview of the case before hand. The chair then facilitates the meeting between professionals families and young people identifying:

- Danger /risk factors
- Child and Family history
- Grey Areas/Complicating Factors
- Child's Views
- Parental Views
- Family strengths/protective factors
- Safety statement

Figure 18



By mid-2013-14 the BSCB became very concerned about a major drop in the numbers of children who were made the subject of a child protection plan. At the end of March 2013 there were 1,149 children who were the subject of a child protection plan. At the end of March 2014, there were 844 children with a child protection plan. Reaching a low of 806 in December 2013 but rising to 1301 by 31st March 2015 (see figure 18). These numbers indicate that Birmingham was significantly below the national average during 2013 and raised concerns that too many children may have been at risk of harm without appropriate protection plans in place. However, a significant number of these led to no further action (NFA) which became a major concern for the Board by March 2014. The number of section 47s NFA was 160 in March 2014 and by September 2014 this had dropped to 31 and by March 2015 it was 29. Part of the problem was identified as a lack of coding in CareFirst and consequently a number of staff were using it inappropriately, new coding was introduced. At the beginning of 2015 it was identified there were 930 S47 cases open.

The Board have been concerned about poor attendance by partners at Initial Child Protection Conference with no agency achieving a 100% attendance to the conferences they have been invited to. Figure 19 identifies a significant improvement in police attendance over the last 12 months primarily as a result of the police establishing a small team of officers who are responsible for attending conferences.

Timeliness of ICPCs has also been inconsistent over the last year (see figure 20). At the end of quarter 3 there was a significant problem in the Child Protection Review Service in that a significant number of chairs where either on leave or off sick, resulting in a large number of conferences being cancelled.

This resulted in a backlog. At the same time a lack of suitable conference venues was identified to resolve these issues two additional chairs have been temporarily employed and temporary additional conference space identified in the city centre.

Currently the service receives a high volume of late ICPC requests. These late notifications delay the booking of conferences within the 15 working day statutory requirement. Discussions are currently being held between CP review and MASH in order to implement an ICPC trigger and discuss the date of strategy closure being the starting date of the ICPC timescale. Improvements in conference timescales have been seen in the March 2015 rising to 45% compared to 8% in January 2015.

Figure 19

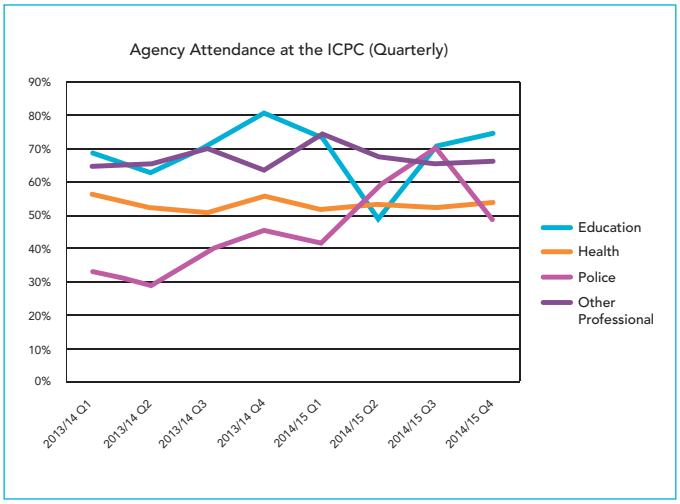


Figure 20

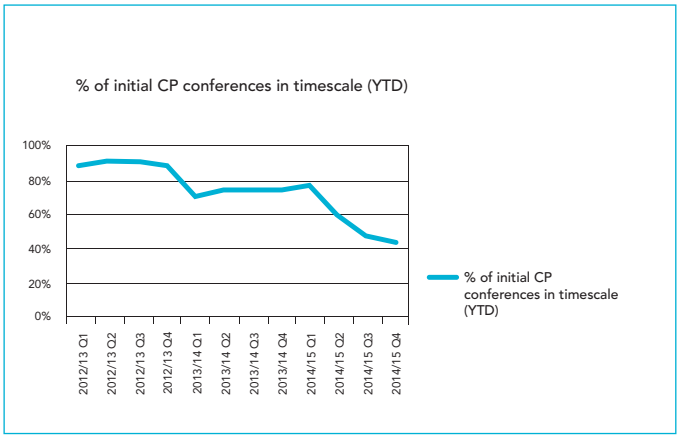
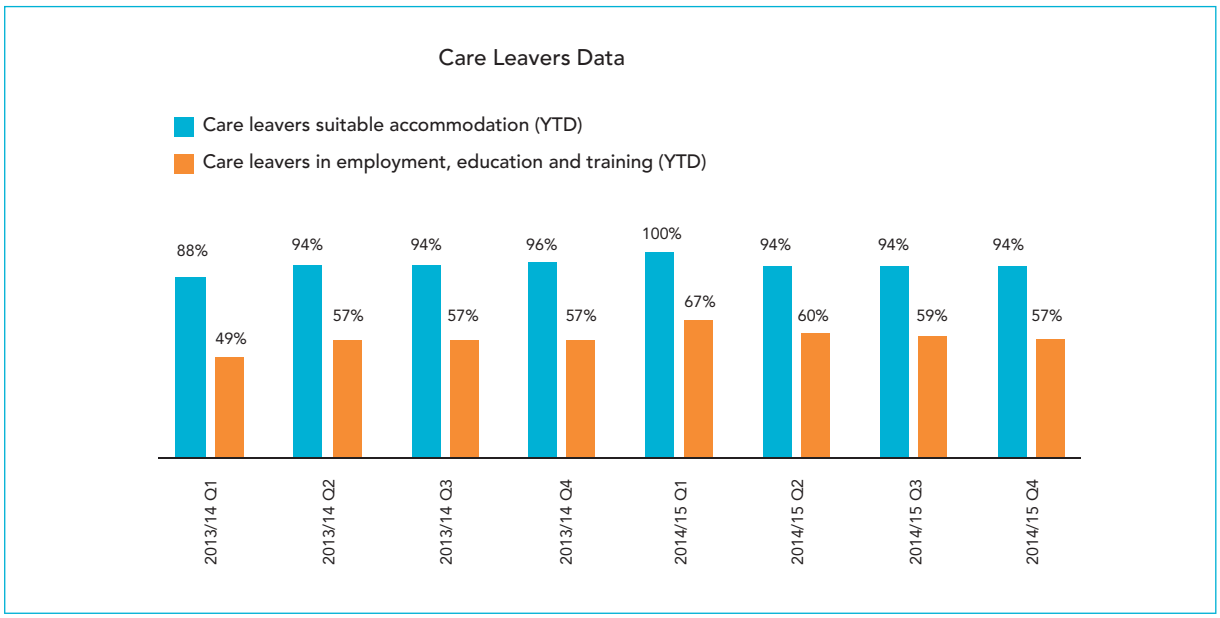


Figure 21

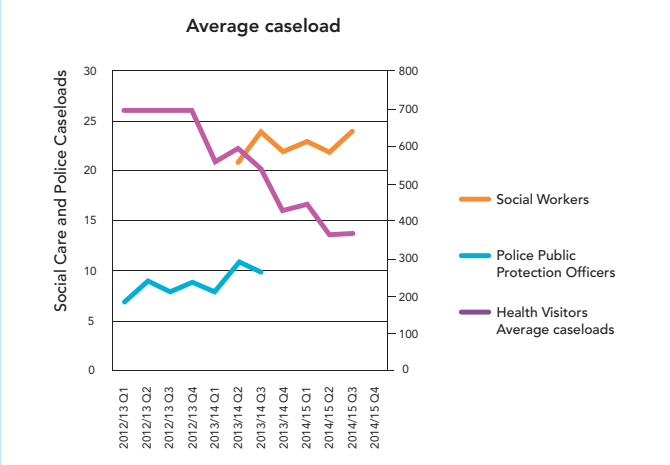


Staffing

Staffing levels in both social care (figure 23) and health visiting have also been a major concern over the last year. The number of health visitors has increased significantly following a national drive to increase the numbers in the last three years. In line with this the average caseloads of health visitors has dropped significantly from 696 in 2012/13 quarter 1 to 368 in quarter 3 2014-15. Social work caseloads are hovering around the average of 24.

Social care still have significant vacancies with over 35% of full time posts filled by agency staff. We do not currently have the police data for staffing (see figures 24 and 25).

Figure 22

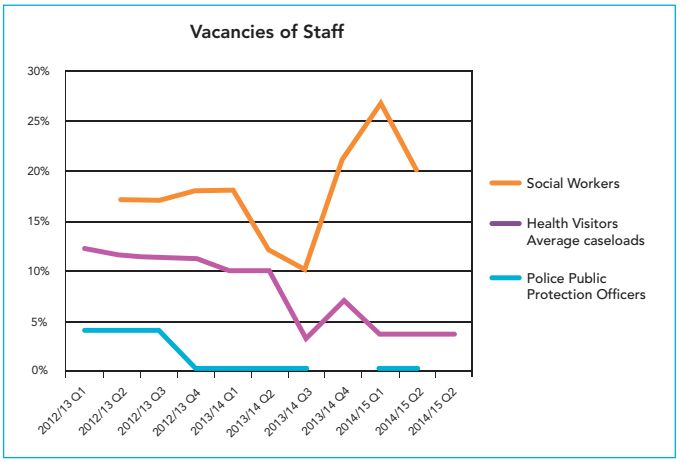


Social work – Agency Data

Figure 23

	Agency	BCC	Total FTE
EAST	5	86	91
NWC	38	89	127
South	27	69	96
MASH	4	54	58
DCSC	0	19	19
Total	74	316	391
% to total	19%	81%	

Figure 24



How well did we do it?

A task and finish group was established in June 2014 to audit referrals into the "Front door" of children's social care. The audit uses a random sample of up to 10 referrals per month for seven months from all referrals to the front door (total 66 referrals). From October the audit sample has been a random sample selected by the Information Management Team. Prior to October the Early Help Brokerage Team selected the sample for audit from the referrals that had been rag rated Green by the MASH. Consequently although comparisons are being made between months it should be noted that samples were taken initially from a much smaller pool and that the samples prior to October had been rated green. The audit has identified that the quality of the referrals being made over the past seven months has shown generally a consistent improvement (figure 25). The audits have been spread across a number of agencies and further work is intended next year to identify the quality of referrals from particular agencies (figure 26). Next year's audit will review re-referrals.

A multi-agency audit pool was established at the end of the year and further child protection case audits have been started in May and June 2015. The results of which will be reported to the Board.

Figure 25

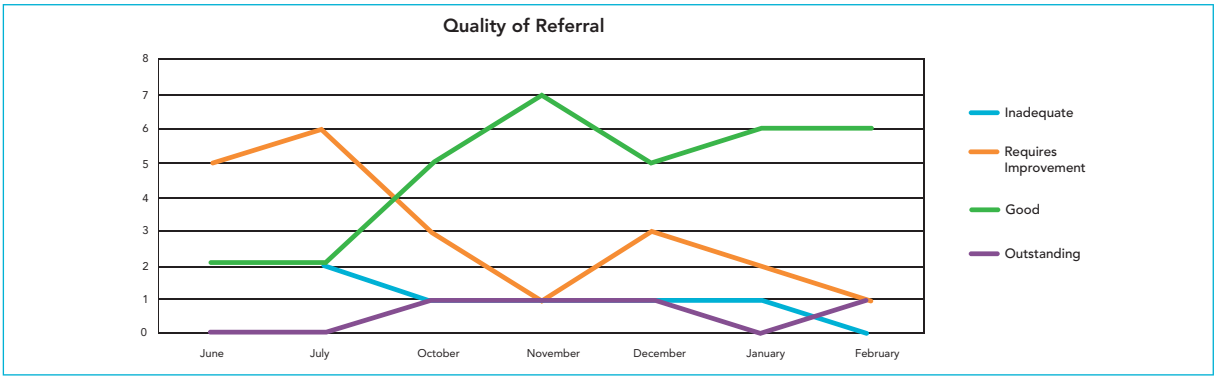
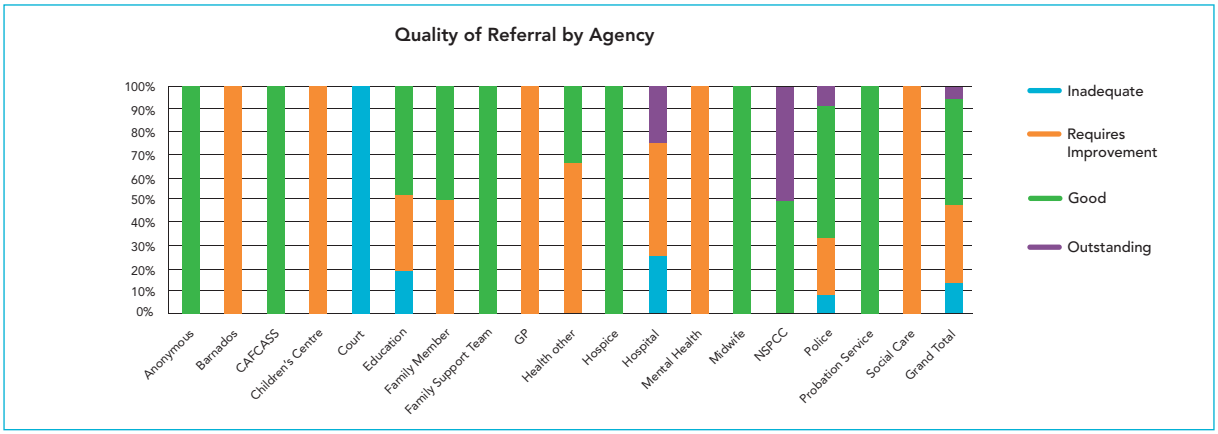


Figure 26



What did we learn and change as a result?
As a result of the concerns surrounding the Unallocated Single Assessments the process for dealing with amber rated referrals has been amended. Amber rated referrals are now assigned straight to an area team who assess the referral and decided whether an assessment should be carried out. Consequently there has been a significant reduction in the number of unallocated assessments. The results of the referral audits were fed into the development of the new multi-agency referral form which was rolled out to agencies in March 2015. Further work is still required to improve referrals from some agencies.

There remain some significant challenges. We have, for example, still not improved the case conference system processes enough to facilitate a strong understanding of multi-agency attendance at child protection case conferences. However, it is clear that there has been sufficient improvement for us to focus far more on the quality of what is being done to safeguard children and promote their welfare rather than on the processes being used.

The key challenge in 2015-16 is for the Board in monitoring effectiveness is to develop robust ways of assuring quality of practice, and to create a learning culture across agencies to allow our understanding of quality to improve practice and make a measurable difference to children's lives.

Ofsted and other regulatory reports
As well as implementing and addressing the requirements of the Ofsted Single Inspection and Review of the LSCB (http://www.ofsted.gov.uk/inspection-reports/find-inspection-report) published in May 2014, we began to receive Inspection Reports relating to all our partner agencies and monitor the implementation of relevant recommendations by each agency in 2014-15. This has provided a more comprehensive understanding of practice across the whole system and supported the identification of key common themes and challenges.

Whilst not undertaking any formal follow up of its Inspection of 2014, Ofsted did undertake a review of the Birmingham Multi-Agency Safeguarding Hub (MASH). This was a helpful review, which provided valuable advice about areas for development and improvement (including timeliness, delay, and the approach to domestic violence contacts) but also praise for the strong front door and multi-agency nature of the MASH.

Ofsted also undertook a significant number of inspections of early years providers and schools in 2014-15, particularly following the initial phase of the period after the publication of the Trojan Horse material, and subsequent inquiries. By the end of the year 12 nurseries had been inspected and all were found to be good or outstanding. This is positive given the learning from the Little Stars Nursery SCR two years earlier. 106 primary schools were inspected. 61 were good or outstanding, 36 were graded as requires improvement and nine were found to be inadequate. Ofsted used data from the Section 175 data returns and self assessments to inform its work. In addition 22 secondary schools were inspected of which 9 were good or outstanding, 6 graded as requires improvement and seven found to be inadequate. Of the nine special schools inspected, seven were good or outstanding, and two inadequate. The Council's School Improvement Service is in 2015-16 working closely with the schools who need and ask for support to improve, as are the schools Safeguarding Coordinator and the Schools Resilience Officer. Some schools are not seeking help but are still being closely monitored by the Council.

The Care Quality Commission (CQC) also undertook a range of inspections in the city in 2014-15. The full inspection reports are available to download at the Care Quality Commission website; http://www.cqc.org.uk/ . This included a full review of health services for Children Looked After and Safeguarding in Birmingham undertaken in September and October 2014. This review included

key provider services (Heart of England NHS Foundation Trust; Birmingham Children's Hospital NHS Foundation Trust; Birmingham Community Healthcare NHS Trust; Birmingham Women's NHS Foundation Trust, Birmingham and Solihull Mental Health NHS Foundation Trust; University Hospitals Birmingham NHS Foundation Trust; Sandwell and West Birmingham Hospitals Trust) and two of the three CCGs in the city (Birmingham Cross City CCG and South Central CCG). Unlike Ofsted, CQC do not provide an overall grade or judgement in these inspections. Nor do they arrive at a general conclusion. Good practice was observed in the provider services and the safeguarding leadership of the Clinical Commissioning Groups was praised. GPs were identified as making a strong contribution to safeguarding in the city. 42 recommendations were made, and the report overall demonstrated that serious consideration was given to ensuring effective safeguarding practice by NHS Organisations across the city. Key themes in relation to partnership activity included concerns about referral challenges and the MASH, delays in receiving essential information such as domestic violence notifications and clear examples of effective partnership working between adult services, children's services and other relevant agencies. The safeguarding leadership provided by the two Clinical Commissioning Groups was praised, and reflects BSCB's experience over the year.

Responsiveness and assertive escalation of concerns was a theme that was also identified in the CQC inspection of Birmingham Community Health Care Trust published on 30 September 2015. Several areas were inspected including community health services for children young people and families. The provider trust was graded as good overall, but one out of the five areas inspected requires improvement was a need to improve the responsiveness of community health services for children, young people and families. In the inspection of Sandwell and West Birmingham Hospitals NHS trust – City Hospital published on 26 March 2015, which was overall graded as "requires improvement" the inspectors found that in their services for children and young people (also graded as requires improvement) the services at City Hospital were "caring and effective and accommodated both children's and parents' needs; however improvements are needed for the service to be safe and responsive; improvements are also needed in the leadership of the service".

Another theme that has emerged is the application of new systems and processes as is the effective use of interpreters. At Sandwell and West Birmingham inspectors "were not assured that incident management and learning at ward level was robust at City Hospital. Parents told us their children had received compassionate care with good emotional support. However, we also observed that on occasion parents who required the use of an interpreter had not always been offered this support". At the same hospital however maternity services were rated as good. The service was effective, responsive, caring and well-led. This indicates that even within organisations learning was not being disseminated effectively and good practice not being used effectively to support improvements.

The opposite is equally true. The Inspection of Royal Orthopaedic Hospital, Birmingham (graded overall as requires improvement) found that their services for children and young people were good. They stated that "Children and young people received safe, compassionate and effective care from appropriately trained and competent staff. Care and treatment was based on national guidelines and directives and were monitored for quality and effectiveness. Children and young people and their parents/carers were treated with dignity and respect. Parents and carers were satisfied with the care and treatment delivered to their children and told us they felt included and involved. Staff were positive about working in the family care division of the trust and felt supported and valued in their roles by line managers. Risks were managed at a local and trust level."

Two NHS providers (Birmingham and Solihull Mental Health Foundation Trust and University Hospitals Birmingham NHS Foundation Trust)were rated overall as "good" in the year, although specific attention was not paid to children's safeguarding in those inspections. However, in the overall safeguarding inspection two recommendations were made for the Mental Health Trust (both in relation to processes that were not adequate) and six recommendations for University Hospital Birmingham relating to processes, recording, supervision and compliance issues.

Heart of England NHS Foundation Trust was the subject of a re-inspection in December 2014 and published on 1 June 2015. This found that the Trust was still requiring improvement with only one of the five areas inspected being graded as good. The inspection did not cover children's services although they did inspect both maternity services and accident and emergency services. The inspection outcome had a significant impact on the whole Trust. The Inspectors found, for example, that :

- Widespread learning from incidents needed to be improved.
- Staffing sickness and attrition rates were impacting negatively on existing staff.

- The culture within the trust was one of uncertainty due to the number of changes which had occurred.
- Staff could not communicate the trust vision and strategy.
- Governance arrangements needed to be strengthened to ensure more effective delivery.
- BHH Emergency department was overcrowded with poor flow, leading to a high stress, high risk environment for both patients and staff.

All these issues impact on a safe service to children and the Trust is working hard on an improvement plan which will improve children's safety and wellbeing.

The CCGs in Birmingham are working closely together on all the issues relating to safeguarding children and young people and are promoting shared learning and mutual support across the system as well as closely monitoring the progress being made in areas for improvement. BSCB has received good assurance and evidence from the Annual Assurance letters and Safeguarding Reports received from NHS organisations of CQC recommendations being responded to, and improvements made.

An aggregate report on six inspections focused on protecting children was published by Her Majesty's Inspector of Probation in August 2014. The then Staffordshire and West Midlands Probation Trust was not inspected and the findings and recommendations now need to be seen in the context of the Transforming Rehabilitation (TR) agenda cumulating in the formation of two district operations which made up the former Probation Trust. Staffordshire West Midlands Community Rehabilitation Company (SWM CRC) is the provider responsible for the supervision of low/medium risk of harm offenders, while the National Probation Service (NPS) has responsibility for high risk of harm offenders, MAPPA arrangements and providing advice to Courts. The NPS and CRC have provided assurance that the report's four recommendations will be taken forward within Birmingham by providers of Probation Services. Through the offender journey an individual will experience services from NPS or from CRC, dependent on the nature of the case and the intended interventions. Probation Services will need to ensure communication systems between NPS and CRC are robust, as are those with other agencies with regard to safeguarding activity. Much of this activity should be covered in effective probation casework activity which is monitored though supervision and performance management arrangements. The TR transition has created more process/case operation issues and safeguarding activity needs to be reviewed in that context.

West Midlands Police were subject to a safeguarding Inspection between 2 and 13 June 2014 as part of their new National Child Protection Inspections. The conclusion of the Inspection Report was that "West Midlands Police has demonstrated a commitment to improving child protection services. The move to build increased capability and capacity is testament to this as is the focus on child protection within the force's strategic change programme. However, at the time of the inspection, not all children at risk of harm were sufficiently protected by West Midlands Police and it is too soon to judge whether the changes underway will deliver the level of improvement required. While the first phase of the programme had been implemented at the time of the inspection, inspectors found that the ambition of the leadership team for service transformation had not yet gained traction among officers and staff working on the front line." This is congruent with the Police and BSCB views of the period.

Inspectors also found "good practice in particular cases, but also significant weaknesses. When the matter was clearly one of child protection, the West Midlands Police often responded well. In difficult, complex or prolonged cases, the response was often much weaker. Many staff were highly committed and knowledgeable, but many of those working in the Child Abuse Investigation Teams (CAITs) showed signs of being resigned to poor practice, claiming 'too much work' prevented anything better. They did not have enough support to carry out their role in child protection and this had a direct impact on the quality of service to children. The force has developed good relationships with partner agencies and LSCBs, but in some areas partner agencies have expressed concerns about police commitment and there is more to do to gain their confidence. There was some co-located multi-agency working, and the plan to develop multi-agency safeguarding hubs is a positive step forward."

The report covered all seven local authority areas but much reflected the experience in Birmingham. This report included 20 recommendations and WMP have been proactive and energetic in addressing them. By the end of 2014-15 the transformation programme was beginning to show dividends although it became very clear over the year that as the police addressed the issues identified, and the MASH in Birmingham began to have a major impact, the allocation of resources to the Birmingham Safeguarding Service was still inadequate to meet need.

Birmingham Youth Offending Service were informed by and involved in a thematic inspection of resettlement led by Her Majesty's Inspector of Probation in July 204 and an Ofsted Inspection of Community Safety and Public Protection Incidents.

We have during 2014-15 been able to gain a much better understanding of the collective views of external regulators across the city about the strengths, areas for development and competence of all partners in relation to their safeguarding practice, and the way their work improves the welfare of children and young people. As far as the Board is concerned the year was spent focusing on progressing the areas for action identified in the 2014 Ofsted Inspection Report. Section 4 contains an assessment of our progress against those requirements. Towards the end of the year we were in a position to assess our performance against the revised Ofsted and set up a task and finish group to identify what we need to do to ensure we can demonstrate our position on a regular basis to Ofsted, act to address identified areas for development, amend the Business Plan and sub group work programmes as necessary and begin to prepare for the proposed targeted joint inspections.

Section 11 Audits and self assessments

Each year all the Board's statutory partners undertake a self assessment of their effectiveness in terms of how well they are safeguarding children and young people and promoting their welfare. Known as the Section 11 audit it is part of their responsibilities under Section 11 of the Children Act 2004 This audit should also be completed by all other organisations involved in or commissioned to provide services to children, young people and their families. In Birmingham the Board asks for a copy of every statutory partner's audit in order to analyse the overarching strategic, operational, practice and workforce themes and achieve a sound understanding of the current quality of what is happening as well as the emerging issues for the city. In addition, Safeguarding Standards for Agencies are outlined in National Guidance "Working Together to Safeguard Children" and Section 11 of the Children Act 2004. The aim of a Section 11 audit is to provide the board with reassurance that organisations have good structures and processes in place to safeguard children and to provide a benchmark of current performance to enable organisations to monitor progress and quantify improvement in safeguarding practice for children and young people over time.

Birmingham Safeguarding Children Board (BSCB) developed a Section 11 Audit Tool in 2013, in partnership with Safeguarding e-Academy. This can be accessed electronically, thereby creating a paperless audit trail with simple uploading of supporting documents to evidence compliance. BSCB will commission agencies on an annual basis to conduct a Section 11 Audit. The Audit Management Tool enables agencies to provide real time updates on progress throughout the year. The section 11 audit was developed with 4 grades for each standard. As part of the analysis of the audits, the overall grades for all the partner organisations in 2013 has been compared against the overall grades for 2014 and 2015.

One agency has not completed the section 11 audit and a further three agencies have not completed action plans this year. The action plan is key to improving the safeguarding in agencies and as such all agencies should have an action plan that is being regularly reviewed and updated. The local authority have completed four separate section 11 audits rather than of one for the whole of the local authority. The West Midlands Ambulance Service complete a standard section 11 for the whole of the West Midlands and is not specific for Birmingham. A well received peer review event was held in November 2014 where partners reviewed each other's section 11s against other agencies. This helped agencies gain an understanding of how to apply the grades in their agency. Further independent validating of the section 11 audit is still required.

Figure 27

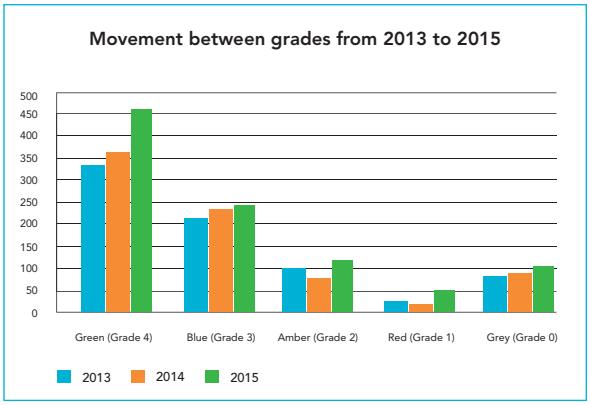


Figure 27 indicates that agencies have reported a slight improvement in the safeguarding standards in their organisations. Although the audit process includes a judgement by their organisations. This year we have added five questions which have impacted on the overall movement of amber and red grades. The results from the new questions on Early Help, Domestic Violence and Child Sexual Exploitation indicate that there is still some work to be done by agencies to raise awareness of these areas amongst staff and to ensure that the appropriate policies and procedures are in place to manage these safeguarding concerns when they are raised.

Work was also carried out on the comparison of grades for individual organisations. This identified that Youth Offending appears to have improved the most in the year followed by Royal Orthopaedic Hospital which has continued to improve and Sandwell and Birmingham CCG.

Figures 28, 29, 30 and 31 set out the responses to the five new questions posed in the 2014-15 Section 11 Audit Tool, in relation to Domestic Violence, Child Sexual Exploitation and Early Help.

Figure 28

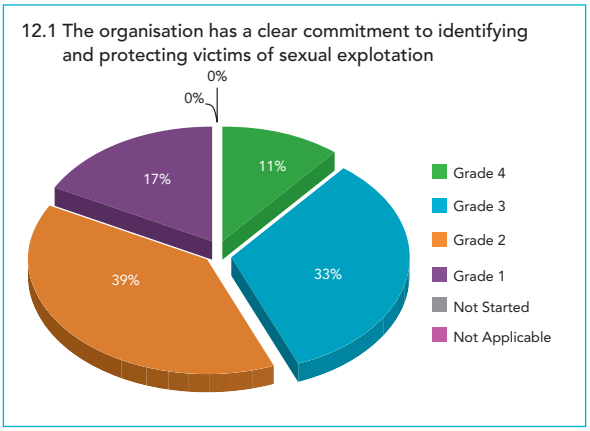


Figure 29

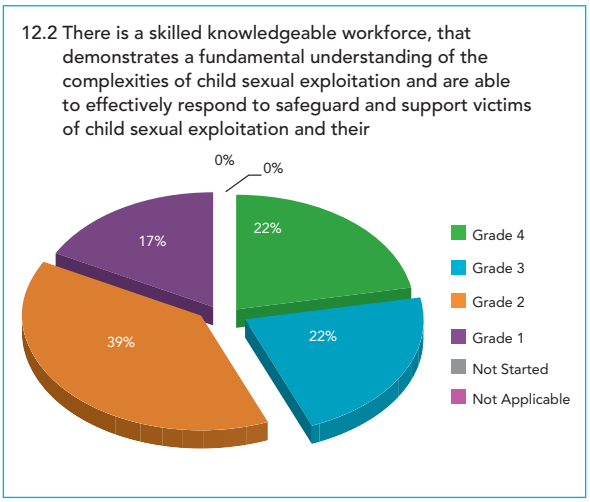


Figure 30

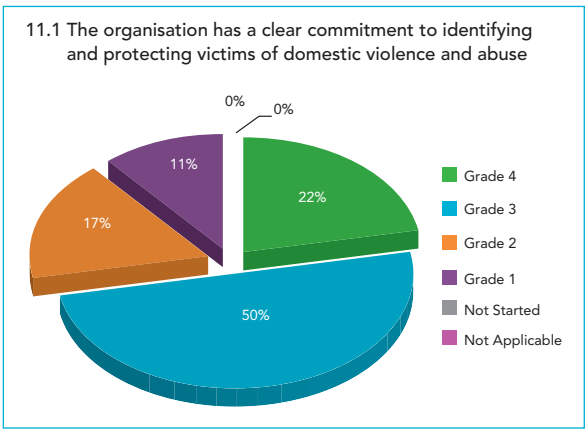
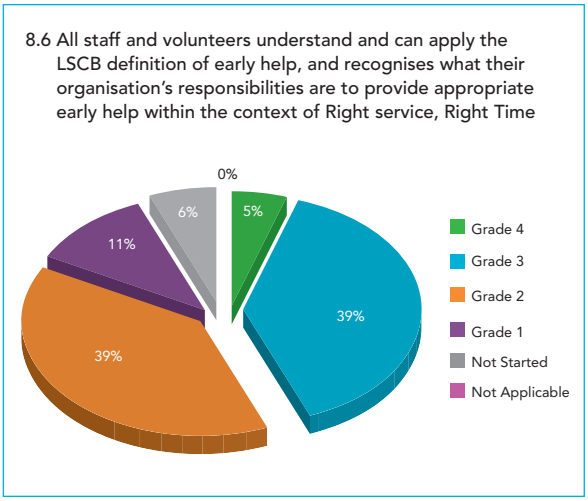


Figure 31



Analysing the Section 11 returns overall there are a number of key learning points to inform our work in 2015-16. The learning points for agencies include:

- Each agency needs to be required to submit a detailed Action Plan to evidence how audit findings will be taken forward
- Each agency should regularly review and monitor progress on the implementation of the audit action plan
- The audit findings and action plans should be disseminated and progress monitored through existing agency management structures that have responsibility for safeguarding
- Agencies should ensure that all relevant documents providing evidence of their judged compliance with each level should be uploaded to the online audit and management system

The learning points for BSCB are that:

- The learning points around action plans are the same as the last 2 years which is a concern to the board in that the section 11 process is not being embedded into agencies safeguarding standards.
- BSCB needs to be assured that agencies are completing their Section 11 Audits and are following up on their action plans to implement the actions they have identified to improve their compliance with safeguarding standards
- The BSCB need to ensure that agencies have access to the appropriate training for domestic violence and child sexual exploitation.

In summary, whilst there has been some improvement in the response from partner agencies on last year's audit, we still need to be assured that, for all partners which have identified areas for development from the

audit have an action plan in place to resolve the areas of concern. We also need to ensure partners provide better evidence of progress and facilitate the sharing of good practice identified through the audit process and through the peer review.

Partner assurance reports– key points and summary
In addition to the Section 11 audits, Board asked formally for each statutory partner to submit an annual report to the board accompanied by an assurance letter from the Chief Executive or Chair of the organisation for the first time in 2013-14. The quality, consistency and depth of the returns in 2013-14 was very variable. As a consequence partners were given a framework within which to report. This asked organisations to report as follows:

- Executive Summary of progress over the year
- Introduction to the service
- Their evaluation of the effectiveness of their safeguarding arrangements
- Their organisational governance and arrangements for evaluating their effectiveness
- Their safeguarding performance and arrangements for quality assurance, audit and learning from practice
- A summary of the work undertaken to engage with and listen to children and young people, and the learning from this
- The number of serious incidents they had had and the learning from them
- The findings from internal reviews and the action taken
- The findings from external inspections and reviews and the action taken
- A summary analysis of the effectiveness of their arrangements in terms of strengths, areas for improvement, and the impact of lessons learnt on practice
- The organisation's response to emerging issues and Board priorities (early help, fCAF, integrated support plans and child in need plans; MASH, attendance at Initial Child Protection case conferences, core groups and reviews, strengthening families protocol and west midlands child protection protocol
- Partnership working
- Training and workforce development (single and multi-agency)

This framework broadly covered the Board's priorities and business plan in 2014-15. Returns were significantly better this year with greatly improved consistency and focus. This has allowed for a far greater understanding of exactly what the common themes are, where there are challenges, and how well learning is being demonstrably used to improve practice. In addition more returns were received with only two who did not respond. Figure 33 sets out the returns according to the quality of the content against the framework, the quality of the evidence provided to support the assurances given, the degree of self-reflection and analysis and the seniority of the sign off of the assurance letter.

Figure 32

Outstanding Assurance statements and Annual Reports	
1.	Birmingham and Solihull Mental Health NHS Foundation Trust
2.	Birmingham Children's Hospital NHS Foundation Trust
Good Assurance statements and Annual Reports	
1.	Birmingham Community Healthcare NHS Trust
2.	Birmingham Women's NHS Foundation Trust
3.	Staffordshire and West Midlands Community Rehabilitation Company
4.	Birmingham Cross City CCG (plus Section 11 action plan)
5.	The Royal Orthopaedic Hospital NHS Foundation Trust
6.	University Hospitals Birmingham NHS Foundation Trust
7.	West Midlands Police
Received Assurance statements and Annual Reports	
1.	Staffordshire and West Midlands National Probation Service
2.	Birmingham City Council Early Help and Children's Social Care Division – People Directorate
3.	Birmingham City Council Place Directorate
Received Assurance statements	
1.	Birmingham South Central CCG (plus S 11 Action Plan)
2.	Heart of England NHS Foundation Trust (plus S 11 Action Plan)
3.	Sandwell and West Birmingham CCG
Received Annual Reports	
1.	CAFCASS
2.	West Midlands Ambulance Service
3.	Birmingham Youth Offending Service (but outstanding quality)
4.	Birmingham City Council Corporate Services
Not Received Assurance statements and Annual Reports	
1.	Sandwell and West Birmingham NHS Trust

Four annual reports were received that were not accompanied by an assurance letter, three of which were from different parts of the city council. There is clearly an issue for the council to resolve in terms of collective corporate leadership and governance arrangements for the "whole council's" approach to safeguarding children and promoting their welfare. Similarly three assurance statements were received without an annual report attached, of any sort. In understanding the overall effectiveness of those three organisations in 2014-15 we have relied on just their Section 11 statement. Four of the assurance letters across all categories were signed off at third tier or below level, providing no assurance that the most senior officers in those organisations have sought assurance before the assurance is sent to us. This is a governance issue for those organisations but it remains a concern for the Board that those agencies are not as robust in governance terms as is expected.

Having said that, overall it is important to recognise that the reports collectively provided sound evidence that in 2014-15 the Board's priorities were recognised and were informing individual agency practice, that key areas of work are genuinely rolling out from the board to the front line, that learning is being applied to practice and compliance with requirements improving. None of this in itself improves the safeguarding experience in an individual case but it is clear there is an increasingly shared understanding of what is required, to what standard and how we can use what we do to improve practice. The majority of reports were analytical, open and evidenced.

In terms of the **Voice of the Child**, nine agencies gave good information about how they were paying more attention to involving children, young people and their families better, listening to what they had to say, using it to inform case based and service level decision making, quality assurance and strategic decision making. Two agencies gave excellent examples and most of the NHS organisations referred to the use of patient stories as a regular tool in improving practice. All responses but one included an acknowledgement that this was one of the weakest areas of their work.

Early Help is at different stages of understanding, engagement and integration into frontline practice in different organisations. Twelve agencies set out how they were disseminating and training staff to use Right Service, Right Time effectively, how they were implementing it, and how they were evaluating its use and impact. Two gave examples of its impact on an individual case. Eleven agencies reported explicitly on what they were doing to improve practitioner understanding of their role in identifying need early and responding to it. Increased capacity, service redesign and the development of new resources were all mentioned in returns. The improved use of the fCAF, CAF, TAF and Family Intervention Teams, and (in five returns) Think Family resources and processes as well as the development of internal provision was referred to by most respondents with agencies being at different stages in rolling out the expectations of their frontline staff. However, the returns gave good assurance that early help was increasingly being viewed as a collective partnership and single agency responsibility, and not the sole responsibility of children's social care.

In terms of **Safe Systems** 12 agencies made significant references to the MASH, and how they were ensuring an improvement in the information used to seek advice or make referrals. All gave examples of how they were working to establish effective practice in relation to the MASH and to ensure all staff could follow the proper processes. However only three agencies were explicitly working on making a good referral. Some agencies also referred to the work they are doing as partners with staff working in the MASH. The majority of agencies reported on the work they were doing to implement the West Midlands Child Protection Protocol, embed Strengthening Families Practice models and tools within the workforce, or to understand and work within the Strengthening Families Framework. A wide range of other key issues were referred to by different organisations reflecting a variety of priorities within the system. Five agencies included the "Think Family Programme" within their reports, six referenced domestic violence and its impact, four included Female Genital Mutilation (FGM) and five set out the MAPPA work they were involved in. In terms of emerging issues, Child Sexual Exploitation (CSE) was discussed by 10 agencies and is clearly a high priority. However work with missing children was only mentioned by two, although five referred to radicalisation and Prevent. The absence of a collective focus on missing children reflects the poor performance across the system in terms of missing children in 2014-15. Four talked about the work they were doing to improve safeguarding practice in relation to children and young people with additional and special needs and disabilities, three about child and adolescent mental health services and associated challenges, and 1 discussed work they were doing on substance abuse and vulnerable parents.

Good governance arrangements including workforce development, learning, and governance was also covered in depth. It is good to see six agencies were working on developing better models of supervision, whilst 13 returns reported on extensive training

programmes for staff, including compliance levels with level 1, 2 and 3 training requirements. Fourteen agencies covered the range of audit work they were doing, and the way they were applying to learning to improve practice, eight discussed how they were using the learning and recommendations from their own serious child care incidents and the Board Serious Case Reviews (SCRs). Six talked about learning from complaints and eight applying the learning from external regulatory inspections. Three NHS organisations also set out how they were applying the learning from the Jimmy Savile Report. Three agencies were increasing their capacity to properly and appropriately focus on their safeguarding and promoting welfare responsibilities and duties and 10 discussed the ways they were strengthening their governance arrangements.

Overall the returns demonstrate significant forward progress, particularly on compliance, process and delivering the Board priorities. The impact of this is demonstrable through the data in the annual performance report. It is a positive sign of real progress and improvement.

The challenge for the Board in 2015 is to improve the span of agencies driving the priorities forward, and the consistency of their focus and "ownership" of the issues, and to share the work across partner agencies more effectively, reducing "silo" working.

An overview of the health "economy" contribution to safeguarding children and promoting their welfare in 2014-15.

A. Commissioner/Provider Assurance

The health system is committed to the promotion of safe and effective care that reflects positive patient experience (Department of Health 2008). Safeguarding is firmly embedded within this duty and is assured through the collaborative relationship between health providers and commissioners. Standard contractual requirements form the framework for this relationship. In addition in 2014-15 commissioners introduced the first safeguarding CQUIN (Commissioning for Quality and Innovation) scheme to directly capture and reflect on the experience of the child. This has demonstrably improved safeguarding awareness and practice in provider services. This is an innovative approach to achieving good practice through clarity of commissioning expectations. The impact is demonstrable as data shows increasing levels of attention being paid by providers to safeguarding practice.

B. Primary Care

Health commissioners have a duty to support improvements in the quality of primary medical care. In 2014-15 this was achieved through the training, learning and development sessions offered to GP practices; by identifying safeguarding leads in all practices and by introducing safeguarding champions to offer personalised and practice based support and guidance. Additional schemes to drive improvements in safeguarding included the Aspiring to Clinical Excellence (ACE) programme and the Quality Premium Framework or Local Improvement Scheme. Both focused on the communication between GPs and health visitors, thus ensuring that the needs of vulnerable children and families have been identified early and that information is shared to support timely intervention and improved outcomes for children.

C. Partnership Working

Despite the challenges over the 2014-15 year in terms of effective partnership relationships the health economy is committed to work with key partners in the city to improve the safety of children and their families. At executive level there is senior health representation at the Birmingham Safeguarding Children Board and on membership of each of the subgroups. Partnership working is further evidenced in the health contribution to the Birmingham Safeguarding Adult Board and the Community Safety Partnership. Working in partnership the Clinical Commissioning Groups have influenced the specification and commissioning of the health team in MASH which is now fully resourced and involves clinical expertise from across the health economy.

D. Child Protection Information Sharing programme (CP-IS) and IRIS

All health providers of "unscheduled care" in the city are planning for the implementation of the Child Protection Information Sharing programme. This will allow information to be shared about children, born and unborn, who have a Child Protection Plan and those who are looked after by the local authority. A pilot of the Identification and Referral to Improve Safety (IRIS) programme has been commissioned and will be trialled across 25 of the city GP practices. IRIS is a general practice-based domestic violence and abuse (DVA) training support and referral programme. It is aimed at women who are experiencing DVA from a current partner, ex-partner or adult family member. IRIS also provides information and signposting for male victims and for perpetrators. The safeguarding champions will act as facilitators for the programme.

E. Child Sexual Exploitation (CSE) and Female Genital Mutilation

Contribution to weekly regional oversight meetings is ensuring that health agencies are

recognised as key partners in addressing CSE. There is an established CSE Health Link Group that is attended by representatives from providers across Birmingham, Sandwell and Solihull. This group aims to achieve consistent standards for children and families to ensure safe, timely and effective service provision. Specialist named nurses for CSE have been commissioned to enable delivery of a bespoke model of operational input into multiagency forums. The service will be representative of the whole health economy, and include raising awareness amongst frontline staff, advocacy for victims, families and communities and outcome focused audit. Health commissioners helped to raise the profile of FGM by contributing to the first Birmingham Against FGM Summit held in March 2015. Work has progressed to review the service provision and care pathway planning for victims of FGM and health continue to be represented at the multi-agency Birmingham Against FGM subgroup.

The health priorities for action in 2015-16 have been identified to provide congruence with the strategic priorities of the Birmingham Safeguarding Children Board the revised version of the Working Together document (2015).They include:

- Embedding of the "Right Services – Right Time – Meeting Children's Needs" model to ensure that children in need and their families receive effective interventions and support.
- Dissemination and implementation of the Early Help Strategy across health agencies.
- Community engagement – developing ways we can actively capture and hear the voice of the citizen in shaping safeguarding arrangements.
- Contributing to safer communities: including Prevention of Violence to Vulnerable Persons/ Hidden crime, raising awareness of Prevent, domestic abuse, and work with the Community Safety Partnership.

4. Key areas of safeguarding activity in 2014-15

Priority 1 – Early Help

Right Service, Right Time Refresh

National guidance 'Working Together to Safeguard Children' published in March 2013 requires LSCBs to publish threshold guidance setting out the process for early help, criteria to determine levels of need and when cases should be referred to social care for assessment and statutory intervention. It further stipulates that the guidance must be understood and consistently applied by all professionals and ultimately lead to services that deliver the right help at the right time. The Ofsted Inspection in 2012 highlighted fragility and inconsistency in professional understanding and application of thresholds of need across the city. In response the BSCB published Right Service, Right Time (RSRT) threshold guidance in May 2013 and carried out a six month evaluation of progress the findings of which were presented to the Board in January 2014. Disappointingly the findings from an employee survey found that only 53% of front-line staff across organisations in Birmingham were aware of RSRT. During the same period the quality of fCAF and referrals to children's social care remained problematical. The Ofsted inspection in 2014 rightly highlighted concerns about how widely it was understood and applied.

In 2014-15 the Board's most significant programme of work was the redevelopment and dissemination of the "Right Service, Right Time Threshold model" (RSRT) in response to these concerns . The refresh was led by a multi-agency task and finish group, working closely with the MASH Programme Board and the Early Help Programme Board on its development. The key principles are that every child needs and receives universal services, and that at times they may also need more input, varying in its types and intensity, depending on the type of need, its complexity and potential to cause harm. It allows for movement between categories without any implication of a progression "upwards" towards the most serious intervention. It expects professionals to intervene early in the life of a problem or expressed need and to seek to meet that need with and through the family or carers of the child. It is predicated on agencies being prepared to accept and work with a degree of risk, and to ensure families are as far as possible supported to find their own solutions and ways to meet their own needs.(**Appendix 7**)

The March 2015 refresh of RSRT takes into account feedback from practitioners who felt the original guidance did not feel multi-agency and failed to engage professionals, particularly colleagues from the NHS. The new guidance includes early help services and provides better signposting to Team Around The Family Panels and Local Family Support and Safeguarding Hubs.

The re-launch incorporated good practice from high achieving LSCBs, reinforcing threshold guidance with a comprehensive training programme for front-line practitioners across all agencies. A series of multi-agency briefing sessions supported the training programme with 98% of delegates indicating they knew where to go for further advice, guidance and training. The Board have agreed clear 'Success criteria' for the refreshed model, which will inform the overall evaluation and impact assessment that will be presented to the Board on 15 December 2015.

The revised model was launched with an extensive programme of awareness raising events and a comprehensive single and multi-agency training programme, utilising training for the trainers and an implementation pack for each partner agency. Early adoption of the refreshed model means that the MASH referral pathways and the whole early help strategy are based on the application of the model. The impact of the revised model will be evaluated in the autumn of 2015-16. However it is clear from a range of data sources that the model has provided a common conceptual framework for all partners, and a shared language to use when considering, assessing and meeting need.

What is also clear is that the RSRT threshold model has not yet had sufficient impact on cultural behaviours across the system. The degree to which the child protection system was failing in 2009 to 2014 undermined confidence in practitioners and drove a culture of pushing things up to social care repeatedly when they had real and genuine concerns. The successful introduction of RSRT and MASH have restored confidence but resulted in a huge amount of work being escalated to social care, when it could be better dealt with in other ways. The development of early help is a key to achieving this change in 2015-16, as is greater clarity about when family support under s17 is an appropriate response and when it is appropriate to move to a s47 investigation. RSRT provides a strong platform to support that drive.

Early Help

At the beginning of the 2014-15 year early help was not sufficiently well developed, co-ordinated or understood within the council and across the partner agencies. The BSCB Board developed and consulted on a "definition" of what we mean by early help in Birmingham (which was congruent with the RSRT refresh). This definition was agreed by the Board, disseminated across the city and used as a baseline for a common understanding of what is meant. This was to ensure that being assessed as "child in need" (under S17 of the Children Act 1989) and provided with social care services was not seen by partners as the only way in which children receive "early help". It was also designed to underpin and support the BSCB Neglect project and campaign being led by the Board with partners and the NSPCC. A dialogue began during this period about how best to build on the development of local hubs on a multi-agency basis, and strengthen the approach of the Team around the Family (TAF) and the use of a Common Assessment (CAF) of a Family Common Assessment (fCAF) that was being developed in the latter part of 2014 and the early half of 2015.

As part of the Warner led Year 1 Improvement plan in the Local Authority the Early Help Programme Board was established to develop the multi-agency early help strategy. This strategy (appendix 8) was supported by the BSCB Board, widely consulted on and debated across a range of services. The successful work being led by the Think Family Programme Board, under the Troubled Families programme led by the Home Office was integrated into these discussions and thinking, as a good example of well led early help provided on a multi-agency basis.

The strategy outlines the vision, principles and approach for Early Help and identified seven strategic priorities.

1. **Leadership Partnership Working and Governance**
   - Develop an Early Help and Safeguarding Partnership and Governance for the ownership and development of Early Help in the City.
   - Develop a set of performance indicators that measure outcomes for children and their families.
2. **Strengthen and clarify the Early Help and Safeguarding front door pathway**
   - Develop online Early Help Information advice and guidance and service directory for families and professionals
   - Effective, streamlined front Door, supporting access to Early Help and Safeguarding services
3. **Assessment and Interventions**
   - Develop and implement an early help assessment and a suite of intervention tools for Early Help.

4. **Information Sharing**
    - Develop speedy and effective process for sharing information between agencies
5. **Localities and Pathways**
    - Develop consistent Area Locality working including level 2 and 3 Family Support/Think Family offer, reviewing the current Team Around the Family Panel arrangements and identifying increased opportunities for integrated working.
6. **Workforce**
    - Develop a skilled and competent workforce across the partnership
7. **Commissioning**
    - Develop a joint commissioning Framework across early help and support a refreshed Joint Strategic needs Assessment.

The Early Help Programme Board has now (2015-16) become integrated into the Birmingham Early Help and Safeguarding Partnership Board (BEHSP). The BEHSP is accountable to the new Strategic Leaders Forum and will report on Early Help performance to the BSCB. The Partnership will agree and oversee the development of consistent and coherent multi-agency Early Help and Family focused partnership work, interventions and approaches, commissioned and/or provided by agencies (including schools) working with children and families. The Partnership will build on the success of Think Family and MASH in bringing agencies together to meet children's needs, by broadening this partnership approach to Early Help, children in need and child protection in the hubs and areas across the City. The BEHSP will produce an annual work plan with milestones and leads. It will also produce an annual report of Early Help achievements/areas in need of development. The first meeting took place on 20 July 2015 and will meet monthly from September 2015.

Ofsted also expected BSCB to ensure that partners urgently agree a definition of early help and drive the implementation of the Early Help Strategy so that partners are fully engaged in the work to achieve and deliver this. The definition is agreed and in use though still not fully recognised and used by individual agencies in their own agency early help work. Assurance and Annual Reports demonstrate a variable engagement in early help although every agency is now involved in developing services.

A Board led BSCB Early Help Working Group was also established as a task and finish group on a multi-agency basis. As well as actively contributing to the development of the strategy the group did an analysis of the evidence for what forms of early help intervention are the most effective. In addition it identified the number of assessment protocols in the city (400 different assessments exist at present), looked at some potential tools for evaluating impact and outcomes as a result of providing early help interventions, and developed a framework for ensuring the provision of a coherent early help offer through a set of service response pathways and assessments, intervention and evaluation tools. In addition it agreed an ideal model for a coherent system of integrated common pathways, processes, and tools to use for all forms of early help within the RSRT model. We also contributed to the development of the strategy and the revised fCAF material and MASH tools. This work has recently transferred to the new Assessment and Intervention work stream of the BEHSP.

Neglect campaign and outcomes

In recent years BSCB and its constituent agencies have run a number of initiatives around the theme of child neglect, including conferences for professionals. In the latter half of 2013 BSCB felt there was a need to reinvigorate work around neglect. Across the city there are a high number of young children where issues of neglect were negatively impacting on their health and well-being. In order to develop an early intervention model and improve outcomes for young children, it was agreed that the approach in Birmingham needed to embed a clear understanding of the impact of neglect, the recognition of signs and symptoms and the use of evidenced based interventions that are monitored and evaluated. The NSPCC was pleased to offer to work with Birmingham Safeguarding Children Board (BSCB) and member agencies to plan and deliver a neglect campaign in Birmingham based on its experience in NE Lincolnshire. A campaign planning group was formed from members of the Neglect Task Group, LSCB representatives and, subsequently, staff from the three localities where the pilot activities took place. A full evaluation of the campaign is attached as appendix 9. Three pilot areas (Handsworth, Aston, and Nechells and Erdington) were chosen on the basis that they were each at a different stage of integrated and partnership working, especially in relation to the introduction of the Team Around the Family hubs (TAF). The differences between the three sites were reflective of the differences evident across the city and therefore, the pilot work could be replicated, if successful, in other areas regardless of an individual area's track record around neglect.

The campaign objectives were to:

1. To increase professional and public awareness of the nature of neglect and its impact on children
2. To ensure adults are aware of sources of support and advice

3. To maximise the capacity of universal services to support children who are at risk of neglect effectively and safely.

In total, approximately, 560 professionals directly accessed the professional-facing campaign events, with others being given access to training materials, workshop information and campaign booklets. The increase in contacts to the NSPCC helpline throughout the campaign, with a particular focus on those seeking help/advice early. On average, the number of weekly contacts that required a referral were between five and 11 and the number of contacts that required information or support were five or under. Anecdotally, colleagues working within the MASH reported a slight increase in the number of neglect cases that were referred to them, which is consistent with reporting, again anecdotally, at Children's Centre level.

Each of the pilot site planning groups report a level of success in terms of numbers reached and increased levels of community engagement/support for the campaign. In total, approximately 2,650 people were engaged with as part of the delivery of a variety of community-led initiatives, looking at raising awareness of and tackling neglect.

The campaign's key findings are that:

1. Asking vulnerable parents to seek help if they are struggling is a very difficult message to hear and even more challenging to expect them to act upon. The core campaign audience must repeatedly hear the messages to affect real behaviour change (asking for help).
2. Branding events with positive parenting messages works well to engage parents and their families.
3. The 'Neglect Matters' booklet was particularly well received by parents and professionals alike. It has since been adapted and used in a variety of guises to support group work and individual work with parents.
4. There was less media pick up of the campaign than we had hoped for. The media is still very negative about agencies working to protect children in Birmingham which may have affected their willingness to support the campaign. These relationships should be addressed.
5. Facebook advertising proved very effective in generating engagement with the campaign.
6. Staff who contributed to the design and the delivery of the campaign through the campaign planning group were, in general, struggling to meet the demands of their 'day job' and couldn't always give as much time to the campaign as they would have liked to due to work pressures.
7. The professional workforce are keen to address the issue of neglect in Birmingham through increased access to training, sharing of good practice, working alongside neglect 'champions', etc. but have concerns that neglect is not a priority for strategic leads due to sheer numbers affected and its complexity.
8. The first seminar and training event were not as well attended by the target audience as the second and third events due to delays in advertising and a lack of targeting the appropriate staff to attend.
9. Pilot site activities need a longer lead in, planning time than was allocated for this campaign. Getting the right mix of local agencies and individuals to come together and identify a plan of action took much longer than was envisaged.
10. All three pilot sites were able to incorporate neglect campaign messages into their 'business as usual' activities which has helped mainstream the messages and reduce costs.
11. Events that were open to the whole of the professional workforce in Birmingham were always oversubscribed, leading to events needing to be replicated and/or disappointed practitioners who are unable to access places.
12. Whilst the campaign planning group were grateful of the financial backing and practical support given by SCB colleagues, the campaign could have had more of a reach with an increased budget focused on paid for advertising over a sustained period of time, rather than one week blocks.

The learning and recommendations from the campaign are being fed into the work of the BEHSP.

Early years review

Over 2014-15 the council led a major piece of work into early years services. The Early Years Review concluded there was scope across several key areas to improve the early years service offer. These included:

- More consistent delivery of outcomes
- Opportunity for better integration with other services including health
- The service model needed to deliver better value for money and a sustainable funding model going forward
- A better and more coherent offer to those more vulnerable and in greatest need

A vision for the future of the Early Years Service in Birmingham was developed and agreed by the Early Years Review Board as follows:

"The vision for Birmingham is to have an early years offer which supports the multiagency early help strategy and which ensures an integrated early years service bringing together health, family support and early education to provide both a universal and targeted offer, improving outcomes for children."

There were a number of conclusions from the review which needed to be addressed through the selected option in order to ensure we have a service that is delivering the outcomes families need and that delivers value for money as well as high quality services. The conclusions that require addressing included:

- The quality of provision is weaker for the most deprived families
- There is potential (and a pressing need) to develop a more cost effective model of delivery
- The relationship between the local authority and local providers needs to improve
- Improving front line relationships with health, including the possibility of joint commissioning, would significantly enhance the system's ability to identify and support vulnerable families
- The relationship with the schools sector via the Schools Forum needs to be more formalised through the Early Years Forum
- There is significant scope to improve the take-up of services – notably amongst vulnerable groups.

The preferred commissioning model around a new integrated early years service will support pre-school children to be healthy and really good learners - it will transform the life chances for many children in the city and give them better lifetime outcomes. Earlier help will be given to those children and families with greatest needs. Parents will be offered support before birth and up to the start of primary school through the integration of health visiting and early education.

The service will help parents to find and stay in work before their child goes to school. The service aims to support families through some of the challenges that they face. It will be a joined up service so parents don't have to work out which particular agency to call. It will work closely with other services which help children and families such as GPs, hospitals, schools as well as local voluntary groups.

Safeguarding and Family Support Hubs and area developments

Throughout 2014-15 targeted early help and children's social work was delivered through three main area offices (North West & Central in Aston; East in Erdington and South in Stirchley) and 14 hubs. Children in care and court teams have been based at the area offices, while the social work safeguarding teams and the Level 3 Family Support teams have been co-located in most cases in the hubs (usually 2 safeguarding and one family support team per hub). Most hubs also include a children's centre and relate to schools and health local to that hub. During the year hubs have been developed to support this co-location of services.

The establishment of MASH enabled the safeguarding teams to focus on long-term work, but as MASH sent out referrals to safeguarding teams and demand grew, safeguarding teams were initially overwhelmed with work from initial (single) assessment to child protection to children in care. Throughout the year about 20% of children in care were allocated in safeguarding teams. To deal with this pressure the year ended with a clear plan to establish Assessment and short-term intervention (ASTI) teams in each area office in April 15. In early 2015 safeguarding teams were getting on top of the work load, were fully staffed (30% agency), and were making sure each case had a meaningful plan of intervention and support.

In each hub there is a family support team who attend TAF meetings and relate to local partners as well as supporting the work of their local safeguarding teams. The introduction of Right Service, Right Time refresh in March 2015 has helped the Family Support teams begin to develop a clear level 3 offer aligned to phase 2 of the Troubled Families programme.

Reflecting the need to change multi-agency practice and improve our focus on non-statutory early help interventions whilst ensuring we provide high quality social care interventions to those children and young people who most need it, the children's social care priorities for 2015-16 are:

- Establishing a strong Assessment and Intervention Service in Birmingham
- Establishing a clear and consistent Family Support offer throughout the City
- Ensure children in care have active plans to long-term stable placement supported within children in care teams
- A focus on the quality of social work practice with children and families in assessment, intervention, Child in Need planning, Child Protection, and children in care/care leaver planning.

Annual summary of the specific work on early help in Birmingham from West Midlands Police

In 2014-15 West Midlands Police (WMP) began to address the need to involve their local policing units (LPUs) in early help work as well as actively transforming their work of safeguarding and child protection. This began to come to fruition in

2015-16 with a Chief Inspector appointed to support the implementation of the Early Help agenda for Birmingham and there is now a delivery structure for the work. It was clear by the end of the 2014-15 year that work is still required around the quality and consistency of information sharing at all levels and this will form a substantial part of the work. The Team Around the Family meeting process across the city also requires greater consistency with approaches varying across constituencies.

Responding early to any identified need for early help was also actively addressed by West Midlands Police (WMP) by changing their approach to referrals across the Birmingham Local Policing Units (LPUs) with regard to referrals of children and young people who come to police attention for a variety of reasons. This includes those who come to the attention of the criminal justice system but also those who are affected by Domestic Violence and Abuse, Anti-Social Behaviour, victims of crime, truancy, mental or ill health, CSE etc. The Birmingham LPUs have adopted the recognised best practice from Birmingham North LPU. Officers attending relevant incidents assess any intervention needs of young people around a range of safeguarding measures. Each LPU maintains a portal referral system that gives options around substance misuse, DV, sexual behaviour, mental health etc. Referrals are also automatically picked up for issues such as children witnessing DVA. Early intervention may also be offered by way of sharing information and liaising with social care re children in care and missing persons. Again this will not be recorded on the referral portal but details will be shown against missing person's numbers. LPU's refer concerns on to Think Family, Princes Trust, MASH, Multi-Agency Sexual Exploitation panel, Home Start, Children's Centres, YMCA and Streetwise. Their concerns range from being homeless to lack of education. Children are also mentioned on referrals for adults, mainly around DV incidents.

The numbers of referrals made about children and young people, annually across Birmingham to partner agencies from the police are significant and increasing. Over the 12 months 5,700 referrals were received through the Birmingham LPU Portals. Around 8% relate solely to children under the age of 18. However, the percentage figure around children who receive support along with adults (family members etc) is likely to be far higher. (These details are at present unavailable). Their concerns range from being homeless to issues around education provision. Children are also mentioned on referrals for adults, mainly around DV incidents. Further performance analysis is required to quantify how many further children have received support.

Think Family work

The Birmingham Think Family Programme has been a high performing programme providing significant amounts of early help interventions in the city for a number of years. A full report on the work of the service is available at **appendix 10**. Case supervision and practice is managed day to day by the services commissioned to provide the Think Family interventions. The core Think Family team matches families to providers and monitors family outcomes, identifying potential outcomes for Birmingham audit who verify them for Payment by Results claims. Birmingham has met 95% of the 4,180 families target set by the Troubled Families Unit in phase one, which has met the target for inclusion in Phase 2. The Think Family referral pack sent to the partnership includes the Right Service, Right Time (RSRT) framework. This supports effective referral and identification to Think Family provision for families with multiple additional needs who require whole family integrated interventions. Substantial and intensive support is offered through Think Family providers including Youth Offending, Place Directorate and Family Support within the 14 Hubs, eight commissioned Third Sector Providers and Multi Systemic Therapy. Intensive Family Support for 2014-15 contracts have been extended to March 2016.

At the end of 2014-15 the Think Family service began to line-manage and review the Early Help and Brokerage support within the city. This involves quality assurance on multi-agency, family common assessments (fCAF). Triage arrangements for Think Family have been strengthened to include co-ordination with the Multi Agency Safeguarding Hub (MASH) allowing appropriate cases to be identified as Think Family earlier and receive appropriate intervention

There are new expectations from the Troubled Families Unit (DCLG) for the expanded phase 2 transformation programme. These include a requirement to agree a Family Outcomes Plan, participate in a National Impact Study and input into a Cost Calculator. There will be an increase in evidence required for the extended criteria which will require additional analytical capacity and the adoption of distance travelled tools to support assessment of outcomes and impact of the model. This would measure work with families and better allows for co-ordinated multi-agency work where those partners adopt the same measures to assess progress. The Troubled Families Unit will require significant and sustained progress with families to be achieved on all measures in order to agree Payment by Results payments.

The emerging themes and areas for improvement in the service in 2015-16 includes areas of concern within families:

- Parents and children involved in crime or anti-social behaviour
- Children who have not been attending school regularly
- Children who need help
- Adults / young people out of work or at risk of financial exclusion
- Families affected by domestic violence and abuse
- Parents and children with a range of health problems

To be successful in expanding the programme, specialist provision to support emerging themes including adult and young people mental health and substance misuse, those missing from home or with long term health conditions not being managed and to address the scale of domestic abuse and violence in the context of both its prevalence and its impact will be needed, which provides a challenge to the newly commissioned 0-25 Mental Health Service. An ongoing challenge is the reduction in funding from the Home Office.

The Youth Offending Service

The principal aim of the Youth Justice Services is to prevent offending and re-offending by children and young people (10-17 years). Birmingham Youth Offending Service (YOS) is a statutory partnership with representation from the local authority (specifically Social Care and Education), the Police, Probation and Health. The model brings together a range of agencies with expertise in welfare and enforcement practices to improve outcomes. The majority of YOS services are prescribed by statute or policy.

Strong partnership working across criminal justice and children's welfare services is essential to effectively addressing the welfare needs of children and young people who are at risk of offending. YOS provides assessment, supervision and management of risk and safeguarding, ensuring a commitment to equality and evidence based practice.

The service works in partnership to achieve the national Youth Justice strategic objectives which are to:

- Reduce first time entrants
- Reduce re-offending
- Reduce custody
- Protect and support victims
- Promote the safety and well-being of children and young people in the criminal justice system

Measures which contribute to better safeguarding include the fact that YOS staff are trained in Right Service, Right Time (RSRT), strengthening families, evidence based assessment and intervention programmes integrated into Early Help provision through TF referrals and provision of specialist services (offending behaviour programmes, intensive multi-systemic therapy, sexually harmful behaviour intervention. They are able to access and use Specialist interventions to address substance misuse, mental health and CSE, provide consistent CSE screening and appropriate interventions which may include referrals to MASH for multi-agency action, have continued partnership work to identify young people with special needs and effective evidence based interventions matched to need. In addition the service has enhanced MASH integration and swift access for young offenders via MASH to Early Help and YOS specialist services.

The services adhere to BCC safeguarding policies and procedures and in the delivery of structured, evidence based holistic assessments. Robust vulnerability and risk plans provide evidence for interventions that reduce offending behaviour and increase resilience. Parental ability to safeguarding and young people's ability to cope with life stressors in enhanced so promoting safeguarding for YOS young people and the wider community. The five multi-agency youth offending teams hold local education, training and employment panels to track and review any young person missing from education, with low attendance levels or who are NEET.

The YOS has national indicators in relation to the above objectives and is monitored on its performance by the Youth Justice Board (YJB). The full report presented to BSCB is attached as **appendix 11**.

Birmingham MASH

One of the major multi-agency programmes in the City in 2014-15 was the development of the Birmingham Multi-Agency Safeguarding Hub (MASH). MASH was agreed as the primary strategic multi agency response to reaching and meeting high levels of "unidentified risk" as articulated by Ofsted, Le Grand, Kerslake and Lord Warner and went live on 29 July 2014. The MASH is a fully integrated and co-located multi-agency team based in the centre of Birmingham. BSCB has played a key developmental role and acted as a critical friend to the MASH board and has undertaken monthly Multi Agency Quality Assurance audits on the quality of referrals, consent and decision making within MASH.

The MASH focuses on receiving referrals for children believed to be suffering significant harm, including

domestic violence. Each agency within the MASH has access to their own IT systems and shares information as appropriate with key partners. This enables partners to gain a much more timely and comprehensive understanding of the current situation, together with any relevant historical information. The team jointly discusses and assesses the risk and needs of the child and agrees what action needs to be taken. Between go live and 31 March 2015, over 16,000 referrals have been made to the MASH.

MASH is embedded within the Birmingham 'Right Service, Right Time' (RSRT) model. The key determination within RSRT is that MASH responds to all children with complex and significant needs under the auspices of an Information Sharing Agreement which has been agreed between the MASH partners. Where concerns identify the child is suffering significant harm the MASH social work teams with Police Child Protection teams will undertake joint or single agency Section 47 enquiries.

Birmingham MASH wanted to be as wide a partnership as possible with contribution beyond the "big three" agencies. As a clear demonstration of partners acknowledging safeguarding is everyone's business Birmingham MASH now has the following services either full or part time as part of the service.

- Birmingham City Council Children's Services
- West Midlands Police
- Birmingham Community Healthcare NHS Trust
- Birmingham Children's Hospital NHS Trust
- Birmingham and Solihull Women's Aid
- Birmingham Education Services
- National Probation Service
- Staffordshire & West Midlands Probation Service
- Birmingham City Council Housing Services
- Birmingham & Solihull Mental Health NHS Foundation Trust
- Birmingham City Council Early Help & Brokerage Service
- Think Family
- Barnardo's – Child Trafficking
- Birmingham City Council Youth Service and Youth Offending Service
- CRI – Substance Misuse
- Birmingham City Council CSE Service

Figure 33 provides a MASH profile for the 2014-15 year. In common with all MASHs nationally, Birmingham MASH has experienced a steep curve of demand but there are now the signs that this demand levelling off and a projected reduction to follow. If the trajectory for the year continues, 2015/2016 would see the below reduction in demand.

Referrals down 9% **ICPCs (MASH) down 31%**

Sec 47s (MASH) down 20% **CPPlans (MASH) down 34%**

Whilst MASH has impacted significantly on children being protected within the City, the rate of children currently on Child Protection Plans is now within comparator statistic.

MASH referral activity

MASH contact statistics show that the Police are the highest referrers to children's social care, followed by schools and educational settings. However, if the number of domestic violence referrals were not included then schools would present as the agency most engaged with the MASH.

Figure 33: Percentage of contacts by referring agency (Oct 14 - Mar 15)

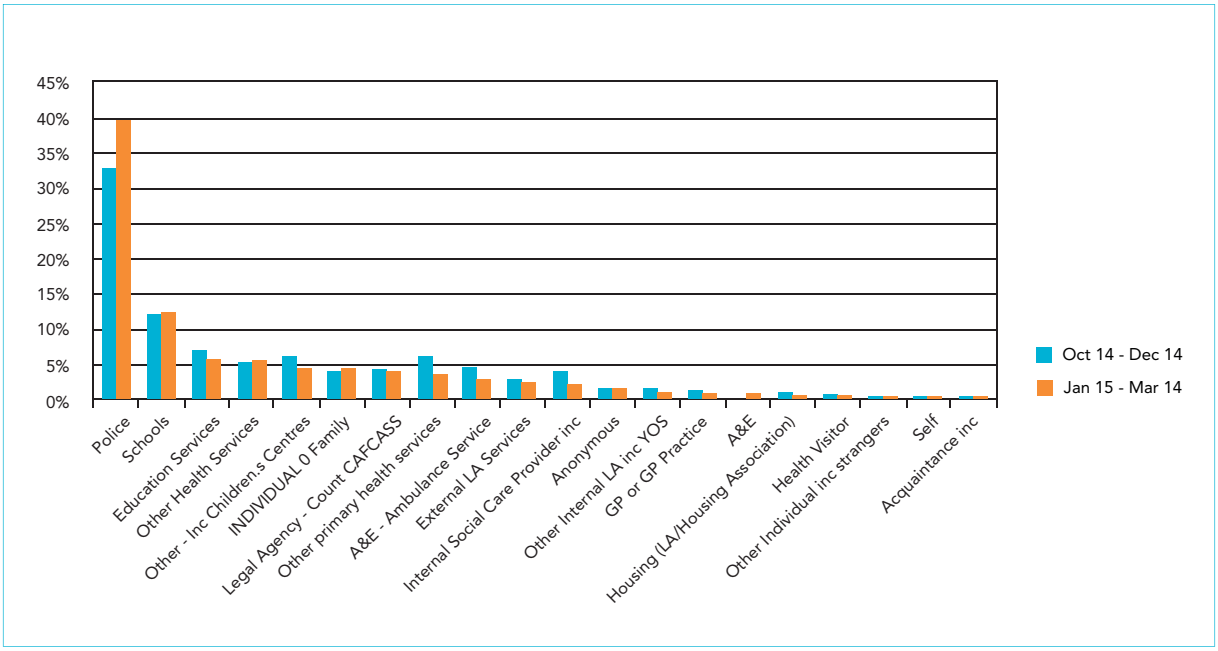
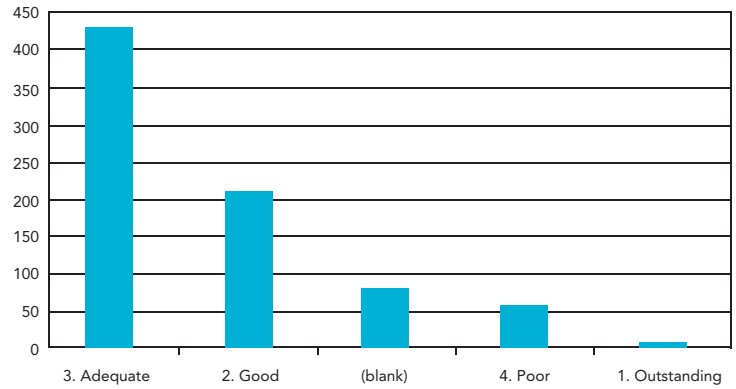


Figure 34



Since the introduction of the new MARF/Contact Referral form, each referral receives a quality rating by the person taking the referral (9 February 2015). Figure 34 shows data for the two month period since the new MARF/Contact Referral form went live. The majority of these were rated 'Adequate'. The BSCB Front Door Reference group (Audits) has reported improved quality of referrals for five consecutive months.

Lord Warner as Children's Commissioner for Birmingham took great interest in the Development of MASH and reported monthly to DfE. As a consequence Ofsted undertook an Improvement Visit to MASH in January 2015. This was undertaken by the same Chief Inspector and colleague who had previous judged services to be inadequate. In feedback from their visit Ofsted reported that as well as being impressed by the progress made there was:

- Discernible and strong partnership commitment and engagement
- That all staff 'go the extra mile'
- Management is strong and visible and staff feel safe
- High level of self-awareness
- Quality of work is good
- The voice of child evidenced
- Quality of referrals have improved.

They also identified where further improvement was necessary:

- There was a high degree of workforce fragility with high throughput, and caseloads
- There was an issue in achieving better Demand Management (by ensuring more children received early help by creating culture change without alienating partners
- The impact of including Domestic Abuse work has created major volumes, backlogs, etc

The MASH service identified that in addition they had to resolve a number of issues and additional challenges it needed to address by the end of the year including:

- The relationship and referral arrangements and pathways between the CSE system and MASH
- The relationship and referral arrangements and pathways between Missing and MASH
- The crucial importance of developing and providing an effective co-ordinate early help service and a range of interventions and offers. Early Help – Need to play catch up

Whilst much progress has been made, it is only fair to say the service is 'safer' but not yet 'safe'. However it is beyond dispute that the impact of MASH on the protection of children has been significant. The below chart indicates that the service has resorted partner confidence that the local authority will respond to concerns (contacts and Referrals), and that children previously unreached are now being reached (Section 47 and CP Plans).

There is little doubt that Birmingham MASH has attracated a lot of local, national and political interest. Year one of MASH was always seen as the Foundation Year with the priority being to restore partner and public confidence in Child Protection services. To this end much progress has been made and this has been publicly acknowledged by Lord Warner, Sir Bob Kerslake and Ofsted. MASH has made a very positive start, has been a catalyst for change and improvement and as its first anniverary of operation approaches it is hoped the progress made continues and becomes embedded as the way we protect children from significant harm in the city.

The challenge for partners in 2015-16 is managing an appropriate rebalancing of the system, to reduce the amount of work going through the MASH when it can be better dealt with at RSRT Additional Needs and Universal Plus needs levels, without undermining agency confidence or the momentum gained by the successful development of the MASH. In addition the rebalancing of the relationships between the highly centralised city wide service (MASH) and the three

local area service delivery model agreed with Lord Warner will be a challenge for the council working with its partners in 2015-16.

The Local Authority Designated Officer Service
The Local Authority Designated Officer (LADO Service) fulfils the Local Authority Statutory Duties under Working Together to Safeguard Children (2015) and sections 10 to 11 of the Children Act 2004. This most recent guidance has significantly reduced the details and complexity of guidance for managing allegations against people who work with children. This allows for much more local discretion and reductions in unnecessary processes and allows for a focus on the key requirements needed to keep children safe.

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

In 2014-15 there were 1,076 referrals to the Birmingham LADO this year as compared to 864 last year, which represents an increase of 24.5%.

Of these referrals 211 were taken forward to managing allegations meetings. This compares to 219 meetings held last year. A large number of referrals will be closed as advice only. Of the total number of referrals during 2014-15 the number that were closed as advice only was 839 cases as compared to 606 last year which suggests that on balance the same proportion of referrals are dealt with at source commensurate to the overall number of referrals. This may well indicate significantly heightened awareness of safeguarding issues within the workforce across most organisations.

The largest number of referrals were received from education and this continuous a year on year trend. The figures for this year are 331 as compared to 270 last year. A significant number of these referrals were received as parental complaints from Ofsted. The referrals from education are now broader and will not just involve staff members but may also include referral about education transport and possibly voluntary agencies that may be using the school site. This reflects a greater understanding about the role of the LADO and schools' willingness to refer anyone of concern that has any connection with the school. The issue of allegations in relation to physical restraint within schools and residential homes continues to feature in the referral base and the police are involved in a great many of these cases.

The second largest numbers of referrals are received Early Years partners with referrals about residential children's services featuring as significant as well. There has been an increase of over 100% in the referrals received from Early Years partners this year 136 as compared to 65 captured last year.

Sexual abuse allegations remain comparatively high and this no doubt results in part from the awareness around sexual abuse that cases post Savile have generated and the high profile given to sexual abuse generally through the media. Across all agencies there were 146 allegations of sexual abuse against a child which would include allegations of use of sexual images/inappropriate texting/inappropriate use of social media by staff working or volunteering with children. There were 438 allegations of physical abuse against children across the agencies. As recorded in previous years by far the majority of these were lower level allegations made against education staff. There were 103 allegations of neglect. In respect of emotional abuse the referrals for this year show as 105.

Due to staffing constraints it has not been possible to meet the National Standards which directs that 80% of cases are resolved within one month. However the other standards have been achieved that being that 90% of cases were resolved within three months and all but the most exceptional cases were resolved within 12 months.

The full LADO Annual report is attached as **Appendix 12**.

Children in care and young people leaving care
Children and young people in care, young people and care leavers continue to be recognised as a vulnerable group in society, despite the attention over recent years paid towards improving outcomes for them. This was not a priority for the Board in 2014-15. However the Board was aware that there were significant issues with the volume, quality and approach to care in the city. As part of the year 1 Improvement Plan a major programme of work took place. This culminated in a new strategy for Corporate Parenting, agreed and published in March 2015 and subsequently scrutinised by the BSCB Board. (**Appendix 13**)

The term Corporate Parenting is used for the collective responsibility of the Council and its partners to ensure the care and protection of children and young people in care, as well as care leavers. The overall aim of this strategy is to reinforce the

corporate responsibility of everyone in the Council, both elected members and staff and of its partner agencies, to improve the life chances of children in care and care leavers and get the right support and services where they live. The strategy will ensure that Councillors and all those who work with this group of children and young people are aware of what their responsibilities are. The strategy will take a whole-authority approach to drive forward, support and strengthen the areas of good practice and work with key partners in the statutory, voluntary and independent sectors. The Corporate Parenting Board will provide governance and an overview to ensure outcomes for children in care improve.

A children or young person who is looked after by the local authority has the right to expect that their corporate parent will care for and protect them and have the same aspirations and commitment to them as any good parent would have for their own children. Birmingham City Council and its partners are committed to provide high quality services that promote good outcomes for children and young people and doing all they can to support them to achieve their full potential and to celebrate their successes. To achieve this, the whole system must work together: to identify need and intervene at the right time to prevent escalation and, where appropriate, to assess effectively, bring children at risk to safety, and as Corporate Parents to move quickly to help those children achieve their long term plans.

There are some key areas for specific focus:

- Consolidations in practice, to avoid drift in the system and to ensure resources are used only where intended. Evidence from 2013-14 suggests that discharges from care are at a lower rate than comparators. Policy, practice and process can be strengthened to enable better planned and more appropriate placement in the first instance and, subsequently, more timely permanence planning, case progression and exits from care.

- Support more children in care to succeed. Recently attainment of GCSE A* to C grades has improved, but the gap between children in care, in contrast to the wider Birmingham CYP population, still requires improvement. Care leavers are still less likely to find Education, Employment or Training in Birmingham than in similar areas. As of January 2015, the number of Children in Care (CiC) in Birmingham is 1,690 and 376 Care Leavers.

The Corporate Parenting Board (CPB) is a strategic board which meets every three months. The board considers issues for children and young people in care and champions how these issues can be addressed. It oversees the Corporate Parenting Strategy to ensure the responsibilities are fulfilled through delivery of services and the achievement of outcomes for children and young people. The Corporate Parenting Working Group is a multi-agency operational group which meets monthly. The group works on key priorities, themes and issues identified and directed by the CPB and aligned with the Corporate Parenting Strategy, to ensure delivery of actions required and the achievement of outcomes for children and young people. The views of children and young people are represented by Children in Care Council presentations to the Board and through young people as board members they participate in decisions about their care and the shaping and delivery of future services and report on this progress. The Corporate Parenting Board members are keen to deliver on improving outcomes in a structured approach aligned to the NICE guidelines (NICE quality standard 31 April 2013. Outcomes are confirmed by gaining feedback from children and young people and evidence from data.

A challenge for the Board in 2015-16 is to include children in care in its safe systems priority to gain a better understanding of how well they are safeguarded and their welfare promoted.

Private fostering

The Children Act 1989 defines a privately fostered child as: "A child under the age of 16, or 18 if the child is disabled, who is cared for (or will be cared for) and provided with accommodation by someone who is not a parent, a close relative or someone who has no parental responsibility for the child for a continuous period of 28 days or more. A close relative is defined as an aunt, uncle, grandparent, brother or sister and this includes step relatives and half relatives. A parent includes an unmarried or putative father. A cousin or great aunt or great uncle is not a close relative under the Act. If the period of care is less than 28 days but there is an intention that it will exceed 28 days it is considered to be private fostering. Some examples of private fostering include:

- A teenager moves in with a friend's family because of a breakdown in relationships at home, or parents move out of the area.

- A child is left with the unmarried partner of his/her parent because of the imprisonment of the parent.

- Host families looking after children at language schools or boarding schools during the summer holidays, where this is longer than 28 days.

There is a duty placed on anyone involved in a private fostering arrangement to notify the local authority. Local authorities do not formally approve or register private foster carers. However, local authorities need to be satisfied that the welfare of privately fostered children, or children who are likely to be privately fostered, is being safeguarded and promoted. Local authorities are responsible for all privately fostered children who reside in their area. The duties of Local authorities are as follows:

- Compliance with the notification system.
- Assessment of the suitability of private foster carers and their households.
- Monitoring of placements.
- Raising public awareness.
- Compliance with the National Minimum Standards.
- Overseeing of Private Fostering via Local Safeguarding Children Boards

On 3 April 2015 there were 28 private fostering arrangements known to the council. This was a reduction of four from 32 at 31 March 2013. The data base has been revised to show 26 children are currently living in private fostering arrangements. Figure 35 identifies the current number of open private fostering arrangements and the year the arrangement begun.

Figure 35

Year	Number
2015	4
2014	10
2013	5
2012	3
2011	2
2010	1
2009	1

*the data is not available of new arrangements opened and subsequently closed in the year. Given the size of Birmingham this is an area of risk which requires some focus over the next 12 months.

5. Safeguarding in schools in the city

What our performance tells us about the work we did to improve safeguarding in schools

The annual Section 175 report and data
Every school is expected to undertake a self assessment of their safeguarding practice annually, report it to their governing body and act on the findings. This is referred to as the Section 175 report. The Safeguarding in Education audit (Section 175) has been carried out in the city for the last three years and there has been steady improvement in return rates and compliance. In 2012/13 63% completed; 2013-14 97% completed; 2014-15, 97.6% complete or partially complete;

The main areas of concern identified in 2013 were:

a) Staff not receiving training on racism and homophobia
b) Schools not providing e-safety briefings for parents
c) Staff guidance on conduct and behaviour outside school which might compromise child safeguarding issues or bring the school into disrepute
d) Evidence that governing body has undertaken training about safeguarding and child protection
e) Annual survey of pupils' views on bullying in school and beyond the school gates

The 2013-14 Audit identified eight main areas of low compliance by schools :

a) The LA is kept updated of any changes to the Designated Safeguarding Leads and the school's central register is updated to show the Designated Safeguarding Lead (question 2.3). This is still at 10% of all schools with 17% of inadequate schools not informing the authority of changes and 16% of secondary schools with 6th forms

b) Where school premises are used by independent services outside of school hours the governing body have sought assurance that the service has appropriate policies and procedures in place, including safeguarding policies, operate safe recruitment practices and have appropriately trained staff to deal with incidents of actual or suspected abuse (question 5.5). 9% of schools report that they still do not comply with this question (6.6), 33% of 14-19 schools, 40% of Independents, 64% of schools judged inadequate by Ofsted responded that they did report.

c) The school offers regular briefings to parents and children on e-safety which includes online exploitation (commercial and sexual exploitation). (question 5.6) – covered later in report

d) The school needs to evidence how they gather

children's views on bullying and how they act on the concerns that are highlighted.(question 5.7) – covered later in report

e) Your staff undertake regular training on racism and homophobia (question 5.9). – covered within training report

f) The school identifies children who are young carers and assesses their needs. (question 9.5) – 24% of schools who responded said that they had no policy covering this area

g) Monitoring of the audit action plan by the Head teacher and the governors

The 2014-15 audit asked schools to complete an online self-assessment tool developed for the Board by Virtual College based upon the statutory requirements of "Keeping Children Safe in Education 2014" and the Ofsted Safeguarding requirements. The tool also combined the section 11 requirements so that Children Centres linked to Nursery Schools could complete one audit rather than having to complete two separate audits. The use of the online tool has brought some benefits in that schools can now print a summary, main report and an action plan from the system. However, the reports are currently considered to be too long and the online tool has been considered somewhat difficult to move around not flowing easily between questions.

Compliance with submitting the audit on 10 July 2015 was 97.6%. At the deadline for submission of 31 May 2015 89% of schools had started the audit (54/489 schools not including Children Centres and Further Education colleges). The largest groups not completing the audit were Independent schools (46%), All Through Schools (43%), Secondary Schools without 6th forms (29%), 12% of outstanding schools and 23% of Edgbaston schools (this district has the most Independent schools at 21%).

There were concerns last year in relation to some schools. These focused on five areas and the changes since last year indicated some further improvements in safeguarding practice but highlighted some specific concerns that will be followed up as necessary:

a) There is a child protection policy which includes references to safer recruitment and employment practices and reporting concerns in respect of children and staff. The response last year was 84% said yes. This year 96% of schools answering the question have said they have a policy which is regularly reviewed by governors. A new Schools Safeguarding Policy was published by Birmingham in December 2014 which will have supported many schools in this area. Schools have been reminded that a new policy was issued by Birmingham in May to cover new Prevent duty. 81% of schools inform parents in their prospectus of their CP policy

b) There is a clear reporting system if a child, young person, member of staff, parent or other person has concerns about the safety of children or young people which includes continued recording of low level concerns which when considered together may mean that action should be taken (question 9.1). The response last year was 96% said yes .This year 100% (question 7.1) of those that responded have said they record low level concerns however 67 schools did not respond to this question.

c) The school notifies the local authority of any children who have gone missing or who have been removed from the school's roll. The response last year was 98% said yes. This year (question 5.6) 100% of those that responded have said they take appropriate action to deal with children missing from education, 64 schools did not respond to this question (46% of these were Independent Schools compared to 6% of Maintained schools not responding).

d) The school has in place robust safe recruitment procedures which are compliant with the requirements of the Disclosure and Barring service (question 11.1). The response last year was 96% said yes. This year 100% (question 9.1) of those that responded said they had robust safer recruitment processes, of the 63 schools not responding 46% were Independent schools and 26% were within the Edgbaston District.

e) The school has the single central record of staff and other adults working in the school, as advised in current Safeguarding Children and Safer Recruitment in Education statutory guidance (question 11.2). The response last year was 98% said yes. This year 100% of those that responded (question 10.1) said they regularly maintained their single central record of staff and other adults working with children and young people in their setting. Numbers of schools not completing section 10 are the same as the safer recruitment section above

Key factors from the 2014-15 audit:
There has been an increased response rate across all schools even with an increase in the number of schools contacted to submit. But within this Independent schools have a significant lack of engagement.

The key areas which schools are responsible for within safeguarding have high response rates that they

comply with requirements i.e. 95% of schools report that they have robust governance arrangements in place, 97% report that they follow statutory guidance, 99% complete risk assessments for offsite activities, 100% of schools responding report that they have systems of reporting safeguarding concerns, they respect and value their students, that DSLs make staff aware of policies and procedures, schools have made appropriate action when students are persistently absent, keep records of low level concerns, have a person designated to attend CP meetings and have a regularly maintained Single Central Record.

Areas which had low rates of responding that the school had areas in place were:

a) Action Plans – 57% of schools who responded reviewed and submitted safeguarding action plans to Governors although 73% of schools responded that they had completed a safeguarding action plan. Of the schools responding to say that they did not review 14% were schools whose Ofsted result was Requires Improvement (RI) whereas Outstanding schools only had 4% who did not review their action plans.
b) Anti-bullying – 22% of schools reported not reviewing their anti-bullying policy with children and young people, 24% of schools did not complete an anti-bullying survey. 92% of Sutton Coldfield schools completed an annual survey, compared to only 60% of Edgbaston, Erdington and Hall Green schools. Only 33% of Independent schools complete an annual bullying survey.
c) E-safety support and training for parents – Only 75% of schools responded to say they gave training or support to parents on e-safety. There were 70 schools who did not respond to this question. Independent schools did worst in this area with only 29% of them providing e-safety support and training to parents. 83% of Selly Oak schools supported parents in this way but only 46% of schools in Lady Wood and 29% of Independent schools did.

Areas in which responses indicated other concerns:

a) SCRs – There was a mixed response to this section, partly due to schools not always using the N/A option on the audit but also schools confusing general recommendations and those more general ones from SCRs from other settings. Only 42% of schools reported that they accessed training and followed up recommendations of SCRs.
b) Reporting students removed from roll - Although 97% of schools who responded reported that they informed the local authority when a student was removed from roll 67 schools did not respond to the question. 46% of Independent schools did not answer this question and 4% of them specifically stated they did not inform the local authority. 6% of Independent schools, 8% of Erdington schools and 8% of Special Schools did not have policies covering missing children
c) Reporting staff to DBS who have been dismissed where there has been a risk of harm to a young person – 76% reported that they reported to DBS, 4% of secondary schools reported that they did not report to DBS, 43% of Independent schools did not respond and only 43% of Independent schools responded that they did report to DBS.
d) British values embedded within the curriculum – 2% of all schools responded that they did not embed British values within the curriculum, 14% of Free Schools made up this number.

Each school is expected to have an action plan in place to address areas for improvement. A separate analysis of the training elements within the audit has been completed to support the strategic development of a safeguarding in education training plan for the city. There are some key learning points arising from this analysis. For the Board there is still significant work to do to ensure schools are complying with the expectations laid on them, particularly in the independent sector.

For the Local Authority the learning includes the need to develop:

a) A strategic plan to address the training needs identified in the attached training report
b) A clear information and tracking system to capture safeguarding concerns and information from schools i.e. which young people are missing from education, what are the contact details in each school of their DSL and LAC teacher, which schools have high levels of non-compliance and need additional support in line with the draft strategy currently being developed by the CSE Strategic Sub-Group and the Child Sexual Exploitation and Missing (CMOG) operational group.
c) Develop a clear "In Birmingham" message about expectations on all schools and how schools can fulfil those expectations focused on low compliance areas.

For schools the learning includes the need to:

a) Ensure ongoing compliance to reporting to the BSCB
b) Make appropriate information returns to the local authority

c) Ensure governors/responsible bodies have the correct information and understanding of safeguarding practice within their schools in order to be able to fulfil their statutory duties

d) Put in place a 'Safeguarding in Education' Action Plan to monitor progress on addressing the areas for development identified in the Audit which is annually reviewed with Governors.

The last year in the education sector:
At the beginning of the 2014-15 year, the BSCB in partnership with the newly formed Birmingham Education Partnership (BEP) funded a 6 month secondment to look at how best to improve safeguarding practice and improve the focus of schools on promoting welfare as well as safeguarding children. This work was also supported by the local authority. The decision at the end of the secondment was that there needed to be increased capacity within the system to support schools with these expectations and requirements. The local authority funded two posts on an interim basis – the Schools Safeguarding Advisor and the Schools Resilience Advisor. At the same time Sir Michael Tomlinson, the External Commissioner for Education in Birmingham reported on what needed to be done to improve education overall, including to improve safeguarding practice. This led to the development of an Education Plan (a companion to the Early Years and Safeguarding Improvement Plan).

Progress on Safeguarding within the Education Plan 2015-17 is monitored fortnightly by the Director of Education and a monthly report is submitted to the Education Quartet for scrutiny. Currently the safeguarding element is reporting as 91% compete with progress against open items registered at 93%, giving an over-all RAG rating of Green. Two key issues that have been identified as amber are:

- The need to monitor the impact of training intervention to demonstrate a change in practice within schools, to demonstrate that safeguarding practice is embedded into core business.
- To further develop the relationship between Education provision and the MASH. The current model of having school staff within the MASH is proving hard to sustain and to the opportunities for schools to support the MASH assessment process are currently being investigated.

A comprehensive programme of training has been developed for schools building on the work commissioned by BCSB during 2014. This is now delivered at a district level (10 similar sessions with a locality focus) encouraging the school safeguarding officer to attend a professional briefing and support session per term, and an area level safeguarding conference (three similar sessions with a city wide focus) looking at the national/strategic issues that schools need to consider per term. The content of these events is set from the training needs analysis work undertaken in the section 175 self-assessment and Keeping Children Safe in Education (July 2015). These sessions are aimed at all schools regardless of designation and currently are attended by 65% of schools across the City. Work for 2015-16 has identified the need to widen further the access to these events for all schools.

The cascade of Right Services Right Time has been coordinated through the Education plan as part of the work of schools relating to the MASH. In conjunction with the BSCB a set of training and cascade tools have been produced and an audit and impact process identified to measure how schools brief all their staff on the threshold model. To date 60% of schools have received this training with three additional sessions booked for September 2015. In addition a programme has been put into place to ensure schools are aware of their responsibilities under the new Prevent Duty and Equalities legislation. Prevent training continues to be delivered into schools, with take up now at 71%, and the LA supports the delivery of two theatre in education programmes around Prevent aimed at key stage 2 and 3, both of which evaluate extremely well.

Work is underway to define the Service Level Agreement for Lesbian, Gay Bisexual and Transgender advisor for the 2015-16 school year to analyse and deliver LGBT+ awareness training. Also the UNICEF Rights Respecting Schools Award is being promoted as a way of engaging the children's rights agenda within the curriculum with 71 schools registered within the first 3 cohorts. A key element of work that is being progressed within the plan is engaging with faith and supplementary settings with a safeguarding tool kit that these organisations can sign up to too ensure good practice and a safe environment for the children. This work was initially led by the LADO service and commissioned from Faith Associates.

Finally work is being undertaken to identify and support schools which need additional support with safeguarding practice. Completion of the Section 175 self-assessment has been monitored through the plan and schools which have not completed or only partially completed will be supported in the next academic year. A programme of safeguarding reviews have been established with a supporting monitoring tool for safeguarding and one for the single central register to ensure that good practice is identified and support offered where required. Data around

safeguarding will be provided to the Education Dashboard and is seen as a key element in the cross cutting reviews of schools around whom concerns are expressed.

Report on the role and impact of the Schools Safeguarding Adviser and Resilience Adviser
The Resilience Adviser has been in post since October 2014 and the Safeguarding Adviser took up post in January 2015. Both officers work together to bridge and broker support for schools and blend skills sets to ensure that bespoke advice is available across universal, targeted and specialist responses. The work carried out during the 2014-15 academic year and plans for 2015-16 include:

Universal Offer
The Schools Safeguarding Adviser and Resilience Adviser have led a co-ordinated package of training and safeguarding briefings for schools across the city since taking up post. This training programme includes the Home Office training product WRAP (Workshop to Raise Awareness of Prevent) with 71% of schools now having accessed or booked this training for the next term. This equates to 9,000 practitioners in the education workforce trained in basic Prevent awareness. Manager training in 'Preventing Violent Extremism' is a more sophisticated package that has been offered during the past two years and 22% of school leaders have taken this up. Termly safeguarding briefings have been delivered across the city attended by 65% of schools, covering all key elements of Keeping Children Safe in Education 2015 with a specific focus on the Prevent Duty. This work programme continues for 2015-16 academic year with 39 planned briefings/workshops across the city to include all schools (academies, free schools, maintained and independent).

Targeted Offer
The Advisers have supported schools around a selection of resilience and safeguarding reviews ranging from single issues response and support, to support to Senior Leadership Team and policy management. Targeted responses follow identification of weaknesses either by schools or by Ofsted. For many schools, the trigger has been the Section 175 Audit that has prompted requests for targeted support. 60 schools have been supported through this pathway and this has informed the training offer through subsequent safeguarding networks. For example, Single Central Record Training accessed by 232 schools.

Specialist Offer
Bespoke support has been generated where serious weaknesses have been identified, either by school advisers, school improvement partners, schools, Ofsted, DfE and parent complaints raised through Ofsted. Specialist advice and support has been identified and action plans are drawn up with support brokered dependent on need. This has included case management, identification of children at risk of radicalisation, CSE, FGM and Forced Marriage. The key themes have informed policy development, for example No Platform, Model Safeguarding Policy, Children Not Collected from School. The challenges experienced by schools in the referral process has led to the development of a multi-disciplinary partnership response involving Police, MASH, EHB, Think Family and School advisers to secure the referral pathways and to develop case studies for schools. 40 schools have been supported.

The specialist advisors focus on the safeguarding priorities set out in the Education Plan, which is monitored through Safeguarding in Education Sub Group and the Prevent Delivery Hub, Workforce Development Theme. This specialist adviser function has been endorsed in Ofsted feedback and validated by the Home Office. Feedback from schools consistently demonstrates that training and bespoke support has had significant impact in securing improvement over time and schools are becoming more focussed on the child's journey and lived experience.

Both advisers have contributed to the development of tools and resources including the Section 175 self assessment and have continued to support the work of the safeguarding board within the context of education.

In preparation for the Prevent Duty, a train the trainer approach has been adopted to ensure business continuity with 60 school and multi-agency partners trained to deliver WRAP and 60 early years consultants and partners trained with a focus on early years. This initiative is being extended to include curriculum leads from all phases to promote safeguarding resources in schools including e-safety. Advisers are now supporting Initial Teacher Training either through Birmingham's teaching schools or with HE providers to ensure that Prevent and safeguarding are given an applied practice focus. A training matrix is being developed to enable schools to access the range of training and support available to them and a resource base will form part of that. This is to include curriculum tools, lesson plans, assemblies and model letters to respond from the increasing requests from parents to withdraw their children from various aspects of school life on the basis of faith, e.g. swimming, music, collective worship, sex and relationships education, religious education etc. This work spans Theme 12 of the Education Plan and includes theatre in education.

Key challenges for 2015-16

- Workforce development and the mandatory inclusion of the Prevent Duty in training
- Including WRAP as the Learning and Development offer accessed through a central point
- Developing trainer capacity across the council to meet need.
- Safeguarding support and co-delivery of services with Birmingham Education Partnership

6. Key Vulnerable Groups and Emerging Concerns

Key Vulnerable Groups and Emerging Concerns

Child Sexual Exploitation (CSE)
We know that there are a significant number of children and young people who have been exploited or are at risk of exploitation in the city. The Birmingham Local Authority Problem Profile in October 2014 and the Education and Vulnerable Children Overview and Scrutiny Report in December 2014[1] both make it clear that the evidence base about CSE in the city is not good enough. There is still a significant lack of information about the numbers of children and young people who are at risk of CSE and underreporting of those who are victims of CSE. There is also a lack of information that allows us to identify the root causes.

The scale of poverty and deprivation in Birmingham means that alongside the broad risk groups described in Working Together, there are many vulnerable children in the city experiencing multiple disadvantages who may be particularly vulnerable to the risk of CSE. Compounding a number of environmental, social and financial factors can impact negatively on a child's health, well-being and future outcomes which increase vulnerability. They also impact on an adult's ability to fulfil their parenting responsibilities.

The Ofsted Inspection in April 2014 concluded that agencies are not yet working together effectively to provide the appropriate level of safeguarding support to children and young people who are at risk or suffering sexual exploitation. The main focus during the last twelve months has been on developing pathways that secure the right Multi-Agency intervention. The capacity to target partnership operational activity through the CSE Operational Group and MASE meetings has been significantly enhanced with two CSE Coordinators, an analyst and administrator. The West Midlands Police have expanded the Public Protection Unit to 800 investigators which includes a dedicated CSE Lead for Birmingham to coordinate a specialist team of investigators to bring offenders to justice. However, this will remain as a priority this year as partners seek to refine and further expand our operational capacity and engagement at a locality level to tackle CSE.

Earlier in the year the BSCB CSE Sub-Group contributed to the regional assessment of the nature and scale of child sexual exploitation across the West Midlands for the period January till June 2014. The findings 'Tackling Child Sexual Exploitation' were published in March 2015 and provided a valuable overview of risk at that time and helped inform the development of our CSE strategy.

We (at 16 March 2015) also know that:

- There were 340 Children and young people identified as at risk of Child Sexual Exploitation in the City.
- 177 were assessed as Children in Need, and have a child in need plan in place
- 75 were high risk and the subject of Child Protection Plans and
- 88 were in Care of the Local Authority.
- Since February 2014 to date there have been 284 referrals with CSE as presenting issue and 423 Single Assessments (incl. S47) have been undertaken with CSE as a contributing factor.
- There have been 67 (MASE) meetings held in last 4 months (Nov 2014-Feb 2015).
- 80% of referrals to MASE are initiated from Children in Care, Safeguarding and Family Support Teams; the other 20% is via MASH and other Agencies. Including Youth Service and third Sector Aquarius
- There have been 18 C(M)OG meetings (Nov 2014-Feb 2015). A total of 98 Victim discussions and 106 Perpetrator discussions have been held within CMOG during the reporting period. These include reviews of progress and agreeing action pending completion.

This snapshot of the current situation represents a significant increase in the numbers of children and

[1] "We Need to Get it Right – A Health Check into the Council's Role in Tackling Child Sexual Exploitation – Birmingham City Council Dec 2014

young people identified at risk of CSE since last reported in November 2014. This is very positive and a direct consequence of the more effective structures put in place over the last year and greater awareness across the partnership. However it is probable that it is still an underestimate about the actual extend of CSE and the risk of CSE in the city.

The BSCB approved a new CSE Strategy in January 2014, following the establishment of a CSE Strategic Sub-Group in 2013. However the complexities and pressures of a range of external reviews of Birmingham, organisational change for the West Midlands Police, the impact of setting up a Multi-Agency Safeguarding Hub in Birmingham have all had an impact on the delivery of this strategy. Ofsted's report in 2013 found that:

"The child sexual exploitation strategy agreed by the Board in January 2014, has not yet been implemented and this delay means that agencies are not yet working together effectively to provide the appropriate level of safeguarding support to children and young people who are risk of/or are suffering sexual exploitation."

Following this, and over the last 12 months the focus has rightly been on establishing a functional and effective operational group (the Child Sexual Exploitation and Missing Sub-Group) and a case management group (Multi Agency Sexual Exploitation or MASE group) in order to respond more effectively to serious and significant cases of CSE. We undertook a self- assessment of progress against the West Midlands and OCC See Me Hear Me framework which indicates that much of what we are doing is in the early stage of development. The strategy was reviewed sporadically by the CSE Sub-Group (which was not meeting regularly or effectively) but was not used as a key driver for change which is not acceptable in the longer term. When it became clear that the Sub-Group was not proactively driving work forward we agreed that the priority and focus should be on developing and getting our responses to children and young people at risk right and on raising awareness. Increasing numbers of concerns, cases and investigations and prosecutions are all indicators of our improving understanding and practice, and are not a sign of failure. This increases the degree of assurance that when risk is identified, action is taken.

The BSCB Benchmark exercise undertaken in the autumn 2014 across all partner agencies indicated that that the majority of partner agencies assessed themselves as still at the stage of development. The Education and Vulnerable Children Overview and Scrutiny Report identified a range of actions for BSCB to take, alongside the individual partners as part of the Scrutiny Report "We Need to Get It Right: A Health Check into the Council's Role in Tackling Child Sexual Exploitation" (**Appendix 14**). In addition, if we are to deliver a genuinely child centred response we know we need to significantly improve the effectiveness and consistency of the arrangements we have put in place so far to respond to CSE.

There was a considerable focus on CSE over the 2014-15 year which has ensured awareness of CSE has risen across the whole City. Some very good and innovative work has taken place over the year, but much has been despite rather than because of a coherent local strategic approach. This has largely been due to the lack of effective work by the BSCB Strategic Sub-Group, which lacked the drive, capacity, coherence, contribution from and commitment of partners with a number of changes of chair leading to an absence of continuity. This is made more obvious by contrast with the MASH Programme Board, Early Help Programme Board and Troubled Families Partnership Board despite the importance of the issue. CSE has been everybody's problem and none in many ways.

Whilst this has been less important over the year as services develop and the whole system becomes increasingly complex a bottom up approach ceases to be either effective or safe. A number of complexities have made achieving strategic coherence difficult. The Regional Preventing Violence against Vulnerable People (PVVP) Programme has driven much of the work that has been done, and it has at times been difficult adapting the regional approach to fit the Birmingham context. Capacity to respond to CSE has been increased by the local authority, and significantly increased by West Midlands Police, but in the absence of a strong strategic set of drivers additional multi-agency capacity has not been scoped, or commissioned. The size of the dedicated CSE team has grown incrementally and opportunistically rather than through a proper needs analysis.

Our current position is that Birmingham is doing some important and bold things as part of our shared approach to tackle CSE. Despite the failure of partners to contribute to and drive the way in which CSE was being responded to in the City progress is being made. There is a strong commitment by all partners and a lot of energy going into it. We are building the necessary structures, processes, and services to identify children and young people at risk of CSE, ensure there are the right interventions and services to support them and their families and to protect then, and to pursue perpetrators.

However, we are only a few steps along the road to dealing with it comprehensively and are still learning how much we have got to do ahead of us. We know that the scale of CSE in the West Midlands is greater than initially identified, that CSE is a regional and national issue and that victims of CSE come from all parts of the city and all walks of life. We now need to better understand prevalence, ethnicity, age and gender issues for offenders and victims, and the patterns of risk and offending across the city, the key areas for strategic focus, the scale of the investment needed and the impact and effectiveness of what we have done. We also need to start to involve children and young people, especially victims, in the design and development of our services.

New Governance arrangements for CSE
As a consequence of the lack of strategic drive to develop and improve CSE services the Board agreed a new Strategy in March 2015. This included a set of key principles to govern what we do collectively and individually, as practitioners, managers and senior staff in each agency, as partners and as the BSCB in responding to CSE.

Birmingham's CSE Framework reflects the West Midlands approach and incorporates the "See Me Hear Me" National Framework.

1. **The child's best interests must be the top priority** – Everything we do puts the child or young person first.
2. **Enduring relationships and support** – Support is given to the child and family as far as possible, by the same person over time, based on individual circumstances and who they most trust.
3. **Participation of children and young people** – We will include children in all decisions made about them.
4. **A shared responsibility** – Recognising and responding to those at risk of or subject to CSE is everyone's responsibility (as part of their everyday professional duties), not just the responsibility of specialists.
5. **Effective information-sharing within and between agencies** – Agencies agree to share information about individuals and know how to, in what circumstances.
6. **Comprehensive problem-profiling** – we use intelligence to identify problems in specific areas in order to understand the patterns of CSE, to identify possible victims, address areas where problems are identified, disrupt offender behaviour and pursue and prosecute perpetrators.
7. **Supervision, support and training for staff** – We ensure we have a confident, competent workforce, at the front line in every organisation in the city which has contact with children as well as in specialist services.
8. **Evaluation and review** – We monitor and review what we are doing, how well we are doing it and what difference we make through performance information, audits and other methods.
9. W**e intervene as early as possible** – by identifying and responding to CSE through services designed to identify and meet need with advice and guidance from the specialist multi agency CSE Team

It also agreed a very clear new governance framework establishing the responsibilities of:

1. **The BSCB** (as required by the 2009 Statutory Guidance) is the accountable body for the work done in Birmingham in terms of delivering a strategy and action plan that supports and influences the coordination of what is done to address CSE in Birmingham, for holding partners to account for their own agency's plans and actions, for assuring practice and for monitoring the effectiveness of what is done.
2. T**he BSCB CSE Sub-Group** is the strategic Sub-Group that drives the multi-agency strategy, develops, and agrees the approach to commissioning multi-agency operating models, and ensures the implementation of, and effectiveness of this strategy. It reports to both the BSCB Board (as the lead body) and the new Strategic Leaders Forum, and Early Help and Safeguarding Partnership (in order to agree operating models and commissioning specification).
3. **The Child Sexual Exploitation Operational Group** is the operational group which coordinates operational responses to high risk cases, and service delivery activity in relation to CSE work. This group, unlike the groups in the other authorities, does not include work with missing children and young people due to the size of the city. It is a multi-agency group which is accountable to the key partner agencies but which has a strong relationship with the BSCB CSE Sub-Group.

Whilst the framework was in place for the end of the year it is still struggling to deliver improvements. The relationship between CSE, CMOG, the MASH and local areas is still unclear for example. In addition having a specialist team in place has allowed practitioners to pass responsibility for CSE to others

rather than integrate it into their daily practice. The capacity of CMOG is severely under pressure as a consequence, and much of the case work is suffering high levels of slippage. It is putting pressure on the MASH, the local authority and West Midlands Police.

Regional Framework, standards and protocols:
CSE does not respect local authority boundaries. It is a regional issue and requires strong regional collaboration and joint regional solutions. The Regional Framework follows the "See me, Hear Me" framework and comprises a set of principles, five components and a set of standards. It has been adapted it to fit the circumstances and local context in the West Midlands. The Framework was adopted by the seven authorities that work with West Midlands Police through the CSE Sub-Group of the Regional Preventing Violence against Vulnerable People Board. We have collectively agreed as a Board to work to the Regional Framework, and utilise and apply the Regional Standards, procedures and tools, as well as the performance indicators and outcomes framework. We will adapted these where absolutely necessary to allow for the size and complexity of the city, the high volumes of children at risk, the very significant number of professional staff needing trained, the significant number of school and the complex commissioning and provider infrastructures in the city. In addition we will apply our local threshold document (Right Services, Right Time) to the identification and assessment of risk, and the responses to that risk and adapt the pathway and risk assessment and screening tools accordingly.

Positive achievements
Two major achievements have had an impact over the year. Firstly the local authority successfully applied to the court for a civil remedy to disrupt the perpetrators of CSE in a specific case. Secondly an innovative and controversial new DVD, BAIT, was commissioned, led by young people and distributed to secondary schools across the City for use with students.

In addition work is now underway to better integrate CSE into "business as usual" in order to equip practitioners in every aspect of multi-agency children's services to recognise and respond to the risk of or actual CSE as part of their case work rather than transfer it to a small centralised specialist team. This is driven by both the principles in the strategy and by the work underway to rebalance the system to ensure the majority of work takes place at as low a level as possible, and in the areas, and local communities children and young people live in.

In 2015 there is however a major challenge to the strategic leaders' forum, early help and safeguarding partnership and BSCB to assertively and decisively strengthen the work of the CSE Strategic Sub-Group, agree a programme delivery plan behind it and deliver the new CSE Strategy. In addition there is a corporate challenge for the local authority as a whole to get a better collective "grip" on how CSE and other safeguarding issues across the whole council are appropriately led and co-ordinated across departments and partnership bodies.

Missing Children
This is another area which saw very significant slippage in 2014-15. At the beginning of the year the local authority was running a small multi-agency missing children group, led through the Safeguarding Division which focussed on children missing from care and home. This group worked on the data made available by WMP to better understand the issues. The Children's Society was commissioned by the local authority to undertake missing from home (72 hour) interviews. There was and still is a separate set of arrangements, processes, data capture and responses for children missing from education. These two systems were not integrated so valuable intelligence was lost.

When the West Midlands CSE Operational model was introduced, and missing integrated into the CSE and Missing Operational Group (CMOG) this group disbanded. Unfortunately the capacity of CMOG was severely constrained, with a significant number of barriers in place preventing forward progress and rapidly increasing demand for case discussions as well as data analysis. As a consequence partnership working deteriorated rather than improved and the systems remained separate with no shared intelligence. At the end of the year the missing element of the CMOG was taken back out and a new Missing Operational Group (MOG) was set up to address the need to make rapid and radical progress in this work.

The challenge for 2015 is for the multi-agency partnership, through the MOG, to develop an integrated approach to identifying responding to and intervening with children missing from home, care, school and from view. This should include the development of a shared database, some simple accessible systems and processes and the ability to ensure appropriate early help or statutory interventions are put in place with each individual child.

Domestic Violence
The Birmingham multi agency screening process of child risk in domestic violence has been in place in the city since 2009. The process is in line with the

evidence from research which indicates the damaging emotional and developmental impact on children who live in families where domestic abuse is a feature of their family lives. In addition the newly defined criteria which includes the 16-18 year old age group has further emphasised the role that safeguarding plays in trying to improve the future safety and wellbeing of children and young people under 18 years of age. For the past 18 months the BSCB has required 6 six monthly reports on the progress of the joint screening teams and the learning for the city in respect of the trends and outcomes of the screening process.

With the advent of the Multi Agency Safeguarding Hub (MASH) the joint screening process now is part of the integrated arrangements in MASH. West Midlands Police, Birmingham Children's Services, Birmingham and Solihull Women's Aid and Birmingham Community Healthcare Trust have three teams working at Lancaster Circus screening sharing information in order to inform which children need assessment or support as a result of the impact of domestic abuse.

By July 2014 and the start of MASH there had been a significant increase in the number of police incident reports moving from a previous average of 11,000 children per year to 13,500 in 2013/2014. The increase was influenced by police service re-design and pro- active training in respect of domestic abuse with police frontline colleagues. The resulting increase in volume was not matched by resource and as a result a significant backlog of cases accumulated during the 12 months. Ofsted cited this as a major risk for the city in their 2014 inspection and the January improvement visit. The staff from the three agencies undertook a significant piece of work committing to weekend and extra hours working in order to remove the backlog of cases which at the time exceeded 2000.

The first anniversary of MASH in July 2015 has seen the historic backlog of cases removed, resources improved and the use of MASH staff flexibly to meet demand. Processes for responding to high risk have changed and now any incident where the police deem the adult to be at high risk is screened within 24 hours. All high and medium adult risk cases are therefore screened within a working day. There is now assurance for MARAC that the screening of child risk will inform their discussions. A database tracks the numbers of cases screened daily and a weekly report allows managers constant oversight of the volumes and outcomes of screening. MASH audit programmes will encompass domestic abuse outcomes.

- The year 2014/2015 saw 18,800 children triaged by the MASH DA teams.
- Under 5s – 6,979/ School age children 11,567/ Pre birth 71/ 213 children out of school or 16-18 yrs.
- In addition 1,549 children identified in households where police were called, lived out of Birmingham where the incident had occurred. In these cases information was shared with their home authority.
- 13.6% of the cases screened required or were already receiving child protection services and had allocated social workers categorised as significant /complex needs (RSRT)
- 24.5% of the cases required referral to the area ASTI teams with a recommendation for family assessment. Categorised as additional /complex needs (RSRT)
- 62% of the cases were shared with Health Visiting, Women's Aid and family support (where relevant) for early help, sign posting and noting.
- Daily monitoring of the outcomes from the screening discussions demonstrate how the information sharing process identified hidden issues impacting on the safety and wellbeing of children even where the adult risk assessment is deemed to be "standard"

Figure 36 shows initial DASH rating and the final Barnado's assessment of the risk level for Incident Referrals created between 01 July 2015 and 31 July 2015.

Figure 36

Sum of Agenda items	(INCIDENTS)		
ASM CREATED DATE	DASH RATING	BARNARDOS Child Outcome	Total
Jul	High Risk Adult	Scale 2 Scale 3 Scale 4	5 6 1
	High Total		12
	Medium Risk Adult	Scale 2 Scale 3 Scale 4	81 25 1
	Medium Total		107
	Standard Risk Adult	Scale 1 Scale 2 Scale 3 Scale 4	53 183 33 1
	Standard Total		270
Jul Total			389
Grand Total			389

Domestic homicide reviews (DHR) provide a unique opportunity to view the interface between adult and child safeguarding in the context of domestic abuse. Since their introduction in 2011, 20 children in Birmingham have lost their mothers and one child was killed at the same time. These forensic reviews

of agency involvement before a domestic violence related death have shown that there is a fundamental misunderstanding amongst our services about how a domestically abusive adult maintains control of a family through coercive tactics as well as through physical violence. To date our responses nationally to protect children at risk have been largely predicated on how physical violence is reported. This places a greater burden on the non-abusive adult (usually the mother) to protect their children through separation from the abusive parent (usually a father).

These DHRs have shown that:

- Separation is the highest risk factor for adult and child victims of domestic abuse and more needs to be done to protect them at the point of separation.
- Domestic abuse creates intimate terror in the victim such that they are rarely able to trust agencies to keep them and their children safe. Nor will the victim have the ability to protect themselves and their children without co-ordinated support and protection.
- Services need to refocus their attention onto the abuser, controlling and containing the threat the abuser poses to the family.
- Domestic violence and abuse escalates over time. Knowing an abuser's violent history in relation to previous partners and their parenting history in relation to other children is vital but often missing from assessments.

Work is underway with both the adult and children's workforce to adapt practice to take on the evidence base in their understanding of domestic abuse and violence, apply it to keeping children safe, and to understand the implications of new laws designed to criminalise coercive control.

Birmingham Against Female Genital Mutilation
Early in 2014 the BSCB Board convened a meeting of the Community Safety Partnership, WMP, NHS representatives and the Adult Safeguarding Board and BSCB to discuss how best to respond to the increasing concerns about the need to better address the issue of Female Genital Mutilation (FGM). There was a very active multi-agency and multi-representative group in Birmingham, the Birmingham Against Female Genital Mutilation Group (BAFGM) which was making significant progress, primarily supported by WMP and an NHS Trust. The meeting agreed FGM should be led by the BSCB rather than the other Boards. It also agreed to ask BAFGM to become part of the partnership governance structure of BSCB. This was agreed so BAFGM is now an affiliated group to the Board, which has also agreed to underwrite some of its budget. The Board signed off the action plan, and takes reports from BAFGM every six months.

Significant progress was made over the year, largely due to the efforts of BAFGM and its inspirational chair, the Police Sentinel Programme, the commitment of the NHS providers and the support of the Regional PVVP. This was helped by new government legislation and guidance.

The model provides a clear opportunity for BSCB with the Community Safety Partnership and the Adult Safeguarding Board to support similar arrangements for other emerging issues and concerns, where community and practitioner led initiatives can be much more effective that statutory arrangements.

Radicalisation and the Prevent programme and other emerging issues
Another emerging issue over the year was the impact of radicalisation both nationally and locally in Birmingham. The Board took a presentation from the Counter Terrorism Unit on radicalisation and its impact on children and young people at the beginning of the year. It took an update report on the joint radicalisation and prevent duty at the end of the year. Prevent is led by the Community Safety Partnership rather than by BSCB and has little impact until relatively recently on the work of the Board. It has latterly highlighted some significant gaps between the two Boards in terms of a common understanding of each other's responsibilities, priorities and strategies, agreements about shared initiatives and shared priorities. It is clear that there is a major gap in relation to the BSCB's relationships with the very wide range of faith communities across the City, and its ability to communicate with them, set expectations, support them to develop safeguarding systems and to better respond to risks including those as a result of radicalisation.

Other emerging issues that the Board has not yet addressed but needs to consider are modern day slavery, trafficking, honour based violence and forced marriage. These also fall with the Community Safety Partnership's areas of concern. This relates to the need for a corporate council led approach to the whole safeguarding agenda, and has implications for the "Future Birmingham" programme in terms of the partnership landscape for safeguarding in the future. The challenge in 2015-16 is for the Community Safety Partnership, the Adult Safeguarding Board, the Health and Wellbeing Board and the BSCB Board to agree a protocol governing the relationship between them, address the issue of who leads on what, agree shared priorities and a shared work-streams within the context of the Future Birmingham Programme.

Part 2 – The effectiveness of the Birmingham Safeguarding Children Board

This part of the report deals with how effective the BSCB Board, Executive and subgroups have been in fulfilling their statutory objectives and functions. It covers the delivery of the Board priorities, the governance of the Board, its business arrangements, budget and major programmes of work.

7. Governance and accountability arrangements

Birmingham Safeguarding Children Board is an independent statutory body established under the Children Act 2004. Its functions and responsibilities are set out in LSCB Regulations 2006 and Working Together to Safeguard Children 2015 which was published in March 2015.

The key focus of the BSCB is to provide independent strategic oversight of partnership working to safeguard and promote the welfare of children in Birmingham. The BSCB is responsible for collectively leading, co-ordinating, developing, challenging and monitoring the delivery across the city of effective safeguarding practice by all local agencies. It is not responsible or accountable as a Board for actually delivering safeguarding services. That is the responsibility of each of the local agencies separately and collectively.

Section 14 of the Children Act 2004 sets out the statutory Local Safeguarding Children Board objectives, which are:

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

Regulation 5 of the LSCB Regulations 2006 sets out in detail the specific functions of the Board. These are to:

Develop policies, procedures for safeguarding and promoting the welfare of children in the area of the authority, including policies and procedures in relation to:

- The action to be taken when there are concerns about a child's safety or welfare, including thresholds for interventions (i.e. who does what when they are concerned a child may need extra help, whether it's early help to stop problems growing, or immediate help);
- the training of people who work with children in relation to matters which affect their safety and welfare;
- the recruitment and supervision of people who work with children;
- the investigation of allegations concerning persons who work with children;
- the safety and welfare of privately fostered children;
- cooperation with neighbouring authorities and LSCBs;
- communicating across the area the need to safeguard and promote the welfare of children, raising awareness of how and encouraging improvements;
- monitor and evaluate the effectiveness of what is done by the local authority and board partners individually and collectively to safeguard and promote the welfare of children;
- participate in the local planning and commissioning of children's services and;
- undertake serious case reviews and advise the authority and their Board partners on lessons to be learnt.

The Board complies with the requirements of 'Working Together to Safeguard Children 2015', with its independence built upon individual and collective responsibility for holding organisations to account, by evaluating how effectively they work together to safeguard children. The Chief Executive of Birmingham City Council is responsible for the appointment and removal of the Independent LSCB Chair with the agreement of statutory partner Chief Executives and lay members. Membership of the Board comprises of 42 members, of whom there are 27 statutory board partners, 2 lay members, 2 participant observers, with Sub-Group chairs and professional advisors making up the remaining 11 representatives. The diversity of the city is reflected by the make-up of membership of the Board, with a gender ratio of 56% female and 46% male representatives from different faiths, cultures and communities. A full list of Board Members at March 2015 is attached as Appendix 2. The interdependencies and lines of accountability between the Board, key statutory bodies and the Sub-Groups are sets out in Figure 37.

[3] Working Together to Safeguard Children 2015 – Statutory guidance

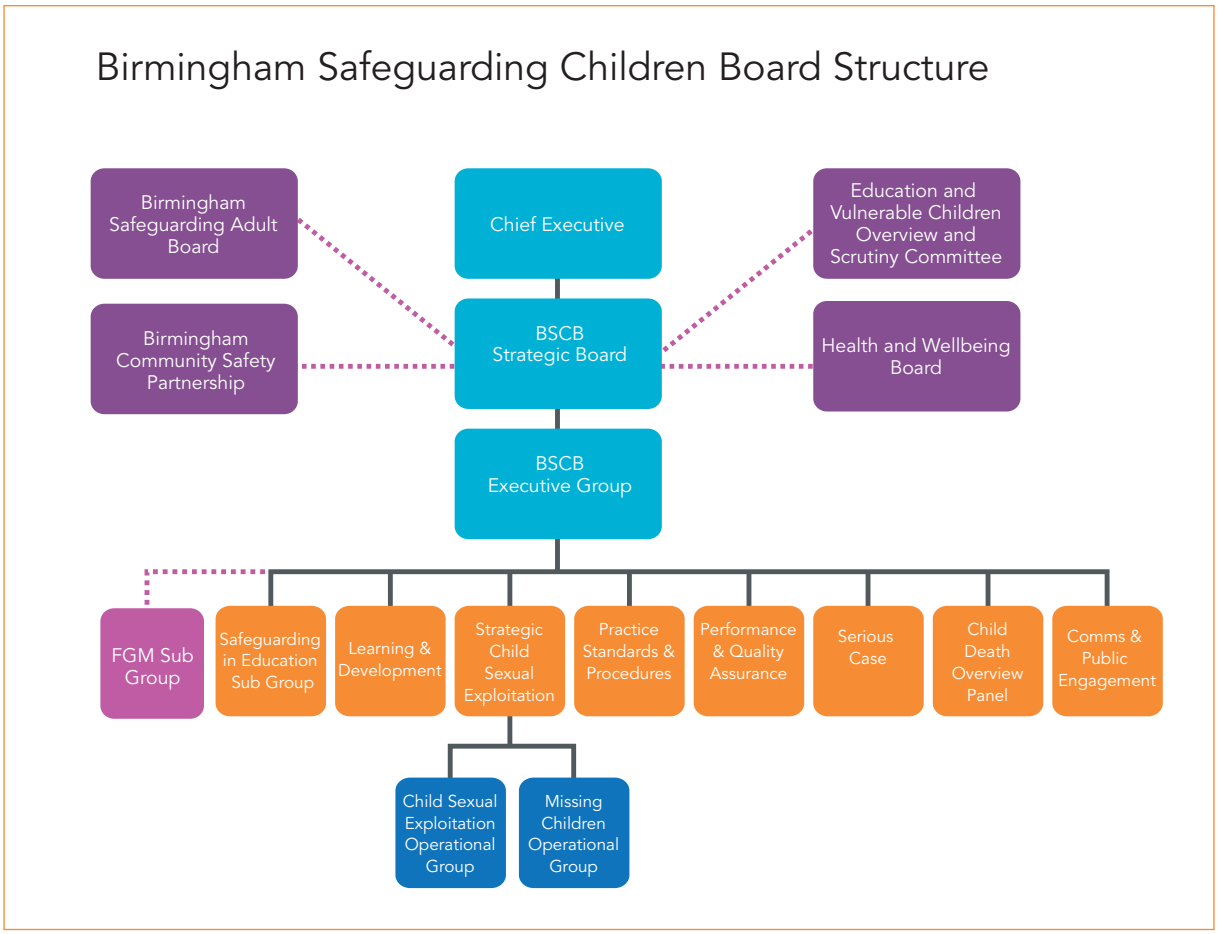
During 2014-15 the Board met on five occasions, supported by the Executive Group schedule bi-monthly meetings. The geographical boundary of the Board's strategic responsibility is coterminous with that of Birmingham City Council and includes all those statutory agencies that operate within this area. The Board's span of influence and collaboration extends to both a regional and national level, focusing on utilising finite resources to maximum effect on tackling safeguarding issues that have no boundaries, such as Child Exploitation, Trafficking and Female Genital Mutilation.

In fulfilling its statutory duties and challenge function the Board has developed working relationships with Ofsted, HMIC, Independent Police Complaints Commission and the Police and Crime Commissioner. In addition the Board liaises with the governance bodies of all statutory organisations, especially the Council's Executive and NHS organisations in Birmingham. There is a shared responsibility for driving improvement in practice in the city. We are also expected to work with the Health and Wellbeing Board, the Adult Safeguarding Board and the Community Safety Partnership on areas of shared concern. Each statutory organisation is required to submit an annual report detailing the outcome of an annual self-assessment of safeguarding compliance, referred to as the Section 11 Safeguarding Audit. The Annual Report is presented to the Board together with a formal assurance statement in relation to safeguarding practice.

The Board works closely with Birmingham City Council's Education and Vulnerable Children Overview and Scrutiny Committee to coordinate both organisations' scrutiny and challenge programme for the year. The Board are required to report formally on an annual basis to the Council's Executive, the Health and Wellbeing Board, and the Police and Crime Commissioner, and will also report to the relevant NHS governance bodies.

The Independent Chair utilises a Practitioners Forum to consult front-line professionals across a range of agencies to test, challenge and develop new safeguarding initiatives and seek feedback on the embedding on practice. This network has 80 members with approximately half attending the five consultation events chaired by the Independent Chair, Jane Held. The feedback from frontline professionals contributed significantly to the board's work over the year. For example the final version of Right Service, Right Time, with members also volunteering to be involved in multi-agency case file audits during the year.

Figure 37



Governance review

In January 2014 the Independent Chair commissioned a review of its governance arrangements to improve the Board's ability to deliver on the aims and objectives set out in the three year strategy 'Getting to Great' 2014-2017 and the Business Improvement Plan 2014-15. The review took account of the findings of Ofsted Inspections and the Independent Chair's Reports to the Parliamentary Under Secretary of State. It also ensured compliance with statutory guidance set out in Working Together to Safeguard Children. The review was also cognisant of the emerging direction of travel of Lord Warner's intervention to improve safeguarding of children in Birmingham.

The Governance Review found:

i) A range of concerns about the size, composition and effectiveness of the current Board structure (figure 37) and ability to deliver requisite changes and improvements in safeguarding practice.

ii) Each Board member needs to fully participate in the work of the Board and agree the work they are going to complete to assist the Board in delivering its key priorities (Early Help, Voice of the Child, Safe Systems and Business Excellence).

iii) There is a need to ensure individuals fully understand their role and responsibilities as Board members. This needs to be supported by a formal review of Board member performance. Board members need to be properly equipped to enable them to do the work of the Board, and enable them to take this work forward within their own organisations.

iv) Lack of a robust appraisal system to ensure that partners at the Board use their role effectively to influence their own organisation's strategic and corporate governance to ensure the Board's priorities are effectively embedded in their own organisation.

v) There are challenges in terms of the capacity of the BSCB Business Unit to assist in delivering the Board's work programme and priorities and the work of the sub-groups.

vi) There is a need to ensure that the right partners are involved directly in the Board. Currently there are some statutory partners that are not actively participating in the work of the Board.

vii) The impact of the sub-group infrastructure in implementing the Board's priorities. This is largely about having the right skills, capacity and commitment of members to deliver the work required.

The review process focused on nine specifics:

i) Board structure, membership and function

ii) Sub-Group structure, membership and function (figure 37)

iii) Forging effective links with other boards and organisations

iv) Effective chairing arrangements

v) Organisational responsibility and accountability

vi) Financial overview

vii) Making the Business Support Unit fit for purpose

viii) Effective implementation of safeguarding initiatives

ix) Looking ahead - preparation for devolved safeguarding structure

In order to improve, radical changes were needed to the Board membership arrangements, governance mechanisms and arrangements, organisational accountabilities, business and administrative arrangements.

The report makes 50 recommendations (Appendix 15), which were all accepted. The Board, the Executive and the Sub-Groups were all dissolved on 31 December 2014 and reconstituted the following day (1 January 2015) under the new arrangements, with new membership of the Board, the Executive and all Sub-Groups, as well as newly appointed subgroup chairs and vice chairs. In addition the new meeting cycle should begin from 1 January 2015.

All the Terms of Reference (for each body) were re-drafted, along with new membership role descriptions, statements of responsibility, appointment terms, membership contracts and individual objectives for agreement at the November 2014 Board. Each statutory partner was asked to sign up to a statement of accountability and commitment to the Board and its requirements. The previous Executive oversaw the changes, negotiated new appointments and commissioned a piece of work to provide the required governance material. At the same time the executive put out to tender a Board Development programme to support the first year of operation.

The existing Board and the Executive was dissolved on 31 December 2014 and the new reconstituted governance arrangements commenced on 1st January 2015. The Executive Group managed the smooth transition to the new Governance arrangements and the establishment of the new Sub-Group structure in place for the new financial year. The Board have commissioned the Executive Group to monitor implementation of the new governance arrangement in 2015.

8. 'Getting to Great' the three year Strategic Plan 2014-17

The three year Strategic Plan 'Getting to Great' 2014-2017 and the Business and Improvement Plan 2014-15 provide direction and focus of multi-agency action delivered by the Board, Executive Group and Sub-Groups. The strategic plan incorporates the priority areas for improvement highlighted through the Ofsted inspections process and the Board's own assessment of progress and priorities on the improvement journey. The Board's vision and values and the key principles that drive partnership activity remain unchanged from the previous year.

The Council Improvement Plan reflects, references and complements the Board's Business and Improvement Plan, forging a shared understanding of the key priorities. The Board's vision is as follows.

"Making it safer for the children of Birmingham through high support and high challenge"

The strategic plan focuses unequivocally on the more vulnerable children in the city through three key priorities that drive partnership action. The table below sets out those priorities and outcome measures:

Figure 38

1. The voice of the child – central to everything we do.	By 2017 we will know that: 1. All the children getting support say they feel heard. 2. Most children getting support say they feel safer as a result. 3. All our statutory agencies have systems in place to engage with, involve, see, listen to, and respond to the children and young people using their services.
2. We provide early help – when problems first arise.	By 2017 we will know that: 1. The majority of children and young people living in families which need early help get it quickly. 2. The number of early help assessments has increased, year on year, and the number of referrals has decreased, year on year. 3. All our statutory agencies can demonstrate how well they identify assess and engage in providing early help services to children and families.
3. We run safe systems – to ensure children are properly safeguarded.	By March 2015, we will know that: 1. The number of re-referrals and children made subject to a protection plan for the second time are both reducing year on year. 2. Children and families are assessed and receive services within statutory timescales. 3. Where children are the subject of a protection plan the family can tell us they know what has to happen, why and by when, and what will happen if this isn't achieved. 4. All our statutory agencies are able to demonstrate how well their safeguarding systems are functioning, what needs to be improved and what action they are taking to achieve this.

The Business and Improvement Plan 2014-15 has focused on three priorities and outcomes measures set out in year one of 'Getting to Great'. The plan also incorporated a fourth priority work stream, 'Business Excellence' to concentrate on delivering the significant change in the Board's infrastructure and governance arrangements.

Business Programme at year end, impact and outcomes

The Birmingham Safeguarding Children Board Business Plan 2014-15 reinforced the continued focus on four key business priorities from the previous year:

Key business tasks for 2014-15 were:

- Ensuring that multi-agency frontline practice focuses on the experiences and life of children
- Understanding and assuring the quality and consistency of front line practice through strong data and multi-agency audit
- Using quality assurance information, review of child deaths, SCRs complaints and other activity to inform a comprehensive learning and development strategy
- Creating a multi-agency workforce development programme which supports excellent practice through practical tools and learning opportunities

- Influencing and supporting multi-agency strategic planning, integrated commissioning and integrated service delivery
- Creating the capacity as a Board Business Support Unit to effectively support the system

It identified 96 specific actions. Throughout the year the Board closely monitored implementation of these themes and tasks and actively intervened to address under performance where necessary and ensured the completion of work within the agreed timescales. At the end of the year 53% (51) of actions were completed and 22% (21) of actions were progressing, but not finalised. Figure 39 provides an overview of progress on key actions within the four priority areas. The outstanding actions were reviewed as part of the Board's formal end of year review of progress and effectiveness 21% (20) of actions had been deferred until 2015-16. There was significant slippage in the below areas:

- Work with, and utilise, existing opportunities for children and young people to help develop a programme of engagement in the Board's work. We are building on young people's feedback from the seminar in October 2014
- Agree with the scrutiny committee the theme We will undertake a joint scrutiny exercise on in 2014-15 and then undertake it
- Implement full annual Quality Assurance Programme, implement and utilise the outcomes to inform learning and development
- Work with partners to develop good quality collection and collation of data on missing children so that partners have a full understanding of the risks to these children and can identify what actions they need to take to minimise these risks. Scrutiny of challenge to this data and related performance must be included in the routine work of the BSCB.

These four areas remain a priority and have been integrated into the Business and Improvement Plan from 2015-16. The Board remains concerned that despite effective delivery of much of the plan it still needs further reassurance of the impact on frontline practice.

Against the performance measures we set for 2015 we delivered as follows:

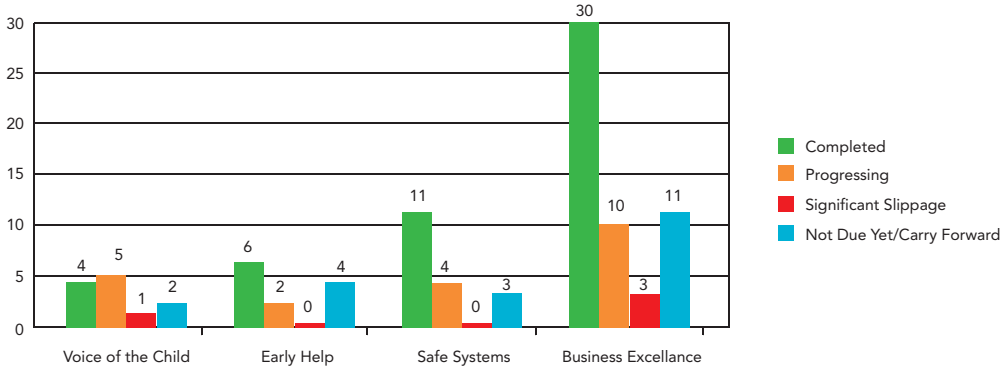
By March 2015, we will know that:

1. The number or re-referrals and children made subject to a protection plan for the second time are both reducing year on year. We have the data to demonstrate activity. Re-referrals are now within the national norm. However we cannot demonstrate the total target we set ourselves.
2. Children and families are assessed and receive services within statutory timescales. We are not yet fully achieving timescales across the Board but have made significant progress. What is more important now timescales are reasonable and most cases are allocated quickly is the quality of the assessments, plans and outcomes achieved.
3. Where children are the subject of a protection plan the family can tell us they know what has to happen why and by when, and what will happen if this isn't achieved. There is still some distance to go to deliver fully on this measure.
4. All our statutory agencies are able to demonstrate how well their safeguarding systems are functioning, what needs to be improved and what action they are taking to achieve this. This has been achieved.

Risk Register

As part of the strategic planning framework, the Board periodically undertakes environmental scanning to identify risks and focus partnership intervention to mitigate the potential impact. The Board's Executive Group is working in partnership with Birmingham South Central Clinical Commissioning Group to

Figure 39 Progress against Business Plan Actions 2014-15



further refine and develop the management of risk utilising good practice from the NHS.

The key risks and mitigation action focused on:

- Children's safeguarding arrangements in Birmingham continue to fail to keep children safe
- Children continue to be invisible to practitioners, managers, senior managers, strategic planners and system governors
- Lack of tangible evidence of trajectory on improvement journey
- The impact of publication of Serious Case Reviews in undermining public confidence
- Impact of MASH and Early Help developments
- Lack of clarity about Early Help model delivery and coordination of multi-agency services for Universal, Universal Plus and Additional Needs
- Lack of assurance of the effectiveness partnership intervention to combat child sexual exploitation
- Impact on safeguarding capacity and delivery during a period of austerity

The future development of the Board's risk assessment model will be incorporated with its strategic and business planning process from 2016.

9. Safeguarding Structure – Agency Attendance, Representation and Engagement

The Board discharges its statutory functions through an Executive Group and six established Sub-Group. During 2015 implementation of the governance review findings saw the creation of two new Sub-Groups, Safeguarding in Education and Practice Standards and Procedures. The Board also provides strategic oversight and direction for the Birmingham against Female Genital Mutilation Group. Greater detail of the specific purpose of each Sub-Group together with an analysis of agency attendance and an overview of performance, setting out priorities for improvement in 2015 /16 can be found in Appendix 16.

Implementation of the Business and Improvement Plan 2014/2015 is predominantly delivered through the Sub-Group structure and approved Work Programmes. The role of Sub-Group Chairs is crucial to the successful delivery of safeguarding priorities. The Independent Chair, Vice Chair and Board's Business Manager ratify the appointment of Sub-Group Chairs and Vice Chairs and there is an effective succession planning process in place. In 2015 the Board Induction Programme was revamped focusing on core roles, functions and expectations of Chairs and new members.

The chairing arrangements appropriately reflect the requisite expertise, seniority from a range of key stakeholders:

1. Practice Standards and Procedures Sub-Group – West Midlands Police
2. Child Death Overview Panel – Public Health
3. Strategic Child Sexual Exploitation – Birmingham City Council
4. Serious Case Review Sub-Group – Birmingham South Central CCG
5. Learning and Development Sub-Group – Birmingham City Council
6. Communications and Public Engagement Sub-Group – NHS Communications and Engagement Service
7. Performance and Quality Assurance – Birmingham City Council

The Independent Chair and Business Manager meet on a bi-monthly basis with Sub-Group Chairs and Programme Managers to monitor progress on Sub-Group agreed work programmes and to resolve issues that impact on the implementation of the BSCB Business and Improvement Plan. Some agencies attendance at Sub-Groups has continued to fail to meet the Board's high expectations. A key recommendation from the governance review is that all agencies are appropriately represented at every meeting. Sub-Group Chairs are provided with an analysis of attendance data by agency to enable non-attendance to be challenged and escalated when required.

Each Sub-Group has a clearly defined function and dedicated programme management support to support delivery on safeguarding priorities set out in the agreed work programme which is subject to regularly monitoring by the Board. Each of the Sub-Group completes a concise annual report identifying

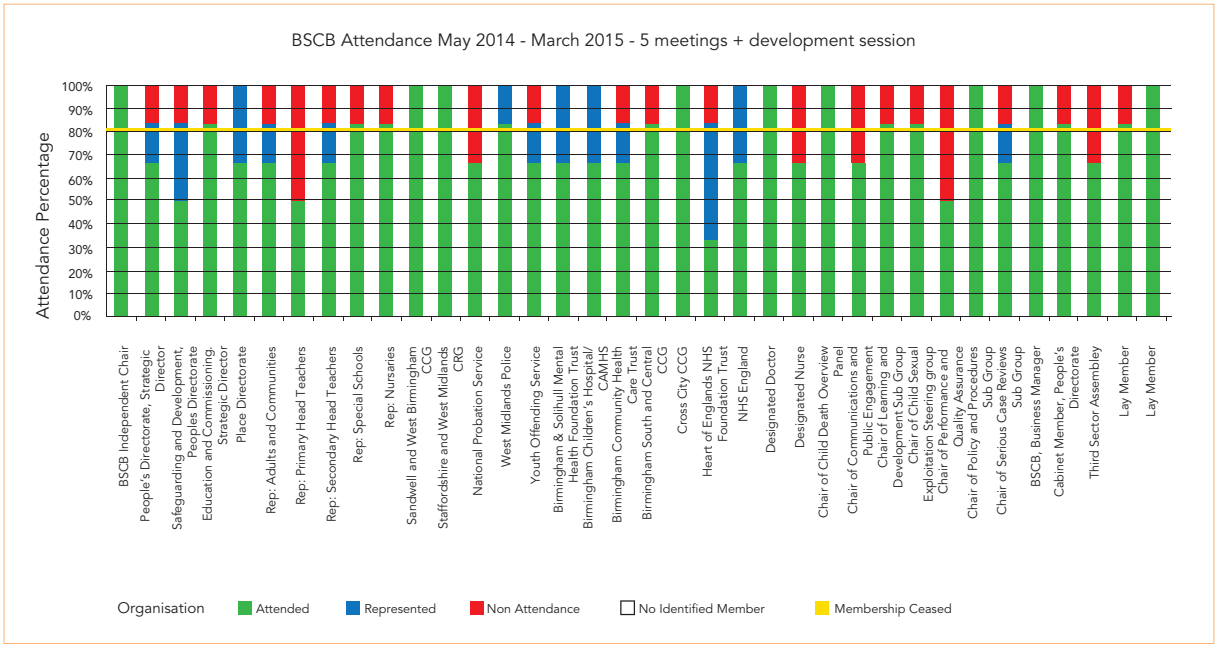
progress, improvements practice and outcomes; emerging themes and areas for improvement and a record membership, representation and attendance.

The Ofsted Inspection published in May 2014 highlighted poor individual attendance and representation by core organisations, undermining continuity and effectiveness of some Sub-Groups. This was a key element of the governance review finding approved by the Board in March 2015 which have resulted in the ratification of a Board Membership Agreement, which incorporates Performance Appraisal, an induction process and attendance standards for members throughout the safeguarding structure.

Board Attendance, Representation and Engagement

Attendance and representation at Board (figure 40) and Executive Level is good, during 2014-15 all statutory agencies achieved attendance targets. Within that overall picture however some agencies with 100% attendance had a significant churn in membership itself, particularly the Local Authority with changes in year to the Strategic Director and to the professional advisers. This necessarily impacted heavily on that Agency's ability to contribute effectively and consistently to the Board.

Figure 40

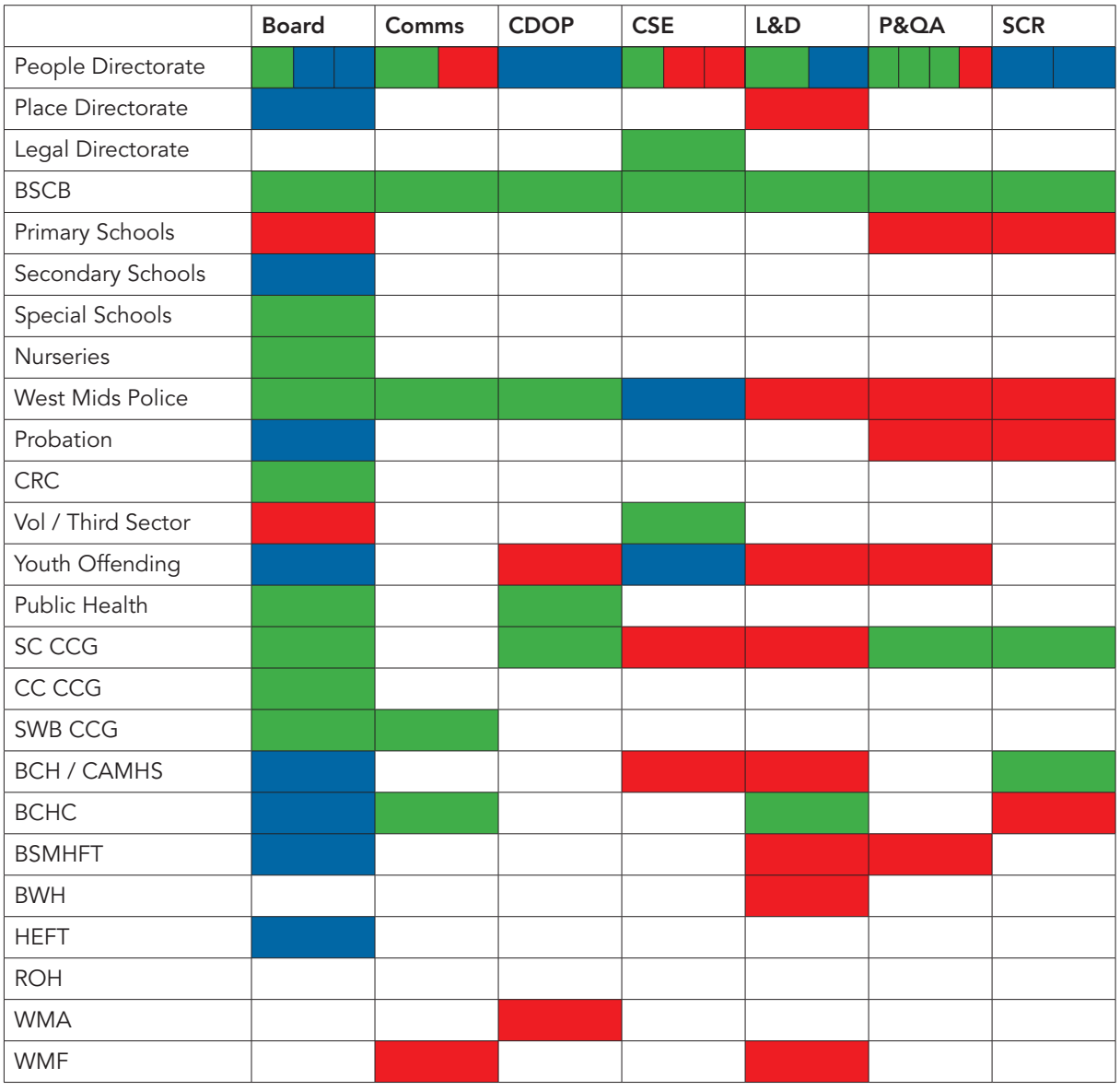


Sub-Group Attendance, Representation and Engagement

In March 2015 the Board ratified the new membership and governance arrangements following a comprehensive review of the effectiveness of the Board, Executive Group and Sub-Group infrastructure and governance arrangements. The findings addressed concerns raised by Ofsted Inspection about poor individual attendance and representation by core organisations, which ultimately was impacting on the continuity and effectiveness of some Sub Groups. Figure 41 provides an overview of agency attendance and representation throughout the safeguarding structure between April 2014 and March 2015. Agency attendance at the Board is good, however at Sub-Group level there is a need for significant improvement. A robust attendance management regime was introduced from 1 April 2015, which has made an instant impact on improving agency engagement and representation throughout the safeguarding structure.

Figure 41 - Agency Attendance by Sub-Group between April 2014 – March 2015

- Green: The named member attended 80% or more of the meetings
- Blue: The named or nominated members attend 80% or more of the meetings
- Red: The named or nominated members attended less than 80% of the meetings
- Pink: The organisation joined the Sub-Group
- Yellow: The organisation's membership at the Sub-Group ceased

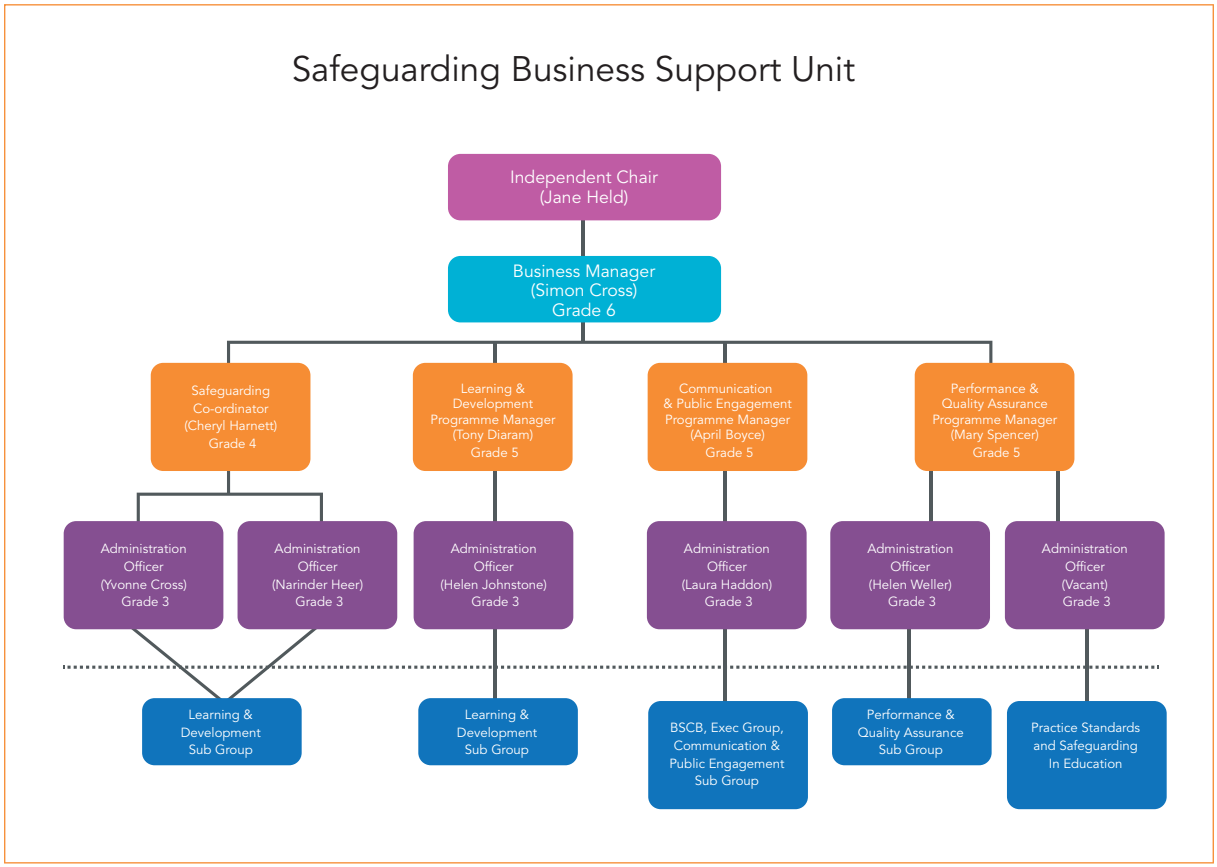


The Business Support Unit

A dedicated Business Support Unit (figure 42) supports the work of the Board and is currently hosted by the City Council, but funded by key statutory partners. In April 2014 the Board appointed three dedicated programme managers and an additional administrator to reflect the expansion of the safeguarding structure and address concerns in relation to capacity and management resilience within the Unit. The changes have made a significant impact in driving forward the Board's Business and Improvement Plan and the Sub-Group work programmes.

The Business Support Unit is directly managed by the Independent Chair, increasing its independence. The Business Manager provides the Independent Chair with regular performance updates on the efficiency administrative systems that impact on the effectiveness of the Sub-Group Structure. The Business Support Unit Structure by the end of the year is set out below:

Figure 42



10. Income and Expenditure 2014/2015

A Zero Based Budget exercise recommended an increase agency contributions, which resulted in a total BSCB budget for the financial year 2014-15 amounted to £834,615. The below chart (Figure 43) provides a breakdown of the components of the budget detailing individual agencies contributions (£659,267), income generation (£7,830) and a carry from the 2013-14 budget (£167,518). Figure 44 provides details of expenditure during 2014-15 which concentrated on five core business areas.

Figure 43 Breakdown of BSCB budget and agency contributions 2014-15

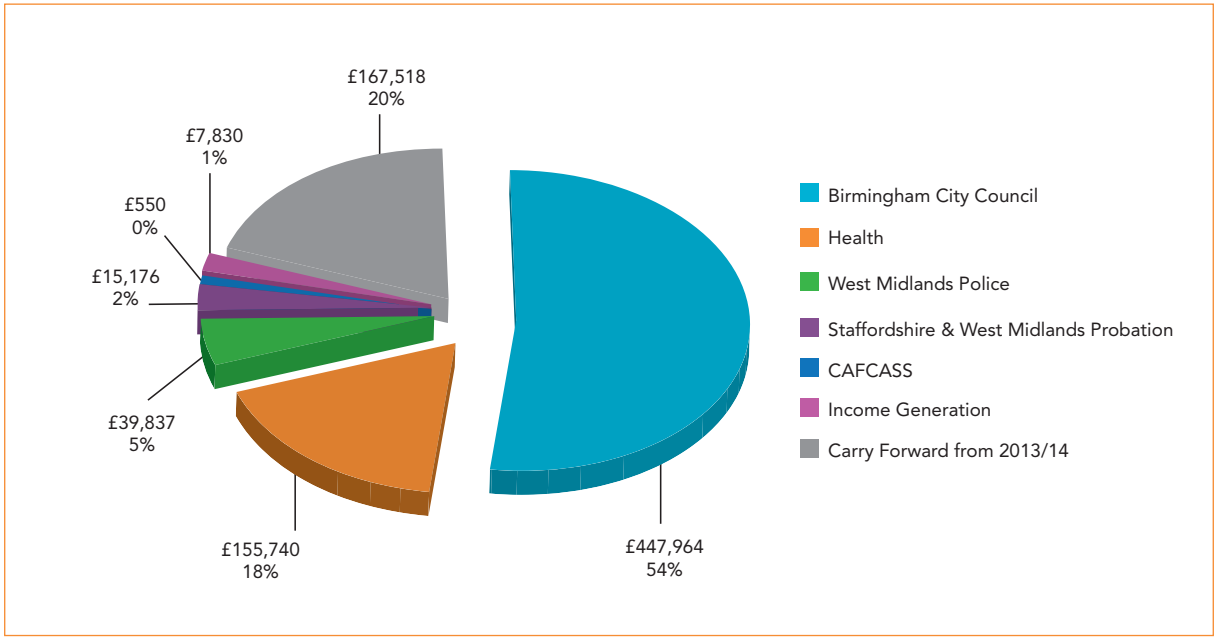
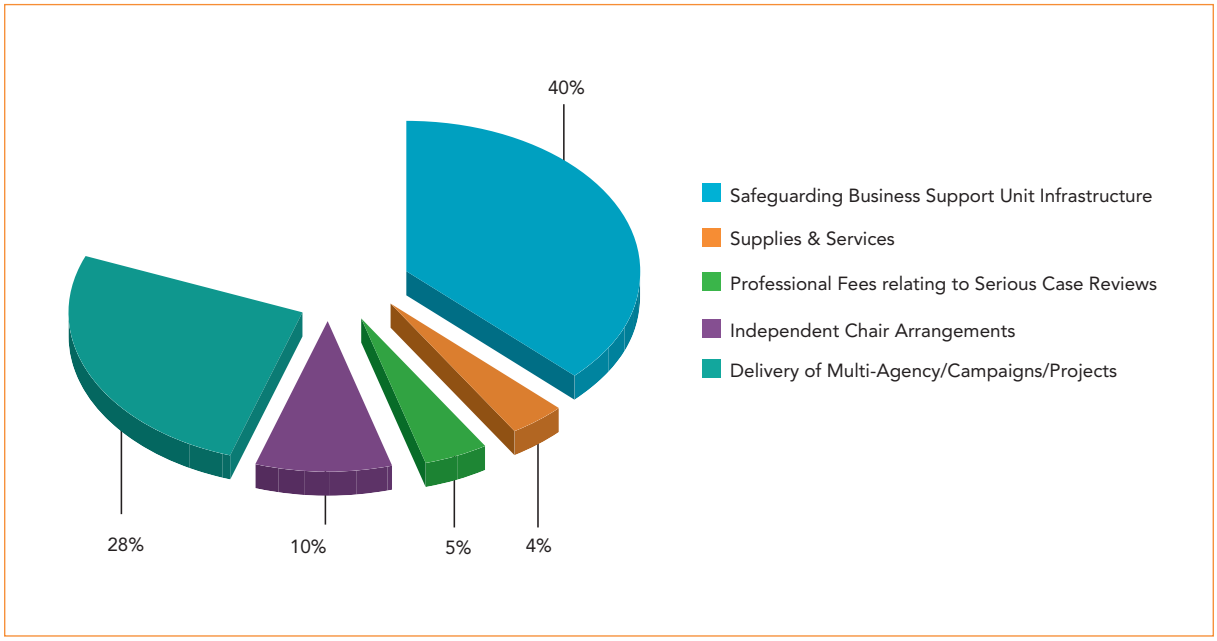


Figure 44 Breakdown of BSCB Expenditure 2014-15



Birmingham City Council also continues to make a significant contribution in kind, by the provision of office accommodation, IT, Legal, Financial and HR support for the BSCB Business Support Unit.

11. The work of the Sub-Groups

Performance and Quality Assurance Sub-Group (P&QA)

This Sub-Group moved forward significantly during 2014-15.

All statutory partners completed the annual Section 11 safeguarding audit return. Of the 445 schools in Birmingham, 97% completed the safeguarding audit. The result of both audits identified areas of good practice and areas of weakness where further work will need to be done. In November the group ran a Section 11 peer review event which all statutory agencies attended which enhanced the moderation of the judgements, facilitated dissemination of good practice and generated challenge and scrutiny of agencies self-assessment.

Since June 2014 a Front Door Reference Group has been running as a small Sub-Group of the P&QA. This group had audited 66 referrals by the end of March 2015. The data has been regularly reported to the group, the MASH Board and the BSCB, the information to date indicates that there has been some improvement in the quality of the referrals since last June.

The P&QA Sub-Group completed four audits of Initial Child Protection Conferences (ICPCs) in October 2014. The findings have been acted upon to enhance training of child protection chairs and the ICPC process. These audits identified that the Voice of the Child is still missing in the child protection conference process with only one case identified as good. The BSCB will seek further assurance of improvement in the conference process during 2015-16.

Towards the end of the year a multi-agency audit pool was developed, with professionals from a range of organisation being trained to undertake joint child protection audits. The audits are due to be completed by the end of June and a final report produced on the outcome of the audits in July.

Development of Performance Information
The Sub-Group provided the BSCB with a performance briefing at each quarterly meeting. The key focus of the BSCB this year has been:

- Proxy early help measures: fCAF, active interventions and family support plans.
- Identification of concern measures: contacts, referrals, conversion rate of contacts and referrals, quality of the referrals.
- Safer systems: unallocated and timeliness of single assessments, rate of children protection plan and children in care, attendance and timeliness of ICPC.
- Staffing levels.

Early Help measures show a clear increase in the early support work being carried out by all agencies using fCAF. Health visitors' activity is evidenced through analysis of active interventions. The increase in health visitor active interventions is attributable to the increase in health visitors, which has also resulted in a reduction in caseloads, moving closer to the national average.

Increase in contacts not only coincides with the start of MASH on 1 August 2014, but was also the point at which police started sending in information regarding Domestic Violence. These contacts do not usually become referrals as the majority are referred to other agencies. Hence the conversion from contact to referral rate has not changed considerable over this period.

The Front Door Reference Group have been auditing referrals since June 2014 and has audited 66 referrals. From October the audit has used a random sample of up to 10 referrals per month for seven months from all referrals to the front door (total 66 referrals). The quality of the referral being made over the past seven months has shown a generally consistent improvement.

The BSCB identified concerns around the number of unallocated single assessments (SAs) and the timeliness of single assessments. The overall numbers of unallocated SAs has decreased significantly over the last quarter and at 31 March 2015 stood at 68 (4% of open SAs) compared to 763 at 1 July 2014. All single assessments should be completed within 45 days. Those over 45 days are out of time at the 31st March 2015 223 SA's (14% of open SAs) were out of timescale. Children's Social Care has changed the process to allow the receiving hub to determine whether a single assessment is needed. This has resulted in fewer single assessments being initiated. Whilst performance has dipped slightly (appropriate) reduced demand will hopefully result in improved timescales and more importantly improved quality in working with the family.

The BSCB remained concerned at the level of unidentified risk and this in particular was reflected by the significant lower rate of children on child

protection plans and in care than statistical neighbours. The rate for children on child protection plans in January 2014 was 24 per 10,000 of the child population (statistical neighbours were 44) whereas in January 2015 was 42 per 10,000. The rate of children looked after in January 2014 was 66 per 10,000 of the child population (statistical neighbours were 78) whereas in January 2015 was 72 per 10,000. These rates appear to be levelling off now with only slight increases up to March 2015 (children on a child protection plan rate 47 and children in care rate 72).

Staffing levels in both social care and health visiting have also been a major concern over the last year. The number of health visitors has increased significantly following a national drive to increase the numbers in the last three years. In line with this the average caseloads of health visitors has dropped significantly from 696 in 2012/13 quarter 1 to 368 in quarter 3 2014-15. Social cares still have significant vacancies with over 35% of full time posts filled by agency staff.

Part of the Sub-Group plan was to develop the Section 175 audit tool so that it could be utilised by all education settings from birth to 18. A Task and Finish Group met and developed the tool so that it incorporated the guidance on Keeping Children Safe in Education and the Ofsted Inspection framework for Safeguarding. The tool has also been developed into an online tool that schools can access from the web. Some delays in getting the tool up and running meant that the deadline for the schools audit had to be extended to the end of May 2015. Work is ongoing with further education colleges to introduce them to the Safeguarding in Education audit tool.

Birmingham audit were commissioned to carry out an audit on the compliance with the safeguarding in education audit in 10 schools. The report has identified a number of concerns particular around the completion of the audit by schools, with two out of the 10 schools audited effectively failing safeguarding. All the schools were provided with an improvement plan by audit and the two schools have made some improvement.

The statutory agencies Section 11 audit has moved to a new online tool which agencies are due to complete by the end of June 2015. A meeting has been held with the voluntary sector to discuss the Section 11 safeguarding audit with them and further work is required to develop a simplified audit tool that will assist the voluntary sector in improving their safeguarding standards. A section 11 peer review session was held on 19 November 2014 with all statutory agencies present. The peer review provided partners with a validation of their section 11 audits and identified areas of concern for partners to resolve within their organisation.

A programme of personal audits conducted by the Independent Chair commenced during the year as part of a three year cycle. Last year the chair audited four agencies, summaries of those audits are currently being complied and the learning identified for the relevant agency.

Practice Standards and Procedures Sub-Group
The Board tendered for a supplier to undertake the detailed work of procedures and Tri-Ex was appointed. They worked on a total revision of procedures which were launched in September 2014. The Practice Standards and Procedures Sub-Group is a newly established Sub-Group as part of the Governance Review, and is chaired by a Superintendent from West Midlands Police. The Sub-Group is focusing on the continued development and dissemination of multi-agency practice standards, protocols and practice requirements. The Sub-Group is also overseeing the development and maintenance of the Tri-Ex on-line procedures that provide the children's workforce with instant access to current national, regional and local guidance. Work is being undertaken at regional level to develop local multi-agency protocols, standards, and service pathways for the West Midlands region.

Safeguarding in Education Sub-Group
During the last year the Board has worked closely with the Local Authority, Schools and Birmingham Education Partnership to ensure processes are in place to support schools to own and fully engage with statutory responsibilities for safeguarding children and young people. The Assistant Director Education and Skills has been appointed to chair the new Safeguarding in Education Sub-Group which commenced in June 2015 following the recommendations of the Governance Review. The Group provide a conduit between the 445 education establishments and the LSCB.

In 2015 the Sub-Group will concentrate on supporting the development and co-production of a safeguarding assurance, improvement and development 'offer' for education establishments in order to:

- Improve the welfare and safety of children and young people (through the delivery of support, training, audit processes and education improvement offer.)
- Provide assurance for establishments and the LSCB of the effectiveness of safeguarding arrangements and practice (through the Section 175, S157) audit process, support visits, external inspections and reviews.

We are starting to see positive outcomes on the stronger relationship, which is evidenced by the 97% completion rate for the Safeguarding in Education Audit 2014. Head Teachers and Designated Safeguarding Leads have contributed to the design and rolled out programme of new on-line Section 175 Audit process. The new Chair of Safeguarding in Education Sub-Group is a participant member of the Board alongside Head Teacher representation form Secondary, Primary, Special and Early Years settings on behalf of the relevant schools forum.

Communication and Public Engagement Sub-Group

During the last year good progress has been made on establishing a foundation for good communications and focused work on:

- The Voice of the Child – working with and utilising existing opportunities for children and young people to develop a programme of engagement: Whilst it is acknowledged that progress on this key objective has been restricted an initial mapping exercise was undertaken in November 2014 to scope and map who is leading on participation within the city. This objective will be carried forward into the 2015-16 work programme.
- A re-fresh of Right Services Right Time information campaign was delivered right across all agencies in Birmingham to help professionals understand how to access right support at the right time and to improve quality of referrals (Right Services Right Time) – this included delivering nine briefing sessions for 1,492 professionals to raise awareness of the threshold guidance model.
- Launch of new way of working in Birmingham – 2014 saw substantial support for the launch of a new Multi-Agency Safeguarding Hub (MASH) in August 2014 – this included delivering 15 briefing sessions for over 2,750 professionals to raise awareness around forthcoming changes.
- Awareness raising campaigns – this year saw:
- Delivery of a full multi-agency campaign in partnership with the NSPCC for raising awareness around neglect and monitoring public and professional response – this included supporting the delivery of a multi-agency conference for 200 professionals.
- Commencement of a safer sleeping campaign to raise awareness of the importance, perception and social views on sleeping arrangements with roll out and implementation expected in 2015-16.
- Public Information – the newly designed BSCB website has continued to be maintained as a key gateway with up to date information. However, there are limited metrics available about the usage of the BSCB website. This will be remedied in 2015-16.
- Agreeing communications protocols and joint working between agencies for media and campaigns so an effective multi-agency response is managed.

Emerging Themes & Areas for Improvement 2015-16

In 2015-16 the Sub-Group will continue to build on the foundations established such as continuing to maintain accurate public information, support ongoing serious case reviews and keeping the newly launched processes in mind for practitioners. With these communications channels now firmly in place, as a Board we are now in a position to engage children and young people in the development and planning of services across the city and identify what they are telling us about their lives which we will use to inform the work of the Board. The Sub-Group have also recognised that social media will be a critical channel for development in 2015-16 in order to reach children and young people.

The Sub-Group will also develop and deliver the following public awareness raising campaigns:

- Child Sexual Exploitation
- Safer Sleeping

In addition to supporting the broader work of the Board, the work programme for the C&PE Sub-Group for 2015-16 will include supporting the Board's Business Plan Priority 1: Voice of the Child by delivering the following priority actions:

1. We know how children and young people are engaged and involved in the development and planning of services across the city and what they are telling us about their lives and use that information to inform what we do.
2. We have developed an involvement model that will enable direct challenge by children and young people in the city to the Board, about its role and work, by March 2016.
3. To ensure that the voice of the child is threaded across all Sub-Group work programmes throughout the year.

Learning and Development Sub-Group

Training Activity & Impact

There are approximately 75,000 front line staff in the city who work with children or with adults who also

have children. This creates a significant challenge in ensuring the Board effectively commissions multi-agency safeguarding training and targets its finite resources at those professionals who can make the maximum impact on safeguarding children and young people across the city. The Board's Training Offer compliment and builds upon each agencies safeguarding training, however there are particular issues in every agency in delivering with sufficiency in terms of skilled practitioners, recruitment and, more importantly, retention.

During 2014-15 the Learning and Development Sub-Group commissioned and delivered multi-agency safeguarding training to 2,524 delegates across the children's workforce. This is significantly fewer that the 5,915 delegates who attended training during the 2013-14 year, this was due to a reduction in capacity to commission training, with 19 less courses than the previous year. Figure 45 provides a comparison of training course delivery between 2010-11 and 2014-15. The Sub-Group have refocused the portfolio of training courses to ensure that it complements the strategic priorities set out in 'Getting to Great'.

Figure 45

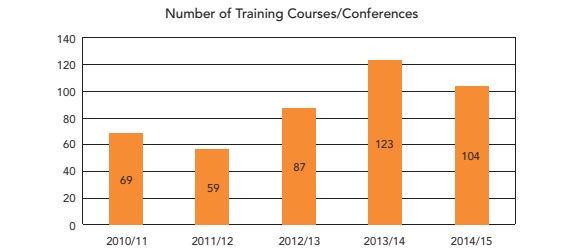
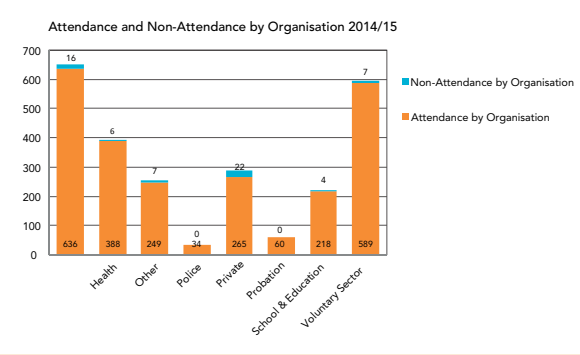


Figure 46 Shows the relationship between agency attendance and the proportion of cancellation/non-attendance.

Figure 46



Figures 47 and 48 illustrates the utilisation of training places, which has seen an increase in take up rates brought about by better targeted marketing of courses and adherence to the training cancellation policy.

Figure 47

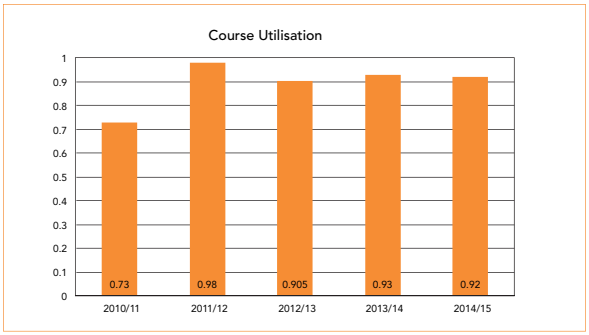
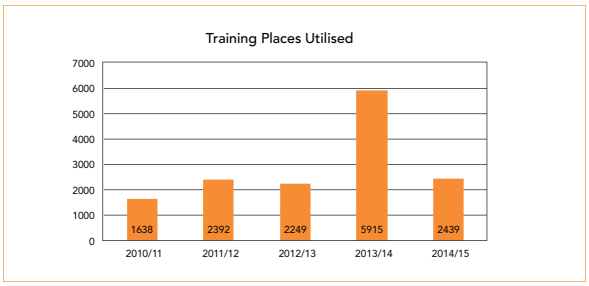


Figure 48



The L&D Sub-Group have been fully committed to the delivery and implementation of the Sub-Group Work Programme 2014/2015 and key achievements include:

- All commissioned training material reflects, 'The Voice of The Child'
- Standard Induction Programme developed.
- Attendance and satisfaction with training deliver remains high, with low levels of non-attendance and cancellation.
- Development of 'Right Service, Right Time' training materials/trainer's pack produced to support a programme of train the trainer events.
- Commissioned a programme of training and briefing during 2014-15.

Training courses remain full, with representation from different agencies enhancing the learning experience. Fewer courses were cancelled due to non-attendance and the importance of attending training has been reinforced through charges for non-attendance.

The Sub-Group now has in place a Learning and Development Strategy, Learning and Improvement Framework and Training Plan. Work will continue to implement the Learning and Improvement Framework, to ensure that we build learning from serious case reviews and learning lesson reviews into future commissioned training activities. The Sub-Group is actively working in partnership with Research in Practice on a number of initiatives including developing an evaluation framework.

The training module for RSRT was recognised as good practice and will act as an exemplar for the development of future training courses in relation to Early Help, FGM, CSE and Strengthening Families Framework. The Sub-Group assisted in developing briefing sessions to prepare and inform the workforce of the practical application of the assessment of needs model in March 2015.

Further achievements include:

- Four year procurement framework established to secure delivery of multi-agency training programme.
- Course utilisation has decreased by 1% from 93% during 2013-14 to 92% during 2014-15.
- The number of training courses excluding conferences has remained stable during 2014-15 at 124, an increase of one course on the previous year.
- Implementation and usage of charging policy to maximise attendance and therefore justify expenditure.
- Delivery of key components within the 2014-15 L&D Work Programme.
- A number of new training courses are currently under development and will be delivered during the forthcoming year, including learning from SCR, FGM and CSE.
- A review of training courses has taken place, leading to a number of courses being revised and updated.

The training courses delivered have increased the knowledge, skills, confidence and understanding of the children's workforce as outlined by course evaluation sheets; however we recognise the need to further develop an Evaluation Framework that will demonstrate the impact that learning and development activities are having at different levels throughout the organisation.

Work will be undertaken in the forthcoming year to revise and update the Cancellation and Charging Policy; however, course take up rates from the Voluntary/Private and Independent sector have improved, showing a significant reduction in non-attendance and cancellation. Course utilisation remains above 90% even though there has been a reduction in the number of courses commissioned. During the coming year work will be undertaken to review and revise the existing course booking process.

Course Evaluation
The British Association of Adoption and Fostering (BAAF) continued to deliver majority of training courses commissioned by BSCB over the year. During 2014/2015, 57 courses were delivered with 1,385 training places available and 1,350 training places were actually achieved which equates to 97.47% places filled. Overall delegates satisfaction with the content of the courses was 98.31% and 98.23% rated as very good and good the delivery of the training.

Training has been updated throughout the year to reflect changing structures in Birmingham, in particular the introduction of MASH in July 2014 and new 'Working Together' guidance 2015.

Forthcoming Year
Ofsted commented on the fact that the Board does not provide multi-agency child protection training at levels 1 and 2 and does not provide a common curriculum with common standards for each statutory partner's own level 1 and 2 training. This remains a priority and work is near completion on developing a standard training package for child protection level 1 and 2 which will be utilised by all agencies across the city.

The 2015-16 L&D Work Programme will further develop and embed the key themes contained within the Strategic Plan around; the voice of the child, early help and safe systems. Therefore our key priorities for the forthcoming year are:

- To ensure safeguarding child protection training at levels 1-3 are delivered via the sub-group.
- Develop specific training activities around Early Help.
- To continue to support, commission and quality assure RSRT training.
- Review, revise and evaluate existing training courses and use intelligence to inform future, commissioning intentions.
- Commission bespoke and multi-agency training specific to target groups.
- Explore the application of e-learning for target group 1 and 2.
- Review, revise, evaluate and develop training around Strengthening Families Framework.
- Develop and implement a multi-agency evaluation framework.
- Develop a 'core offer' of training activities that is fundamental to what we do.

- Develop a robust process for the commissioning, delivery and evaluation of training activities.
- Clearly identify and establish the meaning of multi-agency training.

Work is ongoing to develop courses as a direct result of lessons learnt from SCR, DHR and DV's as well as other sources including section 175 and section 11 audits.

Strategic Child Sexual Exploitation Sub-Group

Earlier in the year the Sub-Group contributed to the regional assessment of the nature and scale of child sexual exploitation across the West Midlands for the period January till June 2014. The findings 'Tackling Child Sexual Exploitation' were published in March 2015 and provided a valuable overview of risk at that time and helped inform the development of our CSE strategy.

The Board are ensuring the continued development of services takes account learning from the Rotherham Review, Birmingham City Council review 'We need to get it Right' and the emerging regional approach being driven by the Home Office supported initiative 'Preventing Violence against Vulnerable People'.

In August 2014 the Sub-Group on behalf of the Board contributed to Office of the Children's Commissioner national review of 'Gangs or Groups'.

The Sub-Group have also contributed to the development of a protocol for hotels; this approach is to become the 'Gold Standard' for the hospitality industry in Birmingham.

The Sub-Group commissioned a training needs analysis specifically focused on equipping participants within the new CSE framework as well as the broader children's workforce. Interim findings were presented to the group in May 2015 and this will be a key feature of the work programme for 2015-16. We have participated in a regional awareness raising campaign to help parents, young people and communities to spot signs of abuse http://www.seeme-hearme.org.uk. In partnership with Birmingham Community Safety Partnership, Birmingham City Council and Birmingham Community Healthcare NHS Trust we have produced a resource pack to help support delivery of the PHSE curriculum in Secondary Schools and Further Education Colleges to enhance 14-17 year olds' awareness and understanding of the dangers of CSE. The BAIT Resource pack which included a DVD, Work Book and posters was launched on 10 March 2015 with a screening of the film at Cineworld on Broad Street, Birmingham. The resource pack has been sent to every secondary school and Further Education College in the city. The resource pack is receiving recognition as good practice at both regional and national level.

In March 2015 the Board ratified the revised Child Sexual Exploitation Strategy 2015-17 to tackle Child Sexual Exploitation. The strategy is built around four key strands, prevention, protection, disruption and prosecution. Successful implementation will be closely monitored by the Board and is embedded within 'Getting to Great' the Board's three year Strategic Plan.

Emerging Themes & Areas for Improvement 2015-16

The Strategic CSE Sub-Group will concentrate on ensuring the effective implementation of the priorities set out in first year of the two year CSE Strategy ratified by the Board in March 2015. The Chair will closely monitor performance and provide regular progress reports to the Board. The main focus in year one will be:

- Explore the feasibility of co-locating the dedicated CSE Team within the Multi-Agency Safeguarding Hub based at Lancaster House.
- Establish and embed the Missing Operational Group to improve our data collection systems to better identify the most vulnerable children so we can intervene earlier to make a difference.
- Strengthen the pathways between CSE Operation Group and the Multi-Agency Safeguarding Hub to secure the requisite expertise earlier in identified cases of CSE.
- Deliver a programme of CSE training that enhances staff skills, knowledge, professional competence and confidence to address CSE. Engagement in National and Regional Networks to share good practice.
- To lead and continue to participate in a regional and local awareness raising campaign to help parents, young people and communities to spot signs of abuse.
- Work with the Performance and Quality Assurance Sub-Group to develop the CSE dataset to meet local priorities and facilitate regional comparison of performance.
- Evaluate the impact on young people of the BAIT educational recourse pack to be undertaken in December 2015. The findings to be shared with Headteachers, School Governors, Governing bodies and the Safeguarding in Education Sub-Group.

The Child Death Overview Panel (CDOP)
The Birmingham Safeguarding Children Board has a statutory duty to review and enquire into the deaths of all children under the age of eighteen. The Child Death Overview Panel (CDOP) oversaw the review of the 165 deaths that occurred between 1 April 2014 and 31 March 2015. The full report is attached as Appendix 17. The responsibility for determining the cause of death rests with the coroner or the doctor who signs the medical certificate of the cause of death and is not therefore the responsibility of the Child Death Overview Panel. The Panel's role, under a chair that is independent of service provision responsibilities, is to:

- Classify the cause of death according to a national categorisation scheme;
- Identify factors in the pathway of death, service /environmental/behavioural, which if modified would be likely to prevent further such deaths occurring; then
- Consider recommendations on these factors for action to the Safeguarding Children Board, who then arrange to ensure any appropriate actions agreed with partners.

Figure 49 provides a comparison of the number of child deaths and serious case reviews commissioned between 1 April 2007 and 31 March 2015. Each year the Board publishes statistical analysis of the causes of child deaths and emerging learning.

A separate detailed analysis of the learning from the review process is commissioned and overseen by the Board through the Child Death Overview Panel (CDOP). A separate annual report analysing why children die is published by the Board. The report provides a detailed overview of the work of CDOP and the associated work of the Sudden Unexpected Death in Childhood (SUDIC) Team.

The findings from the CDOP Annual Report are referred to the Director for Public Health and the Health and Wellbeing Board in order to inform their work particularly in terms of the on-going issues relating to higher incidents in certain populations in the city. Annual Report 2014-15. (Appendix 17)

Deaths in childhood are conventionally divided into six age groups to reflect different stages of development and the different settings, activities and causes during that development (Figure 50). Birmingham is also a very culturally diverse city. (Figure 51) shows the proportion of deaths occurring in different age and ethnic groups during 2012-14.

The dominant age group at death is the neonatal and infancy groups (82%) with Early Neonatal deaths accounting for more than half of these (47%). Different age groups die from different causes. The recorded cause of death on the death certificate and the other information found in the investigations are used by the panel to ascribe the death to a predefined national category. This categorisation is used by the Department for Education to compare the patterns from different panels in England and publish national statistics and comparisons.

The numbers and proportions of deaths in Birmingham by age group and category are shown in Figures 52, 53 and 54.

The analysis in figure 52 shows that 80% of all childhood deaths in 2012-14 were due to congenital anomalies or a perinatal (around birth) event. Deaths in the neonatal and infancy groups accounted for 95% of the deaths in these categories, with the majority (67%) occurring in the Early Neonatal age group. The Late Neonatal and older age groups share more equally the other categories (figure 53).

Figure 49

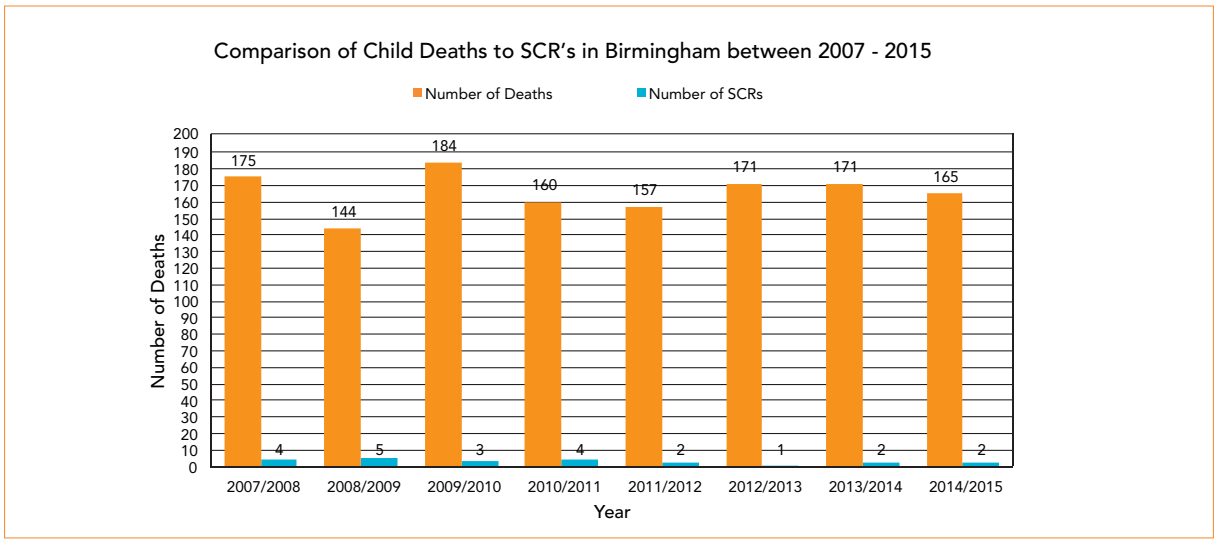


Figure 50 The Analytical Age Groups

Early Neonatal	Late Neonatal	Infant	Toddler	Younger Child	Older Child	Adolescent
0-7 days	2-4 weeks	5-52 weeks	1-3 years	4-7 years	7-12 years	13-18 years

Figure 51 Deaths by Age Group and Gender

Year of Death	Early Neonatal				Late Neonatal			Infant			Younger Child			Older Child			Adolescent			Grand Total
	Female	Male	(blank)	Total	Female	Male	Total	Female	Male	Total	Female	Male	Total	Female	Male	Total	Female	Male	Total	
2012	26	53	2	81	7	7	14	13	29	42	3	5	8	3	4	7	5	5	10	162
2013	25	50	2	77	7	7	14	24	26	50	3	8	11	2	7	9	8	9	17	178
2014	33	31	1	65	6	11	17	16	17	33	5	4	9		3	3	3	5	8	135
Grand Total	84	134	5	223	20	25	45	53	72	125	11	17	28	5	14	19	16	19	35	475

% Deaths 2012-2014 by Agegroup	
Early Neonatal	47%
Late Neonatal	9%
Infant	26%
Younger Child	6%
Older Child	4%
Adolescent	7%

% Deaths 2012-2014 by Gender		
Male	281	60%
Female	189	40%

Figure 52 Age Of Death By Category (2012--2014 Numbers)

CDOP Category of Death	Early Neonatal	Late Neonatal	Infant	Younger Child	Older Child	Adolescent	Grand Total	
Suicide or deliberate self-inflicted harm						2	2	1%
Trauma and other external factors		1	4		1	1	7	2%
Malignancy		1	1	3	2	1	8	2%
Acute medical or surgical condition		2	6	2	2	1	13	4%
Chronic medical condition		1	7	1	2	2	13	4%
Chromosomal, genetic and congenital anomalies	43	9	40	7	3	3	105	31%
Perinatal/neonatal event	140	20	6			1	167	49%
Infection	1	2	1	3		3	10	3%
Sudden unexpected, unexplained death	1	1	14			1	17	5%
Grand Total	186	37	79	16	10	15	343	

Figure 53 Age Of Death By Category (2012--2014 % of Category)

CDOP Category of Death	Early Neonatal	Late Neonatal	Infant	Younger Child	Older Child	Adolescent
Suicide or deliberate self-inflicted harm						100%
Trauma and other external factors		14%	57%		14%	14%
Malignancy		13%	13%	38%	25%	13%
Acute medical or surgical condition		15%	46%	15%	15%	8%
Chronic medical condition		8%	54%	8%	15%	15%
Chromosomal, genetic and congenital anomalies	41%	9%	38%	7%	3%	3%
Perinatal/neonatal event	84%	12%	4%			1%
Infection	10%	20%	10%	30%	0%	30%
Sudden unexpected, unexplained death	6%	6%	82%			6%

Figure 54 Age Of Death By Category (2012-2014 % of Age Group Death)

CDOP Category of Death	Early Neonatal	Late Neonatal	Infant	Younger Child	Older Child	Adolescent
Suicide or deliberate self-inflicted harm						13%
Trauma and other external factors		3%	5%		10%	7%
Malignancy		3%	1%	19%	20%	7%
Acute medical or surgical condition		5%	8%	13%	20%	7%
Chronic medical condition		3%	9%	6%	20%	13%
Chromosomal, genetic and congenital anomalies	23%	24%	51%	44%	30%	20%
Perinatal/neonatal event	75%	54%	8%			7%
Infection	1%	5%	1%	19%		20%
Sudden unexpected, unexplained death	1%	3%	18%			7%

Figure 54 demonstrates the significant impact that perinatal events has on the neonatal age groups and that congenital anomalies has in every age group. In Children and adolescents the challenges of illness, trauma, and self-harm/suicide are more widely spread although numbers are much smaller in these age groups.

In past reports we have been concerned about the influence of premature births upon the pattern of deaths, particularly the perinatal category. There were 100 neonatal deaths in 2014-15, 31 of these were born at less than 22 weeks of pregnancy. The mortality rate in this group is 100%, despite all the technological expertise available. The reviews undertaken by the panel, using our current resources and processes, cannot demonstrate any missed opportunities to prevent these births. The impact of these very premature and inevitable fatal births on families and service providers is, however, significant.

In view of Birmingham's cultural diversity it is important to understand any demonstrable differences in the patterns of deaths in different ethnic groups. The recording of the ethnic group of children overall is not complete (25%) but slightly better than in previous reports, particularly in the neonatal and infancy groups. The children whose ethnicity is unrecorded are spread proportionately across all the age groups which suggests that there has not been a systematic bias in recording ethnicity (Figure 55). However the proportion of deaths is higher for Asian Pakistanis children than British White children. This can be attributed to the proportionately higher number of births to Asian Pakistani women.

Figure 55 Age Of Death By Category (2012-2014 % of Age Group Death)

ETHNIC GROUP	Early Neonatal	Late Neonatal	Infant	Younger Child	Older Child	Adolescent	Grand Total	
Arab			1				1	0.2%
Asian Bangladeshi	3	1	9	1	1		15	3%
Asian Indian	9	1		1	2		13	3%
Asian Other	16	3	10	3	3	2	37	8%
Asian Pakistani	39	7	40	11	4	11	112	24%
Black African	8	3	7	4	2	2	26	5%
Black Caribbean	11		5		2		18	4%
Black Other	4		4		1	1	10	2%
Mixed Heritage	12	1	6	1		4	24	5%
White British	32	11	21	5	1	9	79	17%
White Other	10	2	9			2	23	5%
Unrecorded	79	16	13	2	3	4	117	25%
Grand Total	223	45	125	28	19	35	475	100%
	47%	9%	26%	6%	4%	7%		

Most of the deaths in 2012-14 were expected (85%) (figure 56) particularly those categorised as congenital abnormalities or perinatal events. The unexpectedness of events such as infection or acute medical or surgical conditions is also clear seen in the data below.

Figure 56 Comparison of Expectability of Deaths with Category of Cause Reviewed in Birmingham 2012-14

CDOP CATEGORY	WAS THE DEATH EXPECTED?				
	No		Yes		Total
Suicide or deliberate self-inflicted harm	2	100%		0%	2
Trauma and other external factors	7	100%		0%	7
Malignancy		0%	8	100%	8
Acute medical or surgical condition	8	62%	5	38%	13
Chronic medical condition	3	25%	9	75%	12
Chromosomal, genetic and congenital anomalies	3	3%	102	97%	105
Perinatal/neonatal event	5	3%	162	97%	167
Infection	7	70%	3	30%	10
Sudden unexpected, unexplained death	16	94%	1	6%	17
Grand Total	51	15%	290	85%	341

What happened following last year's report?

The 2013-14 report was discussed at a senior level in a number of partner organisations. In addition work has continued through discussion with professional networks and groups. The issue of reviewing neonatal deaths has resulted in a number of groups expressing interest in the development of systematic investigations of all neonatal deaths and stillbirths. The South West Midlands Maternity and Newborn Clinical Network hosted an important conference and stakeholders day which gathered more support. The Chair of CDOP also chairs the Public Health England Infant Mortality Taskforce which has this as an important central theme. The Women's Hospital is trialling a system to deliver a systematic review process.

The question, is unexpected the same as unexplained? was addressed by the September 2014 conference chaired by HM Coroner. She was able to outline the new Coronial statutory framework and the discussion centred on the importance of starting the rapid response process. This means that evidence is not lost due to delays but the arrangements can be stood down if it becomes very clear that there are no serious child protection or criminal concerns to be addressed.

The issue of expected deaths and advanced care planning is also addressed in this year's report. Advanced care planning is still not as well established as in adults and some of this is the difficulty of managing conflicting parental attitudes and preferences. The panel would still call for the development of the local specialist community palliative care services for children.

The number of deaths occurring abroad is still very small but each one is a challenge. Other Child Death Overview Panels have also been concerned and a number broached their concern collectively with the Foreign Office and Home Office. A recent case suggests that there has been some improvement in their assistance in these matters.

Sudden Infant Death and Co-Sleeping has remained an issue of concern, although not addressed specifically this year. A protocol and training programme has been developed and is offered through multi-agency training. An autumn media event is planned to raise and re-emphasise the importance of proper sleeping arrangements for infants.

Next steps

This section draws together the recommended responses to the identified issues in this report for the partners of the Birmingham Safeguarding Children Board's consideration, approval, and adoption.

Very Premature Births
Giving birth before the 24th week of pregnancy has a high risk of death or ongoing disability for the child. Giving birth before the 22nd week of pregnancy is almost certainly fatal in a short time. In view of the difficulty of reviewing the short life journey of these children it is important that partners support the current trial of a systematic review process. If the experience is positive then it should be used in the other maternity units. This will both enhance our local intelligence and put our community in a strong position when a national scheme is launched in the (near) future.

Consanguinity and congenital abnormalities
A consanguineous relationship will have twice the likelihood of conceiving a congenitally abnormal child, with likelihood of death, than a non-consanguineous couple. In perspective this is a doubling from 2% to 4%. That means that 96% of offspring to consanguineous couples are normal. However, the risk after one affected child is higher still and it is a clinical imperative to offer a genetic assessment and testing if appropriate. NHS commissioners are asked to review the extent and reliability of these services and ensure that community pathways are in place. Discussion and advertising of these services in local communities, including faith communities, will enhance their impact.

The only basis for identifying consanguinity as a modifiable factor by the panel would be to prompt a question of the family General Practitioner: Has this couple been offered genetic assessment? General Practitioners should expect this question more often from the panel in the future.

A Case Management System
The case for change and adopting a case management system has been outlined in this report. The benefits are clear and partners are asked to support this in the Executive Group in the near future.

Panel Membership
The role and scope of the panel is being conducted in an increasingly complex provider environment and with increasing clinical specialisation. CDOP are seeking to expand its membership to meet this challenge during 2015.

Serious Case Reviews and Learning Lessons Reviews

The Sub-Group oversees the commissioning of the independent reviews process when a child dies or is serious injured and child abuse is suspected of being a contributing factor. The Sub-Group also monitors and ensures that the learning and action plans have been fully implemented.

During the year two Serious Case Reviews were commissioned. The first Serious Case Review relates to a family of nine children who suffered sexual abuse at the hands of family members. The other is in relation to a Looked After Child who was sexually abused after absconding from a residential unit.

Also during this reporting period six Learning Lessons Reviews were commissioned. The first of the Learning Lessons Reviews is in relation to a child who survived a house fire; the child's mother was suffering from mental health issues and died suddenly after the fire. The second was in relation to a family who previously lived in Birmingham and moved to another Local Authority, court proceedings were taking place and the Judge requested that BSCB look into the circumstances of why the children were placed with the parents after Birmingham Social Care had previously had involvement. The third case was into a Looked After Child, and it was felt that his care was not managed appropriately. The fourth case was a young person who committed suicide, it was not felt that this case me the criteria for a SCR but it was felt that there would be learning that could be established from a Learning Lessons Review. The fifth case is of a baby whose arm was fractured by her father. She was only four weeks old at the time of the incident. This review only involves two agencies. The sixth case involves a baby who died suddenly and was remitted from the Child Death Overview Panel due to both parents being deaf and information that mother had not been provided with safer sleeping advice.

Serious Case Review Sub-Group were notified of serious injuries to two children, this case was referred on to the Domestic Homicide Review Steering Group as the mother had been murdered by the father who subsequently went on to try to murder the children. Serious Case Review Sub-Group reviewed the Terms of Reference to ensure that the safeguarding arrangements for the children were included.

Work has taken place with the NSPCC and Sequeli to produce a Serious Case Review manual for practitioners, which will assist them in the completion

of reports and chronologies, provide guidance on the differing types of review that can be undertaken, set out the expectations of BSCB board and SCR sub-group members and be a resource for independent reviewers and report authors. This piece of work will be finalised in the forthcoming year.

During the year, BSCB also commissioned Birmingham University to undertake a thematic review of Serious Case Reviews and Learning Lessons Reviews over the previous five years; this was not completed by the year end and will be carried forward.

The Disclosure policy has been developed by SCR Sub-Group and ratified and disseminated.

The scoping document, sent to agencies requesting preliminary information about cases, was not always submitted in a format which allowed considered decisions to be made by the Sub-Group. It has, therefore, been revised to ensure that the Sub-Group has more accurate and complete evidence on which to make decisions.

There has been a significant amount of work performed by BSCB to ensure that SCRs that are nearing completion are quality assured and reflect the guidance in Working Together 2013, and looking ahead will need to reflect the 2015 revision. This has resulted in a revision of timescales to reflect the new requirements.

Published Serious Case Reviews
The Board completed and published the findings from one serious case review, the tragic death of Harli Delves Reid who died at the hands of her father who pleaded guilty to causing the death and was subsequently convicted of manslaughter on 4 November 2013. He was sentenced to three years and nine months imprisonment. The full report is publically available through BSCB website at www.lscbbirmingham.gov.uk (BSCB 2010-11/2).

Homicide Investigation Report
The SCR Sub-Group has been involved in reviewing the death of Christina Edkins who was killed during an unprovoked attack by a stranger who was convicted of manslaughter on the grounds of diminished responsibility in October 2013. He was detained without a time limit in a secure psychiatric hospital. Birmingham and Solihull Mental Health NHS Foundation Trust were required to investigate the circumstances of Christina's death and did so in conjunction with their lead commissioner, Birmingham Cross City Clinical Commissioning Group. Early on in the course of the review it was identified that a number of partner agencies external to health organisations had been involved and a collaborative approach was taken to maximise learning. BSCB agreed that this review fulfilled the requirements of safeguarding legislation. The full report is available through www.bhamcrosscityccg.nhs.uk.

Key learning points from the published SCRs and Homicide Reviews
The key learning identified through the review processes inform policy development, training delivery, communication and public engagement and audit activity to evidence learning has been effectively implemented.

The key messages are:

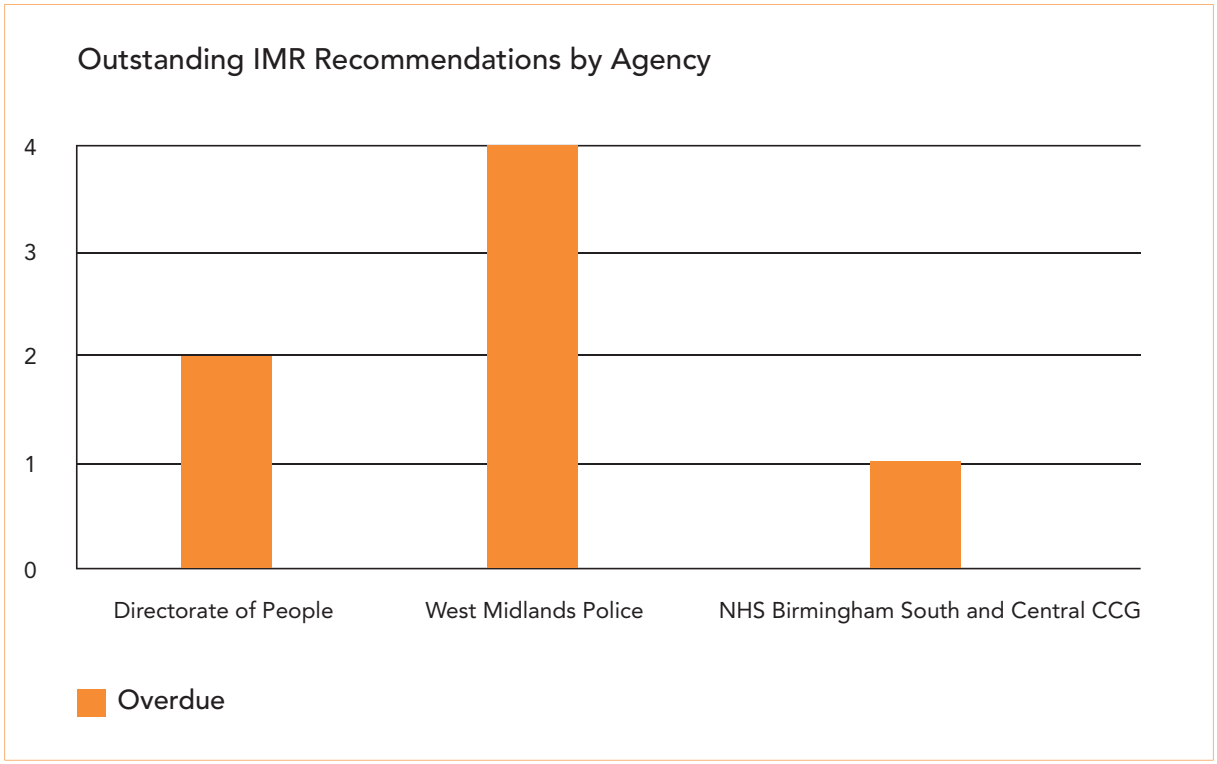
- Lack of focus on the children in frontline and management practice.
- Domestic violence, mental health and substance misuse all featured which is a recurring theme in national reviews.
- Lack of in depth assessment and insufficient support, guidance and explanation of how to safely care for a baby.
- Insufficient attention given to emotional impact of event upon the parents.
- Lack of information sharing between health professionals.
- Organisations failed to listen to and respond to carers and significant others consistently and adequately.
- The accessing and sharing of information between key agencies was ineffective.
- Organisations' information recording and storage were not robust enough to allow good management and care.
- Services need to be more proactive in making it easier for a person with mental health issues to engage with them.

Ensuring lessons are learnt

The Birmingham Safeguarding Children Board closely monitors timely implementation and compliance with the key learning from Serious Case Review. Each agency provides regular reports detailing how learning has been embedded into front-line practice. Six other SCRs are still in the process of being finalised: on completion they will be submitted to the Department for Education and the findings published.

A detailed performance overview is presented to the BSCB on a quarterly basis and an executive summary is provided. The below table (Figure 57) provides details of outstanding Individual Management Review (IMR) recommendations by agency on 31 March 2015. All SCR Recommendations had been implemented; the three organisations with outstanding IMR recommendations have been required to provide a formal progress report detailing target date for completion of the key actions.

Figure 57



Reflection of the work of the Sub-Group

For each case that is discussed at the Sub-Group there can be considerable debate about the type of review that should be conducted. There has been substantial deliberation about the reviews that may be required and their proportionality in ensuring important lessons are identified whilst balancing this with the capacity within organisations to commit significant resources in order to contribute effectively to these reviews. This has been particularly noticeable in recent very complex cases where organisations have to gather and analyse high volumes of material whilst continuing to deliver services which are already under scrutiny within Birmingham.

In some circumstances a statutory review may not be required but does raise issues about safeguarding in its widest sense. This is particularly the case where children are seriously injured, perhaps as the result of an accident, where supervision is of concern but there does not appear to be overt neglect or abuse or concern about the way in which agencies have worked together. These cases lead to substantial debate amongst Sub-Group members. This also requires consideration of the relationship between the SCR Sub-Group with that of the Child Death Overview Panel and Public Health. An example would be serious injuries of children due to falls from open windows which would not result in a CDOP review and do not require an SCR or LLR. Clearly, there are important safety messages that need dissemination and it will be important to develop better links to ensure this happens.

Themes that are emerging are the increasing number of cases involving families who have moved to the UK from mainland Europe and may have unrecognised or unmet needs. The Sub-Group have also considered how lessons from SCRs and LLRs are disseminated and will be taking this work forward, with the Learning and Development Sub-Group, to ensure that frontline staff can access learning in the most effective way recognising that this may be through use of a variety of formats.

Part 3 – Analysis, conclusions, sufficiency statement and challenges

This report sets out in some detail the work of the Birmingham Safeguarding Children Board in 2014-15. It addresses both the effectiveness of what is done in the city by partners to safeguard children, and the effectiveness of the Board itself in delivering its statutory objectives and 14 functions. The report shows that there has been significant progress by the BSCB Board through and with partners across the whole of the Board's functions and objectives, delivering on much of the Business Plan for the year, and on the Ofsted requirements whilst adapting to changing policies and expectations nationally and locally.

The Report is long, largely because of the need to provide strong evidence of that progress, and to set out the range of activities, projects, programmes and service improvements that have been underway during the year. It has been drafted in line with the template available for what a good report should contain. However the report fundamentally addresses six key questions. It assesses the Board's work objectively against the evidence and against the guidance provided by guidance as to what a Board must do. It evaluates the quality of what we are doing against the criteria for what constitutes a "good" Board, and against the evidence we have of the impact of our work.

The conclusions are short, and framed in the context of what the work of 2014-15 tells us about what we need to be doing next, the priorities for 2015-16 and the challenges we are setting.

12. What is it like to be a child growing up in Birmingham?

We now have much better information about what life is like growing up in Birmingham. The Children's Commission Report, 'It takes a City to raise a Child' has provided an in-depth analysis, and demonstrates that the Board's preoccupations are not necessarily those of the children and young people living in the City. We also have in-depth and sophisticated data available to us about the extent and depth of need in the City, both met and unmet. There has been a demonstrable increase in engagement and participation work with the children and young people using services across the partnership which we now need to capitalise on and use to inform our own Board work.

In 2015-16 the BSCB Board will monitor progress generally by the Council and its partners against the recommendations of the Children's Commission Report, "It takes a City to Raise a Child" as well as against our formal performance data set and other scrutiny activity. However, it is clear that children and young people most want to feel safe in open spaces and on public transport. Clearly the City Council through the Place Directorate needs to lead work with children, young people, communities and partner agencies to significantly reduce the expressed sense of being unsafe in public spaces articulated so strongly by the children and young people of the City. **Improving the safety of children's lived experiences in their communities presents a significant challenge to the Council and its partners.**

The key messages expressed by children and young people in the City about their safety and wellbeing will also be taken into consideration when engaging children and young people in 2015-16 in the work of the Board. **However, a major challenge that the Board has not yet addressed, is finding the best ways to engage with and involve children and young people, their families and their communities in the work of the Board and in providing high support and high challenge as critical friends of what we do.**

13. Are children safer in the city?

Overall the data and other evidence combine to demonstrate that by the end of 2014-15 children and young people were demonstrably safer. This does not of course mean they are safe, and indeed we can never guarantee the safety of every single child. In addition we have made significant progress in understanding the degree of need there is for services to support vulnerable children in the city.

We know those most at risk are now getting a speedier and more consistent response to their needs, and professionals are clearer about what to do when they are concerned about a child or young person through the new Right Services Right Time Threshold Model. The significant increase in contacts and referrals to the MASH, the numbers of children and young people getting assessments from

social care, the number who are the subject of child protection plans, court proceedings and in care have all increased, and timescales diminished in terms of drift.

We have a high performing youth offending service, an excellent "Think Family Programme" and some strong NHS services in place. West Midlands Police have reorganised services specifically to build their capacity to respond to children at risk of harm and abuse. New approaches to key services, in particular the 0-25 Mental Health Service, and the planning for an early start service (involving early years services and health visiting) will contribute to that process.

We also have good evidence of the increased ownership of and responses to their safeguarding responsibilities from the majority of partners on the Board, with more investment in services as well as specialist safeguarding staff, and a much stronger approach to dissemination of material, development of learning and practice compliance. The rapidly improving engagement by and with schools, and the demonstrable areas of improvement in the way safeguarding is being built into school improvement work is another positive indicator of progress.

However, that is just the start of the long process of creating a city where children grow up happy, safe, and well, with good futures ahead of them. Paradoxically, although focusing on the children who are most unsafe has acted as a spur it has taken attention away from services to support families to keep children safe themselves, from the cooperation and coordination needed across the partnership in creating effective early help services, and from multi agency ownership of the need to respond early to emerging problems rather than pass the problems on to someone else.

The much used "safeguarding is everybody's responsibility" mantra is still a long way from being realised. Indeed the creation of strong centralised multi-agency safeguarding activity, whilst both very welcome and very necessary at the "front door" into statutory interventions is acting as a draw, rather than a filter, pulling everything up into a level of response higher than may realistically be needed. Partners have not yet fully developed cohorts of strong confident multi-agency staff in every service, school or setting, who can respond to need quickly and effectively, and who have the support, training and capacity to do it well. Neither is there a well developed range of service "offers" they can draw on to create the right support packages.

Over 2015-16 onwards there needs to be a multi-agency focus on to how best to appropriately and safely reduce the amount of work going through the MASH when it can be better dealt with at RSRT Additional Needs and Universal Plus needs levels. This needs to be done without undermining agency confidence or the momentum gained by the successful development of the MASH. In addition the rebalancing of the relationships between the highly centralised city wide service (MASH) and the three local area service delivery model agreed with Lord Warner will be a challenge. This needs to be achieved within the context of reducing capacity across the partnership so needs to demonstratbly realign resources as a consequence of success. **The major challenge for partners is to retain the confidence brought into the system through the work done in 2014-15, whilst 're-balancing' resources, investment, staff capability and capacity so early help takes precedence over child protection for the majority of children and young people needing support.**

14. Are we making sufficient progress with our strategic objectives?

Overall the Board has made some significant progress in demonstrating it is more explicitly working with partners to co-ordinate local work to safeguard and promote the welfare of children and young people. By the end of the year it was also appropriately and positively withdrawing from over-engagement in co-ordinating activity that was more properly the responsibility of others. Significant challenges remain, partially reflecting the internal incoherence in Working Together in relation to our statutory functions as opposed to our statutory objectives. CSE for example is currently being led by the local authority, by West Midlands Police, by the PVVP and by the LSCB leading to a significant degree of overlaps, contradictions confusions for front line staff, middle managers and service providers. It is possible that there are far better ways of delivering some of the BSCB statutory functions than through the LSCB. **This is of course a national as well as local debate. However, there is no reason why the BSCB should not build on its experiences of the last few years by challenging itself to think radically together as partners in terms of examining what functions should be led by whom, how and where in order to be far more effective in contributing to and supporting the co-ordination of what is done collectively.**
As confidence grew about the MASH Board's programme of work across the partnership, the Early Help Programme Board engaged in extensive multi-agency consultation, and discussions began about a new partnership landscape, the Board has been able to redefine its role to better support service planning,

service design, and service commissioning through providing data and intelligence, high support and high challenge. There is a long way to go however.

Across all agencies service redesign has taken place without early engagement with partners. This affects multi-agency working. **There is a major challenge ahead for the new partnership bodies established to lead children's services across the city, in establishing new ways of working, developing real cooperation across the system, rather than cooperation on specific issues and to ensure the most effective ways of delivering services as resources reduce, capacity shrinks, and demand increases.**

This applies equally to the overall partnership framework across the city, and to the simplification and rationalisation of the multiplicity of boards with overlapping responsibilities, and increasingly shared priorities. The BSCB Board has made limited progress in 2014-15 in terms of developing clearer and more effective strategic relationships with the Health and Wellbeing Board, Community Safety Partnership and Adult Safeguarding Board although some discussions have taken place about this with the Adult Safeguarding Board and, to a lesser extent the Health and Wellbeing Board. The LSCB Board has also not yet addressed the relationship that needs to be developed between the Board and the BEP. **The Board's challenge in 2014-15 of developing stronger, clearer and more mutually robust and accountable relationships with all key partnership bodies remains a challenge in 2015-16.**

The Board welcomes the focus of the Council's Future Council Programme on the quality of partnership working across the city. The Board hopes that this work, led by the Director of Public Health will assist the Community Safety Partnership, the Adult Safeguarding Board, the Health and Wellbeing Board and the BSCB Board and others to agree protocols governing the relationship between them, address the issue of who leads on what, agree shared priorities flowing from a common vision and shared work-streams. This work combined with the continued partnership work by InLoGov in Children's Services has given the Board the space to stop acting as a proxy for partnership working, and create meaningful relationships with the new models for partnership, in order better to inform and influence their work and hold them to account. This new role will test the Board in the coming year.

There have also been new challenges in terms of the dynamics between national departmental policy, regional work and local partnerships thrown up by the work of PVVP, which has helped to highlight the issues locally. Whilst strong leadership of the children's agenda has assisted in making progress the multiplicity of national policy agendas and Departments involved, plus complexities locally have meant that at times there has been duplication, overlapping workstreams and confused accountabilities as well as gaps in activity. This has been particularly the case in relation to emerging issues and the role of the community safety partnership. There is no central shared safeguarding group or collaborative arrangement within the council to address common council wide issue.

This impacts on the City Council's relationships and leadership of the overall safeguarding agenda with partners. Improvement is dependent on the Council's progress in developing new frameworks for partnership working, within the context of the Future Birmingham Programme as well as on partner organisations committing to the new frameworks as part of their own strategic and operational planning. **The challenge for the lead agency, Birmingham City Council with every partner will be to design and implement a new whole council partnership framework for multi-agency co-operation, co-ordination, and commissioning of services to meet children's needs. This will need to also feed into the "Future Birmingham" process.**

Ofsted expected us to ensure that partners urgently agree a definition of early help and drive the implementation of the Early Help Strategy so that partners are fully engaged in the work to achieve and deliver this. The definition is agreed and in use through still not fully recognised and used by individual agencies in their own agency early help work. A strong multi-agency strategy was developed over the year and agreed by the beginning of 2015-16. Assurance and Annual Reports demonstrate a variable engagement in early help although every agency is now involved in developing services. The BSCB Early Help Working Group undertook three key pieces of work over the year; an audit and analysis of the range of assessment tools currently in use in the city (over 300); an examination of national evidence about interventions and what works; and the development of a proposed outcomes evaluation tool to use in the city. In addition it agreed an ideal model for a coherent system of integrated common pathways, processes, and tools to use for all forms of early help within the RSRT model. We also contributed to the development of the strategy and the revised fCAF material and MASH tools. This work will now be taken forward by one of the new partnership's work streams

In terms of our ability to monitor the effectiveness of what is done to safeguard children and promote their welfare we have made significant progress. Increased capacity to support this work within the Board's Business Unit coupled with a strong Sub-Group chair in the performance and quality assurance Sub-Group, and a clear willingness by partners to focus on this work have all paid dividends.

15. Do we have sufficient assurance about the practice of all statutory partners?

In addition to the challenges identified in the BSCB 2014-15 Annual Report, the Ofsted Inspection of the LSCB identified a number of areas for improvement. Progress has been made on the majority of them. In terms of an expectation that each partner agency urgently develops and can demonstrate stronger and more effective accountability within its organisation for their roles and responsibilities in safeguarding children and young people in Birmingham particularly at middle and frontline manager level we made significant progress over the year in our assurance and challenge systems. Evidence includes the Section 11 Peer challenge event, the development of multi-agency audit, and the independent chair's audits, as well as the analysis of Section 11 audits (and follow up visits) and the requirements of the Annual Assurance Letter and Annual Report. In addition we are evaluating and testing the effectiveness of "roll outs" of major policies.

We were required by Ofsted to ensure that single and multi-agency audits are undertaken, analysed and evaluated and that findings are used to help to improve standards of practice in all agencies. We developed new frameworks, systems and process for this over the year and it was underway by the year end. Significant progress has been made. The Assurance and Annual Reports demonstrate this and provide evidence to support the evidence from the P&QA Sub-Group. A multi-agency audit pool is in place and auditing, the Front Door Reference Group is working well and having a direct impact and themed multi-agency audits were undertaken over the year. There is good evidence of the outcomes being applied to changes in practice, action plans being implemented and learning applied. However now systems are in place we need to focus on developing the quality of practice rather than just our compliance with statutory requirements.

The City Council as lead agency has been under intensive supervision with Lord Warner as Commissioner for the improvement plan. Although only one year through the plan, the council has made significant investment into services and Lord Warner has overseen the Council's reengagement with partners. Its programme with inLoGov has been a constructive approach to helping agencies consider how they work with others rather than just decide how to structure working arrangements. This challenge and review mechanism will start to be tested over the next year and this will be important for the development of further partnerships.

The development of the local authority "quartet" model of improvement has ensured a really strong grip on the local authority's improvement programmes across social care, early help and education. It has at times meant partners have felt excluded or uninvolved but without it the progress would have been less effective.

The BSCB was also required to work with partners urgently to develop and implement systems and processes to ensure that they fully comply with safeguarding audit requirements. The Annual Assurance process and Annual Report demonstrate the variable degree to which this has been achieved, but it is now underway and the BSCB has presented some important challenges to agencies at a practice level over the year. The Section 11 Audit indicates there is still much to do in some agencies to properly embed the Section 11 cycle of audit, action plan, change, compliance, assurance that is required although increase in number of agencies delivering better on compliance expectations. In address we are monitoring agency progress towards compliance, with a requirement to complete regular audits which are routinely tested and reported regularly to BSCB. We have had a series of reports from key services such as the Child Protection Service over the year as a result.

The BSCB was asked to improve the degree to which partners at the Board use their role to properly influence their own strategic and corporate governance, and to ensure the Board's work is integrated into their own strategic, operational and business as well as workforce development. Progress has been made with strong evidence captured through Annual Assurance Letters and Reports. This has been more challenging for organisations working on a regional basis that are accountable to a number of LSCBs. This has also been a significant challenge for the City Council who have not yet shown that it can address assurance across all its range of functions outside of social care and schools which has not yet been addressed. The challenge to the Board and its partners in 2015-16 is **to improve the span of agencies driving the priorities forward, and the consistency of their focus and "ownership" of the issues, and to share the work across partner agencies more effectively, reducing "silo" working.**

The BSCB was also expected to ensure that a range of mechanisms, platforms and processes are in place to support schools to own and fully engage with their statutory responsibilities for safeguarding children and young people. This has been achieved with good

evidence to support positive comments on progress. The Section 175 audit provides rich evidence as to where compliance is still an issue, and a focus on those settings follows. Termly briefings, new Sub-Groups, and locality based DSL networks are all developing.

Alongside this the BSCB was required to provide robust challenge and scrutiny to ensure that the arrangements between schools and their partners, especially the local authority, are secure and progress on these arrangements should be reported routinely to the safeguarding board. This has been achieved to a degree but at times deflected by the internal improvement agenda over the year. There have been some issues about multiple scrutiny for schools. Reports are now coming to the Board. Senior ownership of this issue still developing but is quickly being established in 2015-16. There is a risk of the BEP transfer deflecting attention from this. The BEP will also need held to account by BSCB.

The Board and the lead partners have completely failed to deliver a programme of work with partners to develop good quality collection and collation of data on missing children so that partners have a full understanding of the risks to these children and can identify what actions they need to take to minimise these risks. Over the year there were various attempts to address it but inconsistent leadership grasp and a focus on getting CSE sorted deflected attention too often. This is a high priority and challenge for 2015-16.

Clearly scrutiny of challenge to this data and related performance must be included in the routine work of the BSCB. This was not done over 2014-15. **The challenge for 2015 is for the multi-agency partnership, through the Missing Operational Group, to develop an integrated approach to identifying responding to and intervening with children missing from home, care, school and from view. This should include the development of a shared data base, some simple accessible systems and processes and the ability to ensure appropriate early help or statutory interventions are put in place with each individual child.**

16. What impact is the Board having?

This report demonstrates that the Board is increasingly effective and has had a direct impact on most aspects of Children's Services across the whole system over the year. However, this has not yet had a big enough impact on the strength, depth and quality of front line practice. **This constitutes a major challenge for the Board in 2015-16, when it is crucial for the Board to build on its successes in 2014-15.**

17. What progress is the Board making in improving its own effectiveness?

Getting to the point when we became an effective Board was a major priority in the 2014-15 Business and Improvement Plan, as part of year one of delivering "Getting to Great". This report demonstrates that progress has been made on all of these challenges. Good progress has been made in terms of the Board's own governance, membership, systems and processes. Participation by statutory partners is more variable. Limited engagement with three NHS Trusts continues but the safeguarding teams within those Trusts are now engaged with the Board's work.

The 2013-14 report also set the BSCB Partnership a series of challenges. The key and primary challenge was to ensure that the Board works collectively and collaboratively, holds the whole system to account and delivers on its statutory requirements, both as a Board and as individual partners. There is substantial evidence that good progress has been made in this respect. In addition there is also good evidence that each partner agency has developed and can demonstrate stronger and more effective accountability within its organisation for their roles and responsibilities in safeguarding children and young people in Birmingham, particularly at middle and frontline manager levels.

Whilst the Board has not been successful in strengthening governance arrangements between the BSCB and other Boards, it has however improved the degree to which partners at the Board use their role to properly influence their own strategic and corporate governance, and to ensure the Board's work is integrated into their own strategic, operational and business plans as well as their workforce development.

Work on improving the attendance of partners at Sub-Groups and ensuring that Sub-Groups are resourced appropriately to undertake the tasks and actions that are required, and that they maximise learning from their work is underway although it has taken a lot longer than planned. Governance arrangements between the local authority and its partners to achieve effective and coherent strategic relationships has only really begun in the latter part of the year but is now developing well and discussions are beginning about redefining accountabilities and responsibilities to ensure the Board has the resilience and flexibility to relate to new service design and delivery models agreed between the local authority and partners.

The Governance Review has successfully addressed the need to improve the attendance of partners at sub -groups and assure that sub-groups are resourced appropriately to undertake the tasks and actions that are required and that they maximise learning from their work. This has been strengthened by the bi-monthly Sub-Group chairs meetings. Sub-Group performance is still however far too variable. A lot depends on the leadership of each group and the capacity and authority of Chairs to drive performance, as well as on the understanding, capacity and willingness as well as ability of members to do the required work.

We also need to ensure that learning from serious case reviews is used effectively to inform practice and that audit work is beginning to demonstrate that learning is having an impact on improving practice across partner agencies. Similarly we need to find far better ways to use audits and other quality assurance information, learning lessons reviews, serious incidents, complaints, and Serious Case Reviews as well as reviews of good practice to improve our practice. It would be fair to say that a learning culture has not been developed and embedded across the partnership or in the Board. We are still too focused on process and who is responsible for what rather how we will learn grow and develop.

Our Learning and Improvement Framework is relatively limited and we are prone to defensive or blaming behaviours at times. Although we talk about providing high support and high challenge we have not yet consistently modelled the behaviours associated with such an approach. We have a huge amount still to do. We have some good examples of application and impact in some of the individual Agency Assurance Annual Reports and in our relatively new audit activity. When monitoring effectiveness the Board needs to develop robust ways of assuring quality of practice, and to create a learning culture across agencies to allow our understanding of quality to improve practice and make a measurable difference to children's lives.

Ofsted also expected us to develop and implement a comprehensive programme of multi-agency child protection training (levels 1, 2 and 3) with clear arrangements for evaluation of impact to inform future training needs. Unfortunately this was not delivered in 2014-15. The matter was the subject of debate throughout year at the Learning and Development Sub and an early presentation of options made to the Board. However, debate has stimulated better discussions within agencies and the project will be delivered by the end of 2015-16.

Summary

Overall the Board has achieved a significant part of last year's priorities and Ofsted's requirements and the impact is evidenced. In addition it is clear that overall progress in improving the effectiveness of safeguarding children is occurring across the city on a multi-agency and a single agency basis. There is no doubt that the MASH has had a transformational impact on this and the over performance of MASH by the year end testifies to how effective it has become (and therefore highlighted the emerging challenge of much more rapidly developing and providing effective early help across every agency and collectively at universal plus level as well as at additional needs). Lord Warner's challenge to the NHS was uncomfortable but ultimately helpful and the Police have invested heavily in the MASH. Lord Warner himself saw MASH as having been a touchstone moment in changing the way the city's partner agencies work together.

The Board's work on systems and processes has underpinned this and the refresh and re-launch of RSRT has also been very important, creating a fully agreed, accepted and disseminated framework for people to use in judging how best to respond to identified need. Work on the West Midlands Protocol and Strengthening Families was also important in underpinning and providing consistency to child protection work in the MASH as well as at ICPCs and through the CP system. The material on how to make good referrals and the focus of the FDRG has assisted in improving referral practice and creating a better understanding about when to seek advice and make contact with MASH and when to make a referral. By year end there was good evidence of better localised partnership working through the Safeguarding Hubs.

We have also made significant progress in tackling CSE, to a degree despite rather than because of coherent multi agency leadership locally as the CSE sub struggled and the new strategy was not

completed until after year end. This, like much of what has been so impressive in 2014-15 is due to highly committed individuals working together. The PVVP leadership has supported and to a large extent driven this although at times it has created tensions, confusions and complexities. Increased investment by the local authority has also had a significant impact. The OCS Report provided another impulse to focus on delivery. **In 2015 there is also a major challenge for the strategic leaders forum, local authority and BSCB who together need to assertively and decisively strengthen the work of the CSE Strategic Sub-Group, agree a programme delivery plan behind it and deliver the new CSE Strategy, as well as continue to improve and develop services to support children and young people at risk of CSE and to disrupt and pursue the perpetrators.**

Work with schools has been intensive, multi-faceted and important over the year despite the complexities and the majority of schools now look to BSCB for advice appropriately. They also understand their responsibilities better, are engaging more and better understand the system.

Priorities for the 2015-16 work programme are to:

- Continue to focus on and improve the delivery of effective practice in relation to the voice of child, early help and safe systems (adding children in care to child protection and court processes).
- Clarify the governance arrangements for and deliver a more coherent strategic approach to CSE, support the development of an effective operating model and implement the strategy.
- Address the gap in relation to missing children.
- Strengthen still more our challenge and scrutiny functions and the use of our intelligence to inform partner and single agency priorities for service delivery, practice improvement.
- Intensify and extend our multi-agency audit work.
- Deliver even stronger accountability and challenge relationships with each agency and use that to inform collective strategic activity.
- Facilitate the development of a much better learning culture and reduce unnecessary processes in relation to LLRs and SCRs.
- Support and challenge the development of a new partnership landscape between partners and Children's Services and corporately.
- Address the question of what a "new" approach to scrutiny, challenge, coordination, performance and quality assurance, learning from practice and from what good practice looks like in order to agree how best to approach these requirements across the system by April 2016.

18. Conclusions and sufficiency statement

In terms of the five dimensions of a Board's responsibilities set out by Ofsted, we are now meeting our statutory responsibilities, with varying degrees of effectiveness, with the exception of missing children. We are able to provide substantial evidence as to how we have worked to support and co-ordinate the work of statutory partners in helping, protecting and caring for children, and we are able to demonstrate how we monitor effectiveness.

We are not yet however monitoring multi-agency training for its effectiveness and evaluating its impact on practice. In fact although we have continued to provide significant amounts of training we have not yet created a learning and workforce development approach to multi-agency workforce training and learning. We do check that policies and procedures and thresholds for intervention are applied properly through our audit programme and the work of the Front Door Reference Group. Whilst partners can be quite challenging of each other in meetings they do not consistently demonstrate how they challenge practice and audit casework in their own agency and across the partnership.

We cannot as yet demonstrate that we meet the criteria for a good LSCB. In fact we are still quite a long way from that, and we certainly require improvement to be able to get to good. However, we can demonstrate progress against the criteria in terms of:

- The priority given to safeguarding by statutory LSCB Members and how that is demonstrated both through Section 11 assessments, sound financial contributions (although how sound varies) and contributions to the audit and scrutiny activity of our Sub-Groups.
- Our policies and procedures, and the way we review these.
- Case file audits and the use of data and audit evidence to determine priorities for the board, the challenge we put into the system, and the assurances we seek.
- Our contribution to and influence in informing senior leaders, and supporting planning and commissioning activity.
- The provision of a high level of high quality training.

- A rigorous and transparent assessment of our performance and effectiveness, as a board and across local services.

However, we will remain inadequate as a Board if we cannot demonstrate that we understand the experiences of children and young people or fail to identify where service improvements can be made. Whilst we have made significant progress in both these areas it is not yet secure, embedded or wide reaching enough.

It is appropriate to say that overall the Board's arrangements are increasingly sufficient to meet our basic responsibilities and to ensure children are safer in the city. The biggest challenge of all is to explore whether there are better ways to achieve the same ends within an overarching statutory framework. Children are getting a better service, but it could be much better if we allow ourselves to think more radically about how we work together and as a Board.

19. Challenges in 2015-16

The challenges we are setting for 2015-16 are:

To the Board:
A major challenge that the Board has not yet addressed, is finding the best ways to engage with and involve children and young people, their families and their communities in the work of the Board and in providing high support and high challenge as critical friends of what we do.

The BSCB should build on its experiences of the last few years by challenging itself to think radically together as partners in terms of examining what functions should be led by whom, how and where in order to be far more effective in contributing to and supporting the co-ordination of what is done collectively.

The Board's challenge in 2014-15 of developing stronger, clearer and more mutually robust and accountable relationships with all key partnership bodies remains a challenge in 2015-16. The Board needs to ensure that the Community Safety Partnership, the Adult Safeguarding Board, the Health and Wellbeing Board and the BSCB Board can agree a protocol governing the relationship between them, address the issue of who leads on what, agree shared priorities and a shared work-streams. It also needs to work with the corporate Parenting Board and add children in care to the 2015-16 priorities in order to gain a better understanding of how well they are safeguarded and their welfare promoted.

The Board needs to improve the span of agencies driving the priorities forward, and the consistency of their focus and "ownership" of the issues, and to share the work across partner agencies more effectively, reducing "silo" working.

The Board needs to build on the impact the Board has made in 2014-15 and increase the degree to which to Board supports the improvements underway in the City in terms of safeguarding children and promoting their welfare.

To the Council with its partners:
Improving the safety of children's lived experiences in their communities presents a significant challenge to the Council and its partners.

The challenge for the lead agency, Birmingham City Council with every partner will be to design and implement a new whole council partnership framework for multi-agency co-operation, co-ordination, and commissioning of services to meet children's needs. This will need to also feed into the "Future Birmingham" process.

To the Strategic Leaders Forum and Early Help and Safeguarding Partnership:
The major challenge for partners is to retain the confidence brought into the system through the work done in 2014-15, whilst 're-balancing' resources, investment, staff capability and capacity so early help takes precedence over child protection for the majority of children and young people needing support.

There is a major challenge ahead for the new partnership bodies established to lead children's services across the city, in establishing new ways of working, developing real cooperation across the system, rather than cooperation on specific issues and to ensure the most effective ways of delivering services as resources reduce, capacity shrinks, and demand increases.

The challenge for 2015 is for the multi-agency partnership, through the Missing Operational Group, to develop an integrated approach to identifying responding to and intervening with children missing from home, care, school and from view. This should include the development of a shared data base, some simple accessible systems and processes and the ability to ensure appropriate early help or statutory interventions are put in place with each individual child.

In 2015 there is also a major challenge for the strategic leaders forum, local authority and BSCB who together need to assertively and decisively strengthen the work of the CSE Strategic Sub-Group, agree a programme delivery plan behind it and deliver the new CSE Strategy, as well as continue to improve and develop services to support children and young people at risk of CSE and to disrupt and pursue the perpetrators.

Part 4 – Supporting material

20. Glossary

A&E	Accident & Emergency
ACE	Aspiring to Clinical Excellence
ADHD	Attention Deficit Hyperactivity Disorder
ASTI	Assessment and Short Term Intervention
BAAF	British Association of Adoption and Fostering
BAFGM	Birmingham Against Female Genital Mutilation
BCC	Birmingham City Council
BCHC	Birmingham Community Health Care
BE	Birmingham East
BEHSP	Birmingham Early Help and Safeguarding Partnership
BEP	Birmingham Education Partnership
BME	Black and Minority Ethnic
BN	Birmingham North
BSCB	Birmingham Safeguarding Children Board
BSMHFT	Birmingham and Solihull Mental Health Foundation Trust
BWH	Birmingham Women's Hospital NHS Foundation Trust
C&PE	Communications and Public Engagement
CAF	Common Assessment Framework
CAITs	Child Abuse Investigation Teams
CC CCG	Cross City Clinical Commissioning Group
CCGs	Clinical Commissioning Groups
CDOP	Child Death Overview Panel
CiC	Children in Care
CMOG	CSE and Missing Operational Group
Comms	Community and Public Engagement
CP	Child Protection
CPC	Corporate Parenting Board
CP-IS	Child Protection Information Sharing Project
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CRC	Community Rehabilitation Company
CSE	Child Sexual Exploitation
CYP	Children and Young People
DCLG	Department for Communities and Local Government
DfE	Department for Education
DHR	Domestic Homicide Review
DSLs	Designated Safeguarding Leads
DV	Domestic Violence
DVA	Domestic Violence and Abuse
fCAF	Family Common Assessment Framework
FDRG	Front Door Reference Group
FGM	Female Genital Mutilation
GP	General Practitioner
HE	Higher Education
HEFT	Heart of England NHS Foundation Trust
HM	Her Majesty's
HMIC	Her Majesty's Inspectorate of Constabulary
HR	Human Resources
HWB	Health and Wellbeing Board
ICPC	Initial Child Protection Conference
IMR	Individual Management Review
IRIS	Identification and Referral to Improve Safety

IT	Information Technology
L&D	Learning and Development
LA	Local Authority
LAC	Looked After Children
LADO	Local Authority Designated Officer
LGBT	Lesbian, Gay, Bisexual, Transgender
LLR	Learning Lessons Review
LPUs	Local Policing Units
LSCB	Local Safeguarding Children Board
MAPPA	Multi Agency Public Protection Arrangements
MARF	Multi Agency Referral Form
MASE	Multi Agency Sexual Exploitation
MASH	Multi Agency Safeguarding Hub
MOG	Missing Operational Group
NE Lincolnshire	North East Lincolnshire
NEET	Not in Education Employment or Training
NFA	No Further Action
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NPS	National Probation Service
NSPCC	National Society for the Prevention of Cruelty to Children
OCC	Office of Children's Commissioner
OSC	Office of Surveillance Commissioners
P&QA	Performance and Quality Assurance
PCC	Police and Crime Commissioner
PCSO's	Police Community Support Officers
PHSE	Personal Social and Health Education
PVVP	Preventing Violence Against Vulnerable People
ROH	Royal Orthopaedic Hospital
RSRT	Right Service, Right Time
S17	Section 17
S47	Section 47
SAs	Single assessments
SC CCG	South Central Clinical Commissioning Group
SCR	Serious Case Review
SEND	Special Educational Needs and Disability
SUDIC	Sudden Unexpected Death in Childhood
SWB CCG	Sandwell and West Birmingham Clinical Commissioning Group
SWM	Staffordshire and West Midlands
TAF	Team Around the Family
TF	Think Family
TR	Transforming Rehabilitation
WMA	West Midlands Ambulance Service
WMF	West Midlands Fire Service
WMP	West Midlands Police
WRAP	Workshop to Raise Awareness of Prevent
YJB	Youth Justice Board
YMCA	Young Men's Christian Association
YOS	Youth Offending Service
YTD	Year To Date

21. Appendices

1. Getting to Great – Strategic Plan 2015-17 and Business and Improvement Plan 2015-16
2. Composition of the Birmingham Safeguarding Children Board - December 2014

   Composition of the Executive Group - December 2014
3. Understanding the needs of children and young people in Birmingham - August 2015
4. Report to the Education and Vulnerable Children Overview and Scrutiny Committee - 10 May 2015
5. Performance and Quality Assurance Framework
6. BSCB Quality Assurance and Performance Scorecards - 2014-15
7. RSRT Delivering Effective Support for Children and Families in Birmingham – Guidance for Practitioners
8. Strategy for Early Help in Birmingham 2015-16
9. Birmingham Safeguarding Children Board (BSCB) and the NSPCC Help Campaign
10. Think Family Programme Report 2015
11. Youth Justice Plan 2015 – 2016
12. LADO Annual report 2014 -15
13. Strategy for Corporate Parenting in Birmingham – March 2015
14. We need to get it right: A health check into the Council's role in tackling child sexual exploitation - December 2014
15. Governance Review - 21 September 2014
16. Summary of Sub Group activity and performance April 2014 – March 2015
17. Birmingham Child Death Overview Panel - Annual Report - 2014-15

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