DRAFT
Annual Report 2015/16

Birmingham Safeguarding Children Board

Contents

Foreword from the Outgoing Independent Chair

I had the great privilege of chairing the Birmingham Safeguarding Children Board (BSCB) for four and a half years. This is my last Annual Report for that term of office, details the Board's work up to March 2016 which is the point I handed the baton on to the incredibly capable hands of Penny Thompson.

This report, which covers the second year of the Board's Strategic Plan 2014-17, shows that in 2015/16 we made further incremental progress, slowly but inexorably forward. We built on the positive progress in 2014/15 and consolidated the major changes introduced that year. At times it felt like we had made real progress and then something else demonstrated that despite the progress things were still not good enough to be assured that all the children and young people in the city were safe, happy and achieving their very best.

In 2014/15 I said that "*there is of course much more still to do*". The ambition to ensure the children of Birmingham get the service they deserve remains foremost in the Board's work. The increase in pace in 2014/15 was increased still more in 2015/16. We focussed on the key priorities we set ourselves, adapted to address additional priorities as the year progressed and began to build the confidence needed to move from inadequate to adequate services.

I left feeling that whatever the future held the Board was in the right place to move forward.

I am grateful to the many great staff in every service that I met, the children, young people and communities who contributed to the work of the Board, the dedicated safeguarding professionals in the city, the Board and the hard working staff in the Business Support Unit for the support over my last year of office and wish them all well in 2016/17 and onwards– stick at it!

Jane Held

Response from the Incoming Independent Chair

Thank you to Jane Held for steering the BSCB over the past four and a half years. I took over the Chair, charged with reviewing partnership arrangements and sustaining and accelerating progress on delivery of the Strategic Plan 2014-17. I am delighted with the spirit of the welcome I have received, and the readiness to contribute to my 'listening and looking' exercise. As a result of my deliberations we have agreed to reinforce the importance of the safeguarding system of leadership, assurance and learning, and connectivity into the wider strategic partnership working.

Our shared and agreed purpose remains to ensure that Birmingham becomes confidently regarded and evidenced to be a safe and sound place in which to grow up in. I am confident that the journey is well underway, the destination clear, and progress is speeding up.

Penny Thompson, CBE

Introduction

Each Local Safeguarding Children Board is required to produce and publish an Annual Report evaluating the effectiveness of safeguarding in the local area.

This Annual Report provides a rigorous and transparent assessment of the performance and effectiveness of the partnership arrangements to safeguarding and promote the wellbeing of children and young people in Birmingham during 2015/16. The report examines how the Birmingham Safeguarding Children Board (BSCB) discharged its statutory role and functions as defined in national guidance Working Together to Safeguard Children (2015).

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

- Co-ordinate local work to safeguard and promote the welfare of children and young people.

- To ensure the effectiveness of that work

Whilst highlighting achievements and progress, the report will identify the challenges ahead, areas of weakness and the action that is being taken to improve performance and outcomes for children, young people and the families in Birmingham. The report comprises of five sections:

- Context and key facts about Birmingham.
- The effectiveness of safeguarding arrangements in Birmingham
- The effectiveness of the Birmingham Safeguarding Children Board
- Analysis, conclusions, sufficiency statement and challenges
- Supporting material

Part 1 – Context and Key Facts about Birmingham

Population

In terms of population Birmingham is the largest UK City outside of London with an estimated population of over 1.1million as of 2014. The City is estimated to have grown by 3% between 2011 and 2014 alone, which is at a faster rate than the national average.

This growth brings with it may challenges; Birmingham already has a larger than average household size and a higher proportion of overcrowded households than a country as a whole. Birmingham's population is expected to grow by a further 150,000 people by 2031, and it is estimated that the city will need a further 80,000 houses by this time. This will have a significant impact on our schools and education services.

Birmingham is one of the youngest cities in Europe with just under 46% of the population aged under 30. Within the next 5 years the population aged between 0 and 4 is due to grow by 1.1% to 87,753 children; the 5 to 9 population is expected to grow by 5.0% to 84,588 but the largest growth in Birmingham's children will be the 10 to 14 age group – increasing by 7.7% to 78,876.

Diversity

Birmingham is a welcoming place and is proud of its "super-diversity". Academic research suggests that there are people from nearly 200 countries who have made Birmingham their home. The 2011 Census revealed that just over two in five people (42.1%) classified themselves within an ethnic group other than which British, compared to 30% in 2001, a rise of 12%.

The demographic makeup of Birmingham's young people has also changed significantly over recent years and is becoming increasingly diverse. For example, according to the 2011 census over 60% of the under 18 population is now from a non-white British background, compared to around 44% in 2001.

Language

Some 7.5% of households in Birmingham do not have/use English as their main language.

Two-fifths (43%) of Birmingham's school children have a first language that is known or believed to be other than English. This equates to 38,089 pupils, which is 1.3% more than in 2014.

Deprivation

Birmingham has significant pockets of deprivation across the city.

According to the 2015 Index of Multiple Deprivation (IMD), Birmingham is ranked the 6th most deprived Local Authority district in relative rankings. The income deprivation affecting children index (IDACI) ranks Birmingham 15th nationally, with over 30% of children living in a deprived household.

Poverty

The most recent estimates of child poverty show that 37% of children in Birmingham were living below the poverty line in 2014 after housing cost. This is significantly above the UK average of 25%. Amongst all local authorities, Birmingham is ranked as the eight highest for child poverty.

In terms of complexity of services there are:

- 447 schools in the city, comprising a mix of academies, free schools, and maintained schools.
- 938 children are receiving elective home education.
- Of the total school population 34,289 have special educational needs.
- There are 73 children's centres.
- 10,750 different young people aged 11-25 received a youth service and 62% of them were from BME backgrounds.
- Between April 2015 and March 2016 there were 2031 crimes against children recorded across Birmingham investigated by specialist child abuse teams, a 34% increase on the previous year.

- The Youth Offending Service provided more than 3,059 programmes during the year.
- There are 3 Clinical Commissioning Groups (CCGs) in the city with 275 GP practices, with 1,148 GPs.
- 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. There were 2,006 young people aged 16-19 years old not in education, employment or training (NEET) (5.4%), there were 1,807 children in care and 851 children the subject of a child protection plan. 95.8% of care leavers were in suitable accommodation and 42 out of 85 care leavers were NEET at the end of March 2016.

Government Intervention

Historically the City's Children's Services have been failing for some time. In May 2014 an Ofsted Inspection rated the service as 'Inadequate' which has resulted in the Department for Education appointing Lord Warner as Children's Commission to oversee a programme of improvement. Children's Services remain subject of Government Intervention. The Children's Commissioner is now Andrew Christie.

Part 2 – The effectiveness of safeguarding arrangements in Birmingham

Three year Strategic Plan 2014-17

In 2014 the Board agreed a three year Strategic Plan, "Getting to Great 2014-17". At the conclusion of the first year of the strategy the Board reviewed progress taking account of new and emerging priorities when ratifying the Annual Business and Improvement Plan 2015/16. The Board's priorities remain focused on the three same key strategic priorities.

- The voice of the child – central to everything we do.
- We provide early help –when problems first arise.
- We run safe systems – to ensure children are properly safeguarded.

The Strategic Plan also highlights the underpinning behaviours referred to as the Birmingham Basics, which are expectations of anyone who works with children, young people, their families and their communities.

The Birmingham Basics are:

- The child comes first.
- Do simple things better.
- Never do nothing.
- Do with, not to, others.
- Have conversations, build relationships.

Strategy and Partnerships

The Council's improvement journey is being driven through three significant strands of work, which are subject to regular ongoing external scrutiny and review by Ofsted, the Department for Education and the Department for Communities and Local Government;

- The Children's Services Commissioner and the Children's Services Improvement Plan
- The Education Commissioner and Improvement Plan
- Implementation of the 'Kerslake Report' findings to improve partnership working and development of performance management arrangements

There is an opportunity to strengthen strategic oversight, coordination and accountability of the BSCB, the Community Safety Partnership, Health and Wellbeing Board, and Adult Safeguarding Board.

As the lead agency, Birmingham City Council are engaging with key stakeholders to review and redesign a new partnership framework for multi-agency co-operation, co-ordination and commissioning of services to meet children's needs. The Board welcomes this approach and believes there is a real opportunity to enhance the role of the Strategic Leaders Forum to take the holistic oversight of partnership priorities, intervention and performance of services for

children, young people and families in Birmingham.

Organisational change across partnerships

As well as the impact of the ongoing improvement programmes, a number of organisations were undertaking significant restructuring, which can impact on the stability and consistency of practice.

During the year reassurance was sought from:

- (Probation) Community Rehabilitation Company
- The National Probation Service
- A merger of Birmingham Children's Hospital and Women's Hospital Trust
- Birmingham Children's Social Care
- Consolidation of drug and alcohol services by Change Grow Live
- Forward Birmingham (Life course based 0-25 mental health service)

The BSCB has secured appropriate assurance, representation and engagement from the new organisations at Board level and throughout the safeguarding structure. Organisation change and its impact remained on the Board's Risk Register and action to mitigate risk is regularly reviewed.

Engagement with Children and Young People

The Board and its partners are very aware of the need to engage with children and young people in a meaningful way to understand and act on their views and concerns.

Whilst work in 2015/16 has continued to map agencies engagement with children and young people it is recognised that the Board does not yet have a comprehensive overview of the impact that children and young people's views are having on the improvement and development of services. During the next 12 months the Board wants to establish the impact of children and young people.

The Board directly engaged children and young people in designing the BSCB Annual Report. Young people have helped to review and develop the BSCB website and twitter page.

The Children in Care Council (CiCC) regularly enable children in care and care leavers to have a voice and meaningful engagement on those issues that impact on their lives. The CiCC are helping to shape the priorities for the Corporate Parenting Board and are actively involved in attending and hosting events.

During 2015/16 the CiCC identified the following campaigns:

- Pocket Money – they initiated a review of the guidance in relation to pocket money so that children and young people are much more aware of their rights and entitlements.

- Sleepovers – they asked for the guidance to be reviewed and reissued to remind carers and social workers that the process should not be as complicated, to ensure young people don't miss out on opportunities.

- Sharing positive stories – it was recognised that people only hear about children in care when things sadly go wrong, which can be particularly upsetting for a child in care. The CiCC wanted to change this perception as they know that being in care can be a positive story and want to ensure the positives get shared as often as they can. Resources have been produced to promote this work and all of the quotes are from the children that were talked to during development.

External Inspections and Reviews

The Board receive and review findings from inspection reports. This provides a more comprehensive understanding of practice across the whole system and supported the identification of key common themes and challenges.

Care Quality Commission Inspections (CQC)

The CQC undertake inspections of health providers and Clinical Commissioning Groups (CCGs), during 2015/16 they carried out 3 inspections in Birmingham, these were:-

- Queen Elizabeth Hospital -8/03/2016 this concentrated on the adult cardiac

surgery and contained no children safeguarding concerns.

- Royal Orthopaedic Hospital – 29.09.2015 covers adults and children's critical care and outpatient's diagnostics and imaging.

The CQC inspection of the Royal Orthopaedic Hospital identified some areas of poor practice. There were two areas linked to children; one was around safeguarding training of staff which was below the trust target, and the other raised concerns around the care of children in the High Dependency Unit. The trust has provided the Board with evidence and assurance that all safeguarding concerns are being appropriately addressed.

- University Hospital Birmingham – 15.05.2015 covers adults and children's urgent and emergency services, medical care, surgery, critical care, outpatients and diagnostic imaging and outpatients (sexual health services)

CQC stated "*staff demonstrated knowledge and understanding of safeguarding and of the trust's process for reporting concerns. They understood their role in protecting children and vulnerable adults*".

The full inspection reports are available to download from the Care Quality Commission website; http:// www.cqc.org.uk/.

Her Majesty's Inspectorate of Constabulary (HMIC)

In June 2014 West Midlands Police (WMP) had a National Child Protection Inspection; this was re-inspected by HMIC in July 2015. A number of inconsistencies remained in the management and the supervision of investigations across WMP, and in the assessment of risk. This adversely affects the quality and effectiveness of safeguarding practice, ultimately leaving children vulnerable to harm. Inspectors found some good examples of WMP protecting children who were most in need of help, with effective multi-agency work and a child-centred approach. However, poor supervision and record-keeping persist, undermining decision-making and safeguarding measures.

WMP identified child sexual exploitation (CSE) as a critical issue and has made some progress to improve its response, but there is still more to do to recognise and respond effectively to all children at risk of sexual exploitation.

The response to children who regularly go missing from home also requires further improvement, although inspectors were pleased to see that in most cases officers and staff understood the link between children who regularly go missing and sexual exploitation.

WMP has good working relationships with the seven Local Authorities and other services that operate within the WMP area. WMP is to be commended for its partnership working to provide 'street triage' services and alternative places of safety for children with mental health problems who might otherwise be detained in police custody. However, more needs to be done through joint working to deliver better services, particularly for children detained in police custody in need of alternative accommodation.

WMP have provided the Board with an update on their progress against the inspection recommendations.

Independent Reviews

An independent review of the Multi-Agency Safeguarding Hub (MASH) was commissioned in October 2015 by the Board following concerns relating to a 'significant dip' in contacts and referrals.

The review made 13 recommendations and the Local Authority have provided the Board with reassurance on how the findings are being taken forward. The review found some variability in threshold judgements, but overall the thresholds within MASH appeared to be consistent with the Right Service, Right Time model. The audit of cases suggested that thresholds are a greater concern in the Assessment and Short Term Intervention (ASTI) assessments than in the MASH.

The review was unable to bottom out the sudden reported sharp drop in contacts in October 2015. An analysis of contacts over the past 18 months

suggested that it was less of an anomaly than was at first thought and in fact the year from October 2014 to November 2015 saw a steady decline in contacts, with a decline (37%) in referrals occurring from October 2014 to March 2015, in comparison with a decline of 16% from September to November 2015.

Birmingham City Council, Internal Audit
A programme of audits for maintained schools is undertaken which includes a section on safeguarding. During the year 36 schools were visited and key findings reported to the Board, which found 60% of schools visited had appropriate internet monitoring system; 72% of schools visited were fully compliant with ensuring due diligence regarding the use of the school building inside and outside school hours as well as lettings; 74% had Governing Body approval for the Section 175 self-assessment.

Partner Compliance with Safeguarding

Each year all statutory partners undertake a self-assessment to determine how well they are safeguarding children and young people and promoting their welfare. This is part of their responsibilities under Section 11 of the Children Act 2004. The 2015/16 audit was completed by all statutory agencies except NHS England and West Midlands Ambulance service who completed a generic Section 11 audit for the whole of the West Midlands.

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. It provides a benchmark of current performance to enable organisations to monitor progress and quantify improvement in safeguarding practice over time. The audit was subject of a Peer Review in March 2016. The audit found good evidence of:-

- Senior management commitment to safeguarding is generally good across all agencies.
- Accountability framework generally good across agencies just one agency needs to do further work.
- Information sharing, listening to children, young people and families, supervision and Domestic Violence sections all showed improvement compared to last year.

Key areas were identified for improvement:-

- Staff understanding and application of Early Help within the context of Right Service, Right Time. There has been improvement since last year, but further work is required.

- The majority of organisations have a clear commitment to identifying and protecting victims of CSE. However, further work is required by organisations to raise awareness of CSE within frontline staff.

The challenges for 2016/17 are to ensure statutory partners all have action plans to fulfil any gaps identified in their Section 11 audit and to develop a simplified Section 11 for voluntary organisations to be rolled out in 2016/17.

The Board requires each statutory partner to submit an annual report together with an assurance letter from the Chief Executive or Chair of the organisation.

All agencies have provided an annual report, and the majority were analytical and open. The reports demonstrated their work to embed the Early Help Strategy and their engagement with the Early Help and Safeguarding Partnership (EHSP). They also provided assurance that CSE and Domestic Abuse have been incorporated into partners safeguarding work, with most identifying additional training for staff and a number of partners developing CSE Champions to support the wider workforce.

The majority of partner's referenced support for MASH and colocation to support decision making. There is strong evidence that all partners have engaged in training on Right Service, Right Time, with a number incorporating it into their internal safeguarding courses. A number of partners, in particular Health, identified that they had expanded their safeguarding teams.

Partners identified the need to improve attendance at child protection conferences. The

Local Authority has an action plan in place to resolve these issues. Further embedding of CSE, FGM and Domestic Abuse was a common theme across partners. The challenge for agencies and the Board is now to ensure the quality of the safeguarding work and that work undertaken can be shown to be having a positive impact on children and young people's lives.

Joint Commissioning

The Children's Joint Strategic Commissioning Board meets quarterly throughout the year and oversees the joint commissioning arrangements for children across a range of partners, including the Local Authority and South Central, Cross City and Sandwell and West Birmingham CCG's. This year the Board has been strengthened by the inclusion of representation from the Birmingham Education Partnership (BEP), bringing the voice of schools within the City.

Good progress has been made on a number of fronts this year in jointly commissioning services, with one of the highlights being the implementation of Forward Thinking Birmingham, a new ground breaking mental health service for children, young people and their families covering ages 0 to 25 years. The establishment of a process to commission a new model for Early Years Services across the City has also been overseen through this Board providing cross organisational input into its design and development. The Early Help and Partnership Board links into the Joint Commissioning Board in order to ensure services such as the Multi-Agency Safeguarding Hub (MASH), Child Sex Exploitation Team (CSE) and Multi-systemic Family Therapy are suitably co-commissioned where needed.

New for this year was the finalisation of a Memorandum of Understanding which ensured a shared understanding of the role and functions of the joint commissioning arrangements, and details those service areas where partners are jointly contributing resources together to ensure more effective and efficient commissioning of services. These include services for Looked After Children, health services provided into Special Schools and those early help service such as Home Start.

The Board monitors performance of these services at each meeting and constructive challenge from all partners is provided alongside supportive input to ensure areas of difficulty are addressed together.

The Annual Performance Report

An overview of performance against the Boards three priorities was presented and discussed at each Board and Executive Group meeting over the year. Further enhancements to the key data set and overall dashboard was made during the year to provide greater insight to performance to channel improvement activity. A detailed annual performance report was produced which examined each of the Board's priorities in terms of our three dimensions: 'how much are we doing?'; 'how well are we doing it?'; and 'what did we learn and change as a result?'

Priority 1 – Voice of the Child

How much have we done?

The Voice of the Child is embedded into the Board's quality assurance programme, with each audit methodology designed to capture evidence of the effectiveness of individuals and organisations engaging with children and young people.

The Board examined the extent of CSE and young people's understanding and awareness of Female Gentile Mutilation (FGM). A group of African pupils from a school in Birmingham helped provide a useful insight on targeting of awareness campaigns for vulnerable groups.

The BAIT CSE awareness programme enabled secondary school pupils to provide feedback on their awareness and understanding of CSE. Further work is required to evaluate the impact of BAIT.

Work is ongoing to capture CSE victims' perspective and to enable the Board to maximise learning in this important area.

How well have we done it?

Ten child protection case file reviews were carried out by a multi-agency audit team. The

audit identified that 7 out of the 10 cases required improvement.

The scope of the work covered the following areas:

- Visits – child's voice and needs clearly articulated.
- Child Protection Plan- SMART actions will clear timescales and outcomes, and that they meet the needs identified for the child.
- Supervision – decision making clearly articulated.
- Partner reports and timeliness of information and intervention by partners with actions in the child's plan.

One of the key findings identified that the views of children were not always clear in the conference and core group minutes or partner reports. Further training will emphasise how to record and capture the voice of the child within the child's case history and plans. Conference chairs and social workers meet with children prior to conference wherever possible regardless of the age of the child.

The audit identified some good practice to ensure the voice of the child is heard:

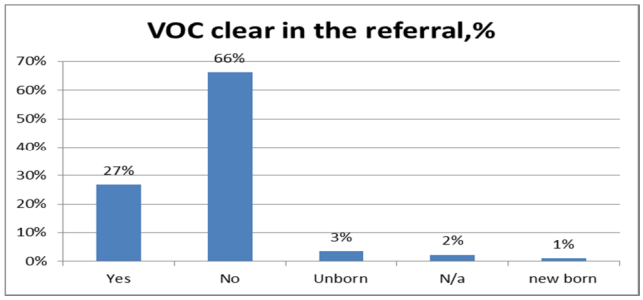
"Child was supported by the social worker to write to the chair to express her wishes and feelings. Her views from the letter were detailed in the documentation."

"There is clear evidence of supportive working with parents and older child to look at acceptable behaviours, practical support and strategies. Evidence that this improved her outcomes in respect of developing friendship groups."

An audit of FGM practice was completed in March 2016. The audit identified in four out of the five cases that the voice of the child was not evident and that opportunities for professionals 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. The recommendations from the audit will be followed up later in 2016, to assess progress against the recommendations.

An audit of re-referrals in 2015 also identified that only 27% of referrals clearly articulate the voice of the child. A good example of engagement found that 97% of looked after children participated in their reviews. Figure 1 - evidences that the voice of the child was taken into account.

Figure 1



What did we learn and change as a result?

All training courses delivered by the Board have been revised to strengthen the input around the voice of the child and incorporated into supervision standards guidance.

Priority 2 – Early Help

How much have we done?

During 2015/16 there were 1, 807 fCAF opened. Family support have opened 4,997 assessments from July 2015 to March 2016.

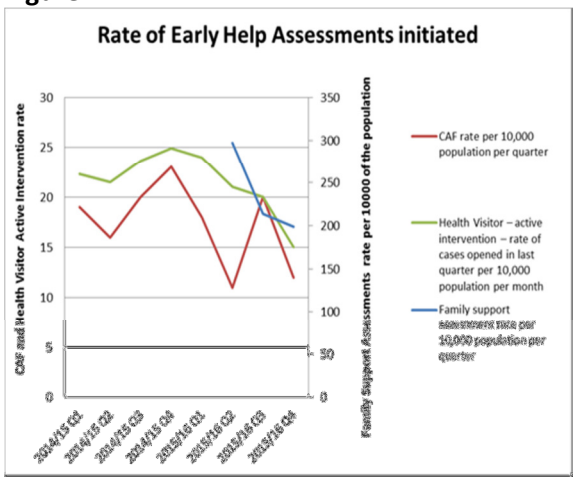
During the year the Early Help and Safegaurding Partnership oversaw the expanded phase 2 of the Think Family Programme a key element of the Early Help Strategy. The target is to achieve significant and sustained progress with 14,170 families by 2020, which equates to a target for 2015/16 of identifying and starting work with 2,409 families.

How well have we done it?

The target was exceeded with 3,623 families being worked with, securing an additional £1.2M funding to continue this work.
There are clear signs of progress in the way vulnerable families with multiple needs are supported. This includes availability of focused

intensive support provision, increased engagement with Think Family criteria by professionals across a range of services both internally and externally, and more widespread adoption of a whole family approach underpinned by family assessments. Figure 2 – Rate of Early help Assessments initiated.

Figure 2



What did we learn and change as a result?

Birmingham is contributing to the national evaluation of the programme through provision of National Impact Study and Family Progress Data submissions, as well as taking part in an Ipsos Mori survey of families receiving Think Family intervention. As yet though it is too early for the results of this evaluation to be available, but lessons have already been learnt and acted upon, including the critical importance of tackling worklessness and reinforcing joint working with DWP colleagues on referred cases, and developing robust methods of capturing distance travelled against Think Family criteria that capture professional judgement and the voice of the family. Important work is also underway to increase the extent to which Social Care colleagues adopt a whole family approach, and intensive Think Family provision is now available to support families with a Child Protection Plan in place.

Priority 3 – Safe Systems

How much have we done?

As part of evaluating whether systems are safe a range of data is considered, particularly data provided by Health, the Council and Police.

Figure 3 shows admissions due to unintentional and deliberate injury for children and young people under the age of 18 and will also include accidental injuries which are not of a safeguarding nature. This shows a clear cyclical trend across the years with an increase over quarter 2 during the winter months and decline in injuries through the spring into the summer months. There has been no significant change in the overall number of admissions due to unintentional or deliberate injury. However, Figure 4 provides a breakdown of deliberate and unintentional injuries. This shows that there has been a steady increase since quarter 2 of 2014/15 of young people who have been admitted for self-harm. There was also an increase in quarter 3 of the number of young people who were assaulted.

Figure 3

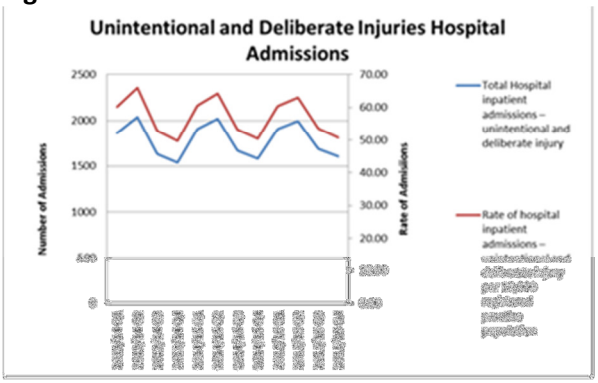


Figure 4

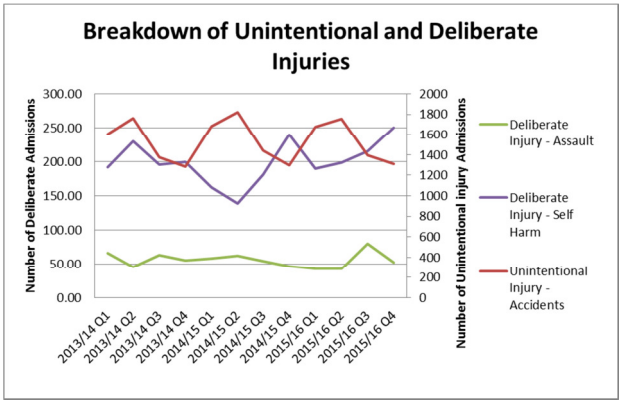
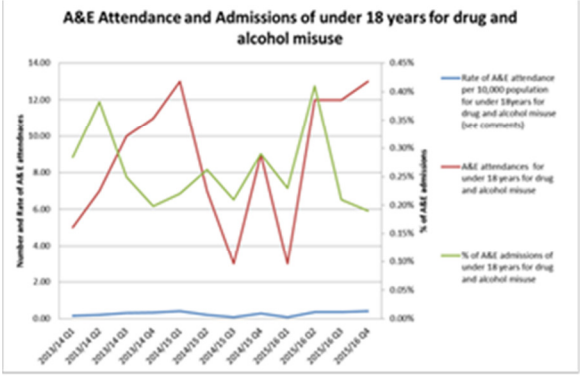


Figure 5 shows the accident and emergency attendance and admissions due to drug or alcohol misuse. The "blue line" represents the rate of young people and this show there has been no significant change over the 3 years. The red and green lines represent the number of

young people and show bigger variations but the numbers affected are really low.

Figure 5

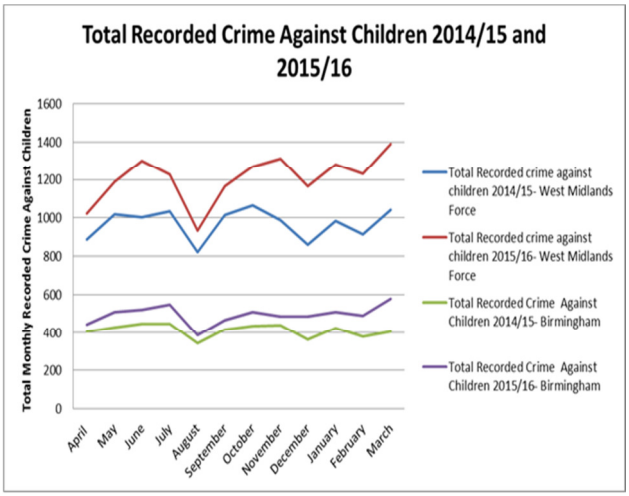


West Midlands Police data

The volume of cases that are being managed by Birmingham Child Abuse Investigation Teams (CAIT) continues to increase. Between April 2015 and March 2016 there were 2,031 recorded crimes across Birmingham investigated by the CAIT, this was a 34% increase from the previous year where 1,517 incidents were recorded.

Birmingham has followed the upward trend over the year for recorded crime against children, reaching a peak in March 2016. 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. Figure 6 details the total recorded crimes against children in Birmingham for the last two years.

Figure 6



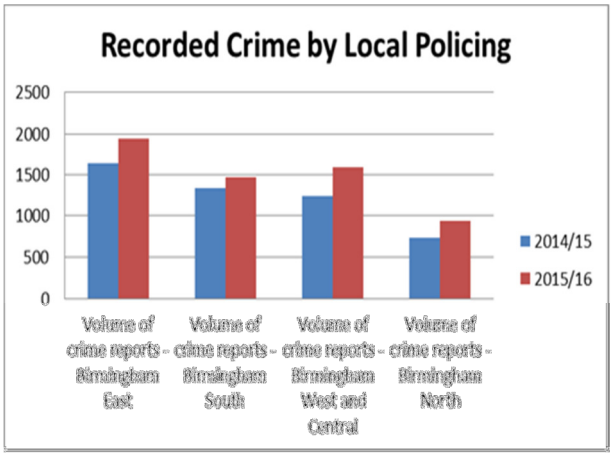
The last quarter (January to March 2016) has seen increased demand for Birmingham, 6% higher than quarter 3 (October to December 2015) and 28% higher than the same quarter in the previous year April 2014 to March 2015.

These crimes were committed by a parent or someone in care or control of the child at the time.

Across the West Midlands there were 5,267 reported crimes, which is a 43% increase from the previous year. The increase is primarily attributable to better recording practice since the introduction of the MASH. Birmingham accounts for an average 41% of the WMP total volumes. As at 1st April 2016 WMP are still investigating 386 of those Birmingham crimes, which is 19% of the Birmingham total.

Figure 7 provides details of the volume of crime reports split across the four Birmingham LPU's.

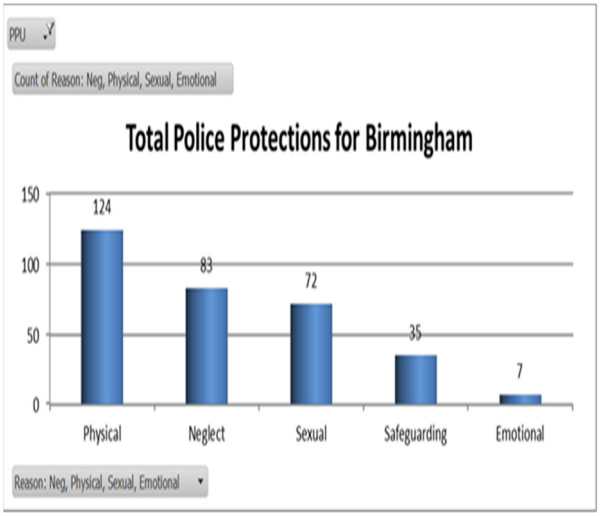
Figure 7



Police Protection

There were 321 (428 2014/15) occasions Police Protection was used in Birmingham between 1st April 2015 and 31st March 2016, involving 467 children. Figure 8 provides a breakdown by category.

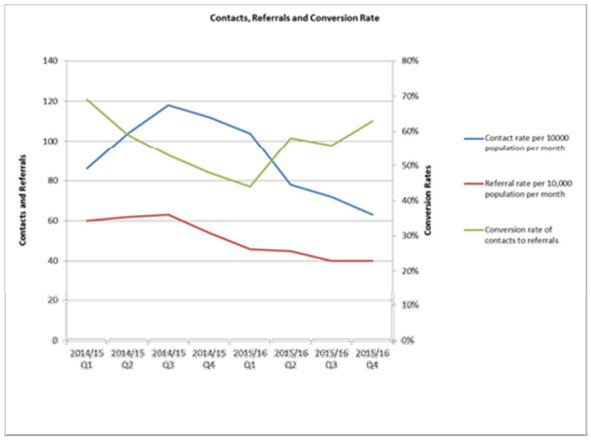
Figure 8



Multi-Agency Safeguarding Hub

In 2015/16 there were 13,013 referrals, 11,470 assessments were carried out, of which 3,781 were S47 enquiries. Figure 9 shows the conversion rate of contacts to referrals.

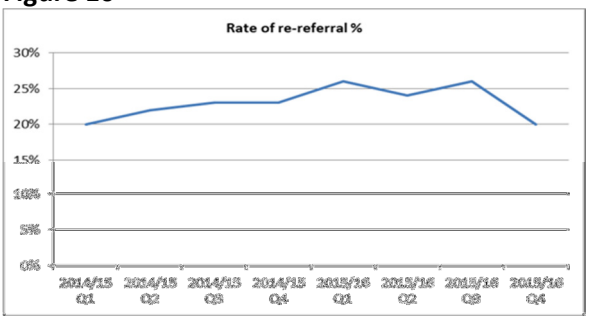
Figure 9



MASH had discretion in recording contacts deemed inappropriate or quickly providing advice, these were not logged as a contact. This practice ceased in May 2016. It is anticipated that there will be an increase in the number of contacts recorded.

Figure 10 shows the re-referral trends over the last 2 years. Re-referral rate is within target 18-25%.

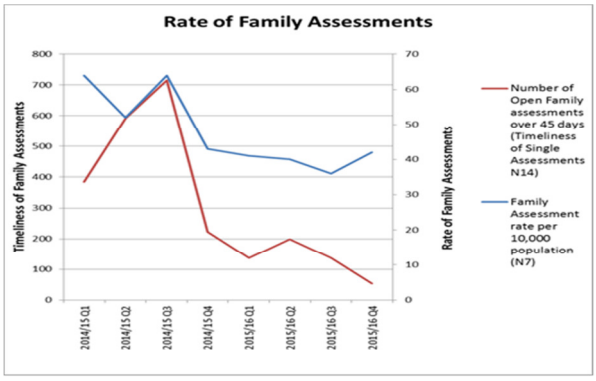
Figure 10



Family assessments should be allocated to a social worker within seven working days. During the year the number of unallocated family assessments dropped from 194 in Quarter 1 to 0 in Quarter 4. This indicates there has been a significant improvement in the allocation of cases within 7 days during the year.

Figure 11 shows the rate of open family assessments as at 31/03/2016 and how long they have been open. All family assessments should be completed within 45 days. Those over 45 days are out of time. In Quarter 1 137 Family Assessments were out of time, this came down to 53 in Quarter 4. The reduction in the last quarter is in line with the drop in the number of family assessments being opened.

Figure 11



The number of children with a child protection plan has steadily decreased from March 2015 to March 2016, this trend is continuing with the rate below the England average rate of 43 and the statistical neighbour average rate 50 at 31st March 2015.

The rate of children looked after in Birmingham at 31st December 2015 was 68 and by the end of March 2016 was 66. Birmingham is currently

above the England average rate which was 60, but below the Statistical Neighbour average rate 78.9 at 31st March 2016.

The number of children subject of a child in need plan increased for the first three quarters of the year and there was a slight drop in the last quarter. At the 31st March 2016 there were 2,088 children on a child in need plan.

Figure 12 shows that majority of child protection plans were in place to respond to children suffering emotional abuse or neglect. Only a small number of child protection plans were in place for children suffering from physical or sexual abuse (Figure 13).

Figure 12

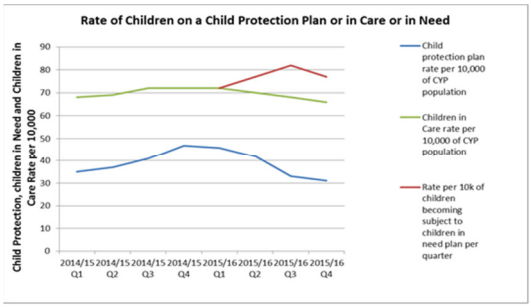
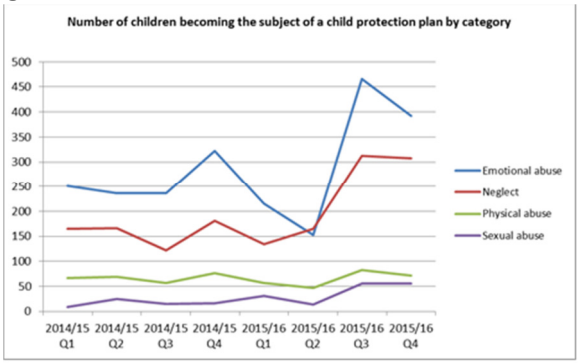


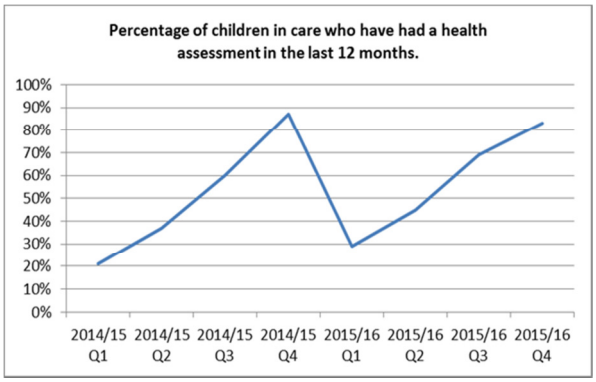
Figure 13



Health Assessments

Health assessments start at zero on the 1st April and build up over the year. Quarter 4 stands at 83%, in comparison to last year which stood at 87%. National average at 31st March 2015 for Health assessments was 90% over the year. Birmingham did not achieve the national average at the end of this year. Figure 14 – percentage of children in care who have had a Health Assessments in the last 12 months

Figure 14

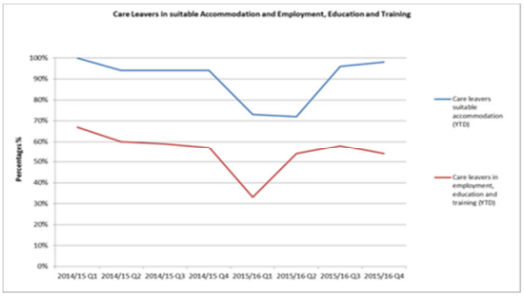


Care leavers

The data for care leavers starts again on the 1st April at which point any child aged 18 or over is included. Thus the first two quarters reflect work done to identify the current position with the new care leavers to see whether they are in suitable accommodation and in employment, education and training.

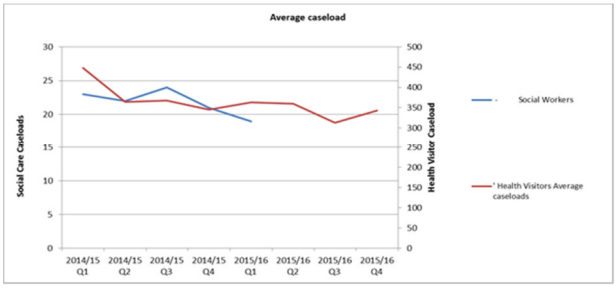
Care leavers in suitable accommodation stands at 98% (94% Q4 14/15). Care leavers in Employment, Education and Training stands at 54% (57% Q4 14/15). (Figure 15)

Figure 15



Average caseloads at the end of Quarter 4 for social workers were 15 cases and health visitors 343 cases. There have been reductions in professional's caseloads over the year. (Figure 16)

Figure 16



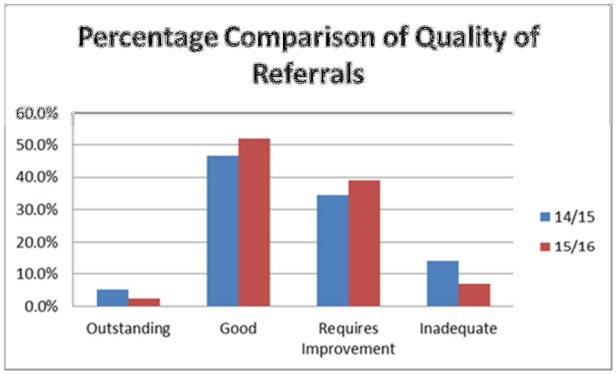
How well did we do it?

The Board audited referrals received by Children's Social Care. The audit used a random sample of up to 10 referrals per month. Over the year the following areas have been reviewed:-

- Voice of the Child (lived experience of the child moving forward).
- Quality of Referrals.
- Quality of Referral Judgments.
- Whether a re-referral could have been avoided?
- Why has the case been referred?
- Do we agree with the Front Door?
- Assessment of the Quality of referral?
- Consent.
- Referring agency.
- Family details.
- Partner agency details.

Whilst inadequate referrals decreased and good referrals increased slightly, some 40% still required improvement. (Figure 17)

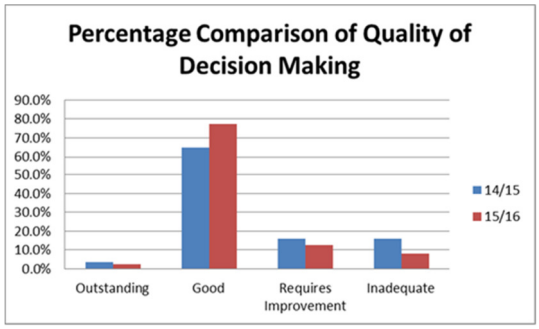
Figure 17



During the year the Board raised concerns around the recording of domestic violence on CareFirst as it shows as a police referral but it is actually from the DV triage team. These concerns were shared with MASH managers.

Quality of decision making is also assessed during the audit and this has shown a slight improvement in the decisions made in MASH. (Figure 18)

Figure 18

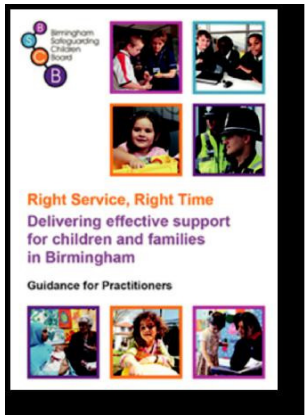


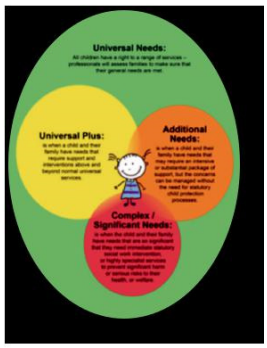
Right Service, Right Time

There is a requirement for 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 Children's Social Care for assessment and statutory intervention. '*Working Together to Safeguard Children'* 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.

In March 2015 the Board revised and re-launched its threshold guidance Right Service, Right Time (figure 19), producing a comprehensive implementation plan to assist organisations embed the guidance in front-line practice. Supplementary guidance was also provided focusing on improving the quality of family assessments (fCAF) and referrals. An ambitious training programme aimed to train 15,017 front-line professionals throughout the year. To ensure consistency of approach 'Train the Trainer' events were held with 86 professionals from a broad spectrum of organisations being trained to deliver the Right Service, Right Time module.

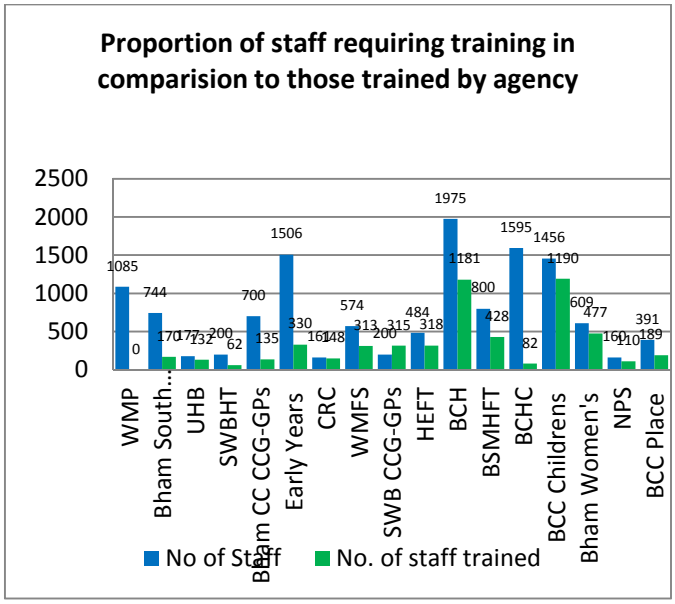
Figure 19





The Board conducted a six month impact assessment to evaluate how successful organisations had been in embedding the new guidance in front-line practice. Considerable progress had been made with 5,580 (37%) of staff having attended the Right Service, Right Time training. Figure 20 highlights the delivery of training during the first six months. There is good evidence of the positive impact of single agency training, with 80% of staff expressing confidence in determining levels of need and who to approach within their organisation for advice and guidance. The training package received unanimous praise from both trainers and delegates. The Board has now embedded Right Service, Right Time into both Level 1 and Level 2 Safeguarding training across the partnership.

Figure 20



The Board monitored the quality of referrals received by the MASH, between July and December 2015, to triangulate the findings from employee surveys and agencies own assessment of progress. The *'Front Door Reference Group'* audits identified incremental improvement in the quality of referrals but recognised further work is still required to ensure all organisations achieve the required standard. This supported the findings of the independent review of the MASH presented to the Board in March 2016

In September 2015 the Board required all statutory organisations to participate in an employee survey which provided important feedback from practitioners with 1,175 respondents from seventeen organisations taking part. There was a noticeable improvement in the levels of awareness with 83% of respondents confirming they knew how to access guidance on how to make a good fCAF and referral, disappointingly in 2013 only half of respondents displayed the requisite knowledge and understanding, triggering Board intervention to embed Right Service, Right Time across the children's workforce. The importance of which was reinforced by the recent Ofsted monitoring visit of Birmingham Children's Services in June 2016, which identified inconsistency in the application of thresholds between early help and statutory intervention across partner organisations.

The refresh of Right Service, Right Time scheduled for autumn 2016 will build in the learning from the Ofsted monitoring visit, changes to Children's Services which come to fruition in September 2016.

Early Help

The strategy for Early Help was agreed by partners, following consultation and was ratified by the Board in March 2015. An effective Early Help Strategy is a prerequisite of Local Authorities judged as Good or Outstanding by Ofsted. In summer 2015 the Early Help and Safeguarding Partnership, jointly chaired by Birmingham Children's Services and West Midlands Police, was established to operationalise and implement the strategy.

There are seven key workstreams to drive forward delivery of the Early Help Strategy, each jointly chaired by a senior manager from different partner organisation. There is strong evidence of partnership engagement into the early help agenda, with all of the workstreams making good progress in this first year.

1. Leadership Partnership Working and Governance
2. Strengthen and clarify the Early Help and Safeguarding front door pathway
3. Assessment and Interventions
4. Information Sharing
5. Localities and Pathways

6. Workforce
7. Commissioning

The Partnership has developed and agreed a 'plan on a page' to help communicate key messages, it has also developed a complementary outcomes framework that establishes a baseline for progress, with 10 outcomes and use 14 performance measures agreed to capture future progress. Each of the outcomes is owned by leaders from across the partnership.

There is now a more coherent 'front door' to early help services through the MASH. The model is being further refined and continuously improved with the launch of the Children's Advice Support Service and the creation of five locality based Early Help Panels planned for September 2016. There is agreement on adoption of 'Signs of Safety and Wellbeing' as a Framework for partnership working.

A conference on Early Help and Safeguarding was held in June attended by over 200 practitioners across all partners. Delegates received feedback on progress and contributed to shaping the future development of Early Help in the city.

The Early Help and Safeguarding Partnership's new framework has been endorsed by the Board and the Strategic Leaders Forum will be invited to ratify the proposals as Birmingham's approach to delivering Early Help and Safeguarding. The Strategic Leaders Forum will also be asked to consider supporting the aspiration of Birmingham becoming a ***Family Friendly City***.

Children in care and young people leaving care

Research and experience tells us that children and young people in care, as well as care leavers, are more likely to experience poorer health and lower educational achievement as well as having few employment opportunities. This year the Board closely monitored implementation of the Corporate Parenting Strategy, which set clear priorities, responsibilities and the aspirations of young people in care.

The Board have been reassured by the substantial progress made during the year, through effective engagement with the Children in Care Council (CiCC) to address those issues at the top of children's 'to do list', pocket money and overnight stays. The 'Birmingham Pledge' a series of ten promises to children in care, helps focus support to enable children to achieve and succeed.

The Board continues to seek tangible evidence that the ten promises are being kept and the CiCC strategy is fully implemented.

Private fostering

The Local Authority has a statutory duty for ensuring they are satisfied that the welfare of privately fostered children, or children who are likely to be privately fostered, are being safeguarded and promoted. The term privately fostered appertains to children 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. 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.

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.

During 2015/16 there have been 34 new private fostering arrangements assessed, of which 15 remain and 19 have ended. There are currently 23 children being cared for under these arrangements, a slight decrease on previous years. Children living in private fostering arrangements receive regular visits from a social worker and there is evidence that good practice is being adhered to in that the children are being seen alone and their health and development needs are kept under review.

Given the size of Birmingham there is still under reporting of children in private fostering arrangements, the focus over the next 12 months will be on;

- Ensuring Privately Fostered children's views and interests are the focal point of the review process
- Reviewing the marketing material and Private Fostering webpages to enhance awareness raising activity

Safeguarding in schools

The Birmingham Education Partnership (BEP) has taken over supporting school improvement. However, the Local Authority has retained responsibility for supporting safeguarding in schools and has confirmed the safeguarding adviser's role and the resilience officer as permanent roles.

During the year the Safeguarding Officer established new arrangements for a cycle of 10 district Designated Safeguarding Leads (DSL's) briefings and three area conferences which were all held on a termly basis. The attendance at one or more of the briefings and conferences increased from 65% to 85% of schools and is accessed by schools regardless of designation. This has encouraged peer to peer support and allowed the localisation of data feedback, and the strategic conferences at an area level. The events draw upon the analysis of the 2014/15 Section 175 safeguarding self-assessment and Keeping Children Safe in Education and Working Together (2015). A consistently high level of delegate satisfaction was received from these sessions with an average 29% increase in delegates' knowledge and skills after the session.

The focus on building resilience has enabled engagement with schools across all designations in the UNICEF Rights Respecting Schools Award. To date 130 schools are registered to achieve the award. This is a proactive process weaving the UN Convention on the Rights of the Child through the life of the school and academic research evidences impact on improving safeguarding.

Advisers are now supporting Initial Teacher Training both through Birmingham's teaching schools and with Higher Education providers to ensure that Prevent and Safeguarding are given an applied practice focus. This spans early years to secondary. A training matrix is in development to enable schools to access the range of training and support available to them and a resource base will form part of that. This includes curriculum tools, lesson plans, assemblies and model letters to respond to the increasing requests from parents to withdraw their children from various aspects of school life.

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 is offered and action plans are drawn up with support brokered according to need.

This 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 Policy.
- Model Safeguarding Policy.
- Children Not Collected from School process.

This specialist adviser function has been endorsed in Ofsted feedback and validated by the Home Office. Feedback from schools consistently demonstrated 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.

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. Safeguarding in Education (Section 175) has been carried out in the city for the last four years. The compliance rate has significantly improved from 63% in 2012/13 to 97.3% in 2015/16, this also now includes Children's Centres and Further Education Colleges, 99% of schools completed the self-assessment.

Analysis of the findings this year shows an improvement in all the areas identified last year.

During the next year the Board will focus on:-

- Review the self-assessment tool in conjunction with new Keeping Children

Safe in Education 2016 and Ofsted Safeguarding Inspection methodology

- Work with colleges and children's centres to improve their self-assessment of safeguarding in their settings.
- Develop and deliver training for school DSLs on supervision.
- Develop peer to peer support within schools to ensure that the work on the self-assessments is being moderated by an external person.
- Further analysis on self-assessment findings to be undertaken for different school settings i.e. secondary, primary, independent, maintained, to identify their specific needs.
- Develop curriculum support for primary schools safeguarding training.
- Local Authority to ensure DSL networks and conferences include specific inputs on the training needs identified.

There remains a significant gap in school practice in relation to children missing from education, the recognition of safeguarding risk and appropriate response for children with additional needs and disabilities, children who are excluded, and children educated at home.

Ofsted carried out a review of education in May 2016 and identified a number of areas of concern. An action plan has been drawn up to deal with the issues raised and work is ongoing to resolve the key issues as quickly as possible.

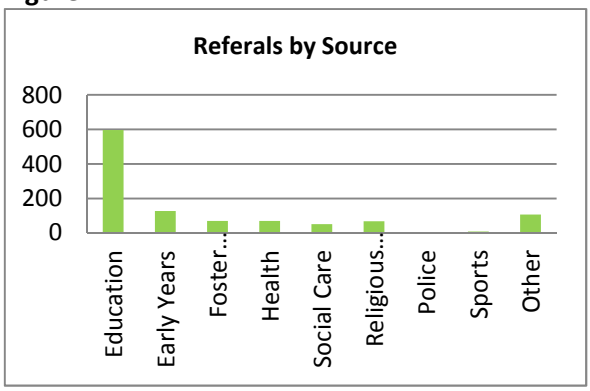
Allegations against persons in positions of trust

The role of the Local Authority Designated Officer (LADO) is a statutory function defined within Working Together to Safeguard Children (2015) providing a national framework for the management of allegations against people who work with children regardless as to whether they are paid or unpaid or volunteers, casual, agency or self-employed.

During the year Birmingham strengthened resilience and capacity within the LADO service to meet rising demand and ensure compliance with the latest guidance, which requires a qualified social worker to oversee the allegation procedure. The LADO provides advice and guidance to employers and voluntary organisations, liaising with the Police, Ofsted and other agencies to ensure transparency and cases are dealt with diligently and expeditiously. In 2015/16 the LADO received 1,100 referrals, compared with 1,076 last year and 864 in 2013/14, which represents an increase of 24.5%. Just under a quarter of the referrals (270) proceeded to formal investigative meeting. Although dealing with a significant number of allegations all cases were resolved within the 12 month timescale prescribed in national guidance.

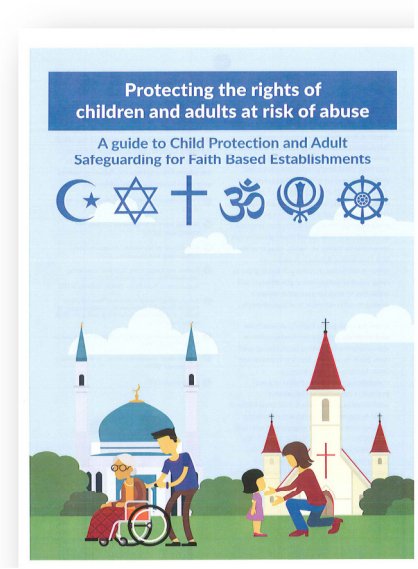
The largest number of referrals were received from education and this continues a year on year trend. The figures for this year are 596 as compared to 331 last year, an 80% increase. A significant number of these referrals were received as parental complaints from Ofsted. The referrals from education 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. Figure 21 provides a breakdown of referrals by source.

Figure 21



The LADO service continues to strengthen its support for faith based organisations, supplementary schools and madrassas. Working alongside Faith Associates Birmingham has produced a guide to child protection and adult safeguarding for faith based establishments (figure 22). The research behind this work received recognition as good practice at an international conference hosted by Birmingham University.

Figure 22



The main focus for the next twelve months will be enhancing data analysis to identify trends to cascade good practice. The service will also seek to expand training for voluntary sector, residential care, colleges and fostering services on the management and reduction of allegations.

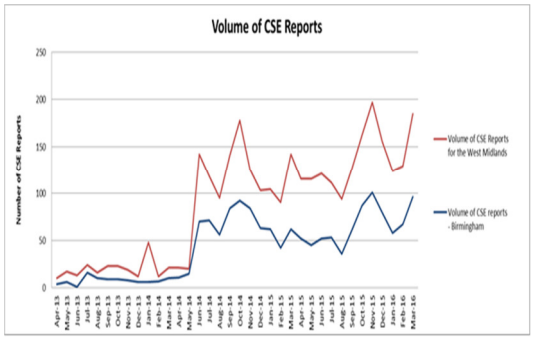
Key vulnerable groups in the City

Tackling Child Sexual Exploitation (CSE)

Home office has identified CSE as a national threat; tackling CSE is and will remain a top priority for the city. It is known 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 red line in figure 23 shows the total number of crime or non-crime recorded by WMP during 2015/16 with a CSE "Special Interest Marker. The Blue line shows the number for Birmingham.

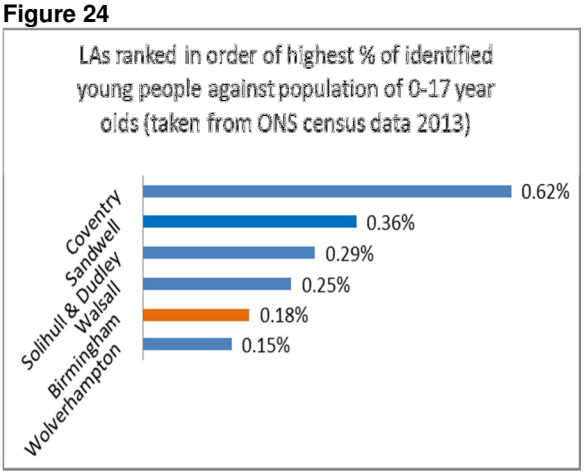
Figure 23



The police recorded 1,635 incidents involving CSE across the West Midlands in 2015/16, a 27% increase on the previous year. Birmingham accounts for 48% of all CSE reports across the West Midlands. There were 787 CSE related incidents for Birmingham, an 11% increase on last year's 712 incidents. A rise in the level of reporting was anticipated as increased awareness raising has enabled professionals to better identify risks of CSE. This resulted in 248 young people aged between 11 and 17 being identified as at risk of CSE in March 2016.

When taking into account the population of young people aged under 18yrs, the city has a lower level of young people identified at risk of CSE in comparison with other Local Authorities across the West Midlands. Figure 24, identifies level of risk by Local Authority. It is probable that the date underestimates the actual extend of CSE and the risk of CSE in the city.

Figure 24



Partnership work to eradicate CSE is coordinated at a regional level through the West Midlands Preventing Violence against Vulnerable People Board (PVVP) and locally through the BSCB Strategic CSE Sub-Group. The PVVP Board provides quarterly Strategic Assessments, which analyse the scale and nature of CSE across the region. They coordinate the ongoing regional public awareness campaign, whilst providing a regional framework to maximise partnership intervention focused on victims, offenders and locations.

Throughout the year the Board have worked closely with Birmingham City Council's Education and Vulnerable Children's Overview and Scrutiny Committee to review and drive progress on implementing the 19 recommendations from '*We Need to Get It*

Right' – A Health Check into the Council's Role in Tackling Child Sexual Exploitation, published in December 2014. The findings informed the refresh of the Birmingham Multi-Agency CSE Framework and Strategy 2015-17. Significant progress has been made on taking forward the key findings from the Health Check and implementing the first year of the CSE Strategy, which has concentrated on embedding the Child Sexual Exploitation Operational Group (COG) and Missing Operational Group (MOG). Although, there are some very good examples of partnership working, overall progress has been slower than expected. Further work on strengthening the local strategic and operation arrangements is still required.

At an operational level partnership work is driven through the COG, which is chaired by West Midlands Police. The sharing of intelligence helps co-ordinate partnership activity at vulnerable locations, identifies patterns of offending behaviour, protects potential victims and targets perpetrators. COG has built upon the success of the ground-breaking injunctions to disrupt perpetrators, taken out last autumn, taking action at a number of licensing premises which were a risk to vulnerable young people. There is a need to further enhance the intelligence capacity and infrastructure that supports the COG, MOG and the Multi-Agency Sexual Exploitation (MASE) meeting arrangements.

At an individual case management level, there are standardised risk assessment processes in place where young people deemed at medium or high risk are subject of a MASE meeting chaired by a CSE Co-ordinator in Children's Services. Each MASE meeting results in a plan which is followed up and reviewed. MASE meetings focus on the needs of individual young people and their families; the intelligence from MASE is aggregated and informs tactical action undertaken through the CSE Operational Group. The number of CSE Co-ordinators are being expanded to three, to enable MASE meetings to be chaired by Area team managers who hold case responsibility for the young person, so there is no disconnect between the social work and the multi-agency plan.

Progress has been made in building the necessary structures, processes, and services to better understand prevalence, ethnicity, age and gender issues for offenders and victims, and the patterns of risk and offending behaviour. However, further work is still required to improve the consistency of information gathering and assessments to better target intervention. The recent Ofsted monitoring visit in May 2016 also highlighted inconstancy in these areas.

There is no doubting partner agencies commitment in the fight against CSE, from Chief Executive Officer through to frontline case workers. This was demonstrated in June 2016 by the Council's Chief Executive who hosted a national conference in Birmingham aimed at sharing best practice in tackling CSE. It gave a strong leadership message of personal commitment and the strength of partnership working to combat CSE across the region.

Missing Children

Last year WMP recorded 1,622 incidents of missing children in Birmingham, the vast majority relate to young people aged between 12 and 17, with 68 incidents relating to children under 12 years of age. There is correlation between heighten risk and the frequency and duration children are missing from home.

Figure 25 and 26 - The police system for recording missing persons is Compact Misper Live.

Figure 25

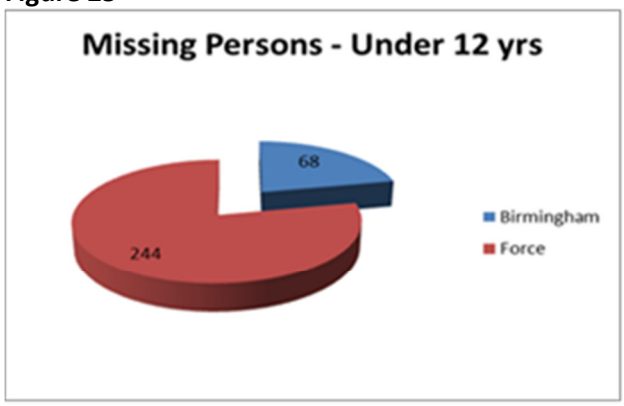
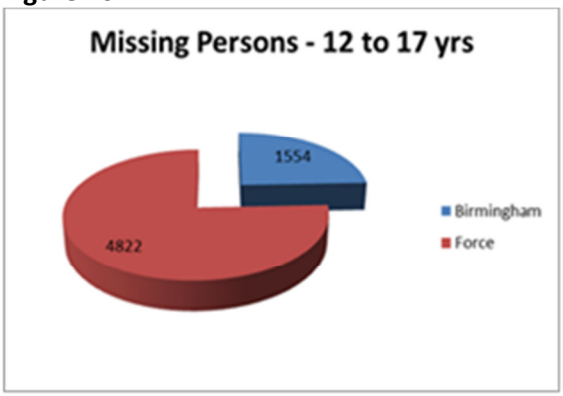


Figure 26



The Board gave evidence to the Birmingham City Council inquiry into Children Missing, published in January 2016. The inquiry found an absence of an overarching strategy for missing children. There was recognition of existing good work being undertaken, but there were concerns in relation to safeguarding practice and a lack of joined up working between partners and with the City Council is of great concern.

An Ofsted monitoring visit in May 2016, found that return home interviews are not always offered or undertaken and findings are not used to prepare and plan for interventions to reduce risk.

The Missing Operational Group established in autumn 2015, has made a significant impact on addressing the inquiry and Ofsted's findings to develop a more integrated approach to children missing from home, care, school and from view. The group have issued new 'Missing from Home and Care Practice Guidance' and are ensuring that there are robust data collection systems in place to enable the dissemination of intelligence to reduce and manage risk to children who go missing. The group facilitates the provision of intensive partnership intervention for those children at greatest risk. There is further work required to build confidence in the effectiveness of children in need and child protection practice for children who frequently go missing.

The Council's Overview and Scrutiny Committee continue to monitoring implementation of the findings and highlighted the commitment of West Midlands Police, The Children's Society and the Council in prioritising the improvements and for implementing the 'The Runaways' Charter' which aims to enhance partnership working to build a safety net for children who run away from home.

Domestic Abuse

Birmingham's multi-agency response to domestic abuse and other forms of gendered violence is led by the Violence Against Women & Children Steering Group of the Community Safety Partnership. The group oversaw the implementation of the West Midlands Domestic Violence and Abuse Standards published in September 2015.

In March 2016 the Board advocated for stronger strategic leadership of the way Birmingham as a whole city and whole system deals with domestic violence and its impact on victims and families, especially children. Strategic planning, service developments, response capacity and commissioning practice as well as the response to individual families and their children is disconnected, incoherent and silo'ed and that there is both a duplication of activity and significant gaps in activity.

It is crucial that the Adult and Children's Safeguarding Boards, Community Safety Partnership and the Violence against Women Steering Group collaborate more effectively to tackle domestic abuse. The Strategic Leaders' Forum for children could provide this requisite oversight. In 2016/17 proposals to extend the formality and remit of the Strategic Leaders' Forum are being developed.

In responding to the Board's concerns a detailed needs assessment has been undertaken which identified that by the time they reach adulthood, at least 1 in 5 children in the city will have been exposed to domestic abuse and low levels of reporting often hide their experiences from public services. There has been an increase in reporting to the Police, partly because domestic abuse has increased since the economic crisis.

During 2015/16, 77% of children in need were living with domestic abuse locally, compared to 48% of those nationally; notifications to joint screening of domestic abuse cases known to the police increased by 29%; referrals for adults (including parents) at high risk of serious harm or death increased by 36%. The findings from domestic homicide reviews emphasis the scale of the problem and the detrimental impact on

children living in violent households that requires a change in approach.

Weaknesses in the multi-agency response to safeguarding children featured in over 80 percent of domestic homicide reviews and significant numbers of Serious Case Reviews in the city. The requirement to undertake a domestic homicide review arises where domestic abuse has led to a person's death.

Since the reviews were introduced in 2011, 13 children in Birmingham have been bereaved through the homicide of their mother, two during 2015/16 and in one case, a baby was killed alongside their mother. The reviews have revealed archetypal patterns of abuse and a lack of awareness on the part of most agencies in how the features of coercion and control in domestic abuse impact upon families.

The domestic homicide reviews have suggested that the national approach to safeguarding children living in violent households is intrinsically flawed, as it fails to understand how agencies inadvertently increase risk. Meaningful engagement with abused mothers and their children requires a different approach in the face of the often overwhelming coercion and control that they face. In the light of this understanding the city is embarking on a new domestic abuse strategy which will focus on the three areas of prevention:

- Changing attitudes to domestic abuse amongst children , young people and communities (primary prevention)
- Early identification and early help in domestic abuse with 'trusted professionals' and across health and social care settings, accompanied by a workforce development plan, best practice guidance and toolkits (secondary prevention).
- Safety and support of those known to be experiencing domestic abuse and a stronger focus on those perpetrating abuse: developing an abuser management framework and strengthening the relationships between adult and child public protection processes (tertiary prevention).

The Board have been consulted on, and endorsed the draft strategy, which will be launched in autumn 2016. In order to drive this change there will be an expectation that each strategic partnership charged with public protection and safeguarding in the city, will drive elements of this strategy forward over the coming year.

Tackling Female Genital Mutilation (FGM)

The Board provides strategic oversight, support and scrutiny of the partnership activity to eradicate FGM, which is coordinated regionally by the Preventing Violence against Vulnerable People Board and locally through Birmingham Against Female Genital Mutilation (BAFGM). In 2015/16 the Police received 38 reports in relation to FGM, with the courts issuing 3 FGM Protection Orders.

BAFGM have contributed to the West Midlands Police and Crime Panel enquiry in tackling FGM undertaken in June 2015. Commissioning multi-agency training for professionals dealing with FGM and launching a bespoke website to enable access to training and resources, the site has had 2,500 hits already. A lesson pack for Key Stage 2 children was developed and training provided for all schools attended by over 100 teachers.

The Serious Crime Act 2015 brought about mandatory reporting of FGM by healthcare professionals and teachers from 31st October 2015, however, despite this welcomed legislation, there has not been a successful prosecution anywhere in country. Birmingham has gained the first FGM Prevention Order in the region to protect the daughter of an asylum seeker who was still resident in the country of origin.

The key challenge remains changing the mind set of communities to this abhorrent crime; this requires continued emphasis on raising community awareness of the health risks and the criminal sanctions for perpetrators. To this end a conference is planned in Birmingham to coincide with International Day of Zero Tolerance for FGM on 6th February 2017.

Tackling Radicalisation

The Community Safety Partnership provides strategic oversight of the Birmingham Prevent Programme, delivering a comprehensive programme of multi-agency and multi-

disciplinary training. During 2015/16 WRAP training was delivered to over 15,000 front-line staff in schools, and are moving into a train the trainer model for 2016/17 with a target to have over 300 Workshops Raising Awareness of Prevent (WRAP).

In October 2015 the Council appointed a family support worker for Prevent providing additional capacity for family support guardians engaged in raising awareness and delivering a consistent message across all services. The role has supported families where there has been a heightened risk of influence to extremism and radicalisation. Support has included the use of child protection plans and multi-agency early help plans, as well as being support through universal services.

Through the 'No Platform' Policy, the Council have put into place a system to prevent the use of Local Authority venues from providing a platform for extremist speakers. There are also established 'due diligence' systems in place to ensure groups that work with the Birmingham Prevent Programme do not hold, or engage with, extremist views or groups. In September 2015 the 'No Platform' Policy was rolled out to schools.

Alongside the Prevent Duty the Counter Terrorism and Security Act 2015 also placed Channel on a statutory footing. Channel is a multi-agency panel that aims to provide a mechanism to identify and provide support to vulnerable individuals at risk of radicalisation. It is modelled on other successful risk management processes such as child protection, domestic violence and management of high risk offenders. Channel helps to evaluate referrals of individuals at risk of being drawn into terrorism and must work alongside mainstream safeguarding processes. The Birmingham Channel panel is fully established and membership constantly reviewed. Interim referral pathways to Channel from MASH are in place and are being reviewed alongside work with the Public Protection Unit.

In March 2016 West Midlands Counter Terrorism Unit launched 'Project Caireen' to enhance safeguarding of children, young people and vulnerable adults from the risks of terrorism and domestic extremism.

Modern Day Slavery

West Midlands Police hosted a partnership event in November 2015 to focus on Modern Slavery and new legislation that makes provision for the prosecution of and prevention of a number of exploitative crimes involving both adult and child victims. Exploitation includes Domestic Servitude, Forced Labour and Sexual Exploitation. The West Midlands Regional Anti-Trafficking Network draws together a number of statutory and non-statutory agencies, to raise awareness, improve information flow and enhance partnership arrangements to identify and recover victims. The National Referral Mechanism is key and the West Midlands area is now the second highest generator of victim referrals.

Unfortunately, although identification is steadily increasing, victims' are rarely supportive of Criminal Justice intervention and work is underway to explore non-victim centred opportunities to tackle those responsible for these crimes. To further support issues aligned to the trafficking/exploitation of children, the Panel for the Protection of Trafficked Children has recently been set up and is chaired by Barnado's as a sub-group of the Regional Anti-Trafficking Network. This is supported by a Regional CSE Co-ordinator, and looks to enhance the understanding of Slavery within relevant partner agencies so as to enable a better understanding of the true nature and extent of Modern Day Slavery within the area.

Forced Marriage and Honour Based Abuse

Forced marriage is a hidden based crime and the level of reporting does not represent the true picture, with only 12 forced marriage incidents within Birmingham being reported during 2015/16, which resulted in the granting of 6 Forced Marriage Protection Orders. There is a need to enhance both professional and community awareness, building on the event hosted in Birmingham in June 2016 to commemorate the tragic death of a victim of forced marriage.

Some of these cross cutting safeguarding issues require effective intervention at both local and regional level. The Strategic Leaders Forum could provide the requisite strategic oversight

to maximise finite partnership resources to tackle CSE, trafficking, honour based violence and forced marriage.

Children's Social Care

This report does not comment in-depth on Children's Social Care, as both the quality and effectiveness of practice is the subject of a range of other reports. The Council's own self-assessment identifies the same areas of strength and weakness that the Board considered over the year, and addressed a range of issues that had been raised. Over 2015/16 there was increasing evidence of improvement, and the stability of a strong leadership team, was clearly beginning to make an impact. Much of the core business of Children's Social Care chimes with the core business of the Board. At times over the year keeping the Board's priorities aligned with the improvement plan priorities and actions was difficult.

Children's Social Care Leaders made sensible decisions for their own service and drove them forward, but without the degree of multi-agency discussion needed at times to avoid perverse consequences. The Board became increasingly able to debate these matters maturely with appropriate constructive challenge as the pace and quality of change increased.

The significant changes made include "*Our model for children's services*" in August 2015, and in February 2016 "*Our support for children and families"*. These, plus the establishment of the multi-agency Early Help and Safeguarding Partnership in summer 2015 all had a positive impact, with a calmer more stable service, more manageable caseloads and reduced staff turnover. The new Assessment and Short-Term Intervention Teams (ASTI) were established by the autumn 2015 and were very busy and still needing stabilising and embedding by March 2016.

There remained many areas of weakness. The MASH front door was still fragile, systems to respond to missing children under-developed, stability of the workforce was not achieved in every area of the city, and support to teenagers and care leavers in need of improvement.

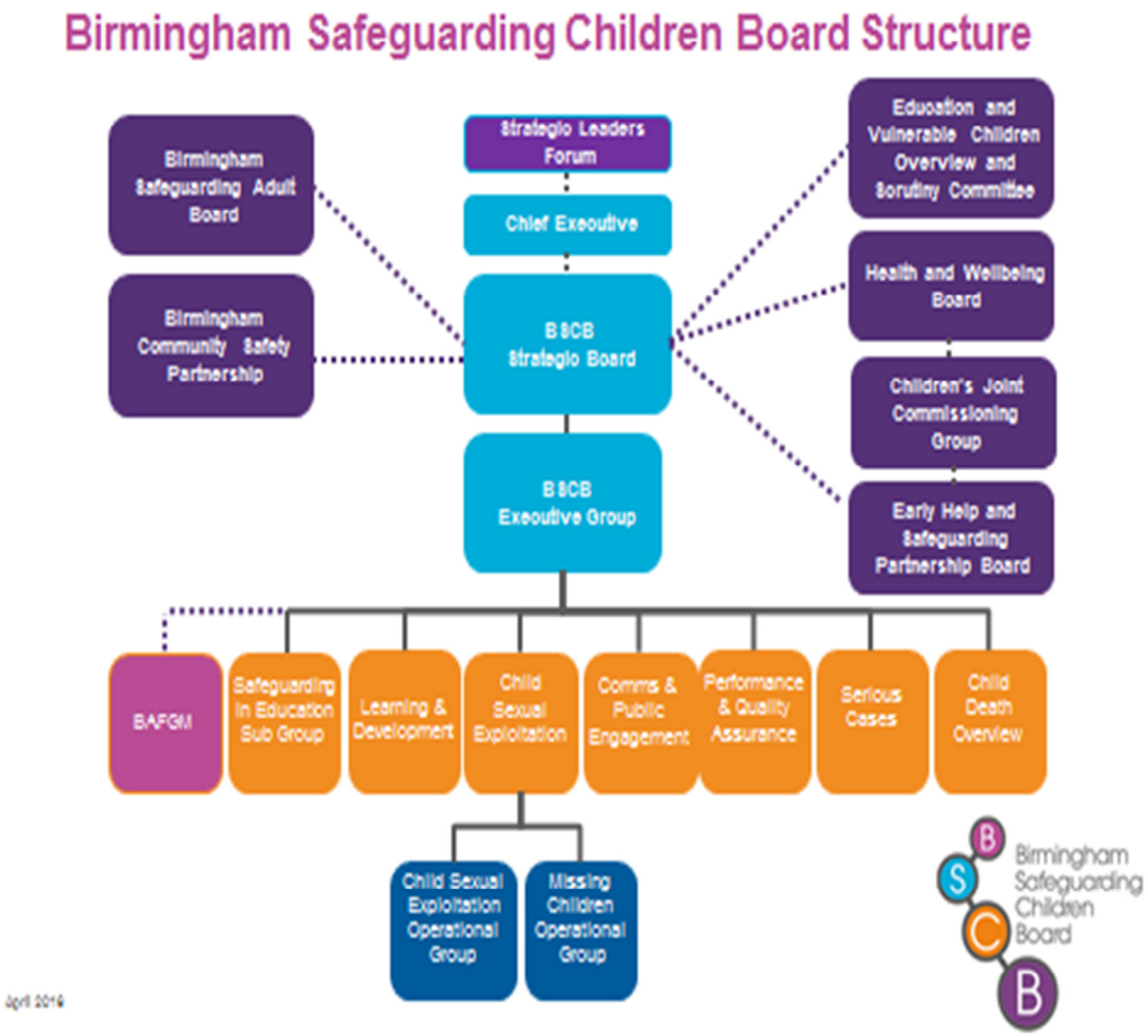
Part 3 - The effectiveness of the Birmingham Safeguarding Children Board

The Board discharges its statutory objectives functions supported by an Executive Group and series of Sub-Groups (figure 27). This section of the report examines the governance and accountability arrangements, budget utilisation and implementation of the Business and Improvement Plan 2015/16.

The strategic role of the Board is to provide independent oversight of the effectiveness of partnership collaboration to safeguard and promote the welfare of children in Birmingham. The Board provides leadership, co-ordination and appropriate challenge to drive improvement safeguarding practice across all local agencies. However individual agencies are responsible and accountable for the provision of services.

Working Together to Safeguard Children 2015 sets the national context and framework for Local Safeguarding Children Board's. The Board fully complies with the strategic guidance. The Chief Executive of Birmingham City Council is responsible for the appointment and removal of the Independent LSCB Chair with the agreement of statutory partners Chief Executives and lay members. Membership of the Board comprises of 53 members, including Lay Members and a participant observers. The diversity of the city is reflected by the make-up of membership of the Board, with a gender ratio of 55% female and 45% male representatives from different faiths, cultures and communities.

Figure 27



During 2015/16 the Board met on five occasions, supported by bi-monthly Executive Group 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 has expanded regionally through the Preventing Violence against Vulnerable People Board to tackle Child Sexual Exploitation, Trafficking and Female Genital Mutilation this approach maximise resources to impact on those issues that transcend geographical boundaries.

Independent Oversight

The Board's two Lay Members operate as full members of the Board, providing further independent oversight and challenge on the safeguarding arrangements in the city. The lay members have helped strengthen links with the public and community groups on child safety issues, particularly through their contribution to public awareness campaigns and quality assurance programme.

The Lead Member for Children's Services is actively engaged in the drive to improve outcomes for children, regularly attending the Board in her role as a Participating Observer.

The Independent Chair established a Practitioners Forum to consult and engage with front-line professionals across a wide range of agencies. The quarterly meetings enable professionals to influence change and provide direct feedback on new initiatives and how effectively they are be implemented. The 149 members have made a significant contribution to the Board's work over the last year, particularly around the redesign of the Multi-Agency Referral Form and the refresh of threshold guidance. Representatives from the forum participated in the independent review of the MASH and the programme of joint case file audits overseen by the Performance and Quality Assurance Sub-Group.

Transformation Project

The Board responded to concerns raised by Lord Warner and some partners about the effectiveness of Local Safeguarding Children Board's ability to provide strong independent challenge and impetus to the improvement journey.

The Independent Chair is overseeing a Transformation Programme to implement the findings of the National Review of LSCBs undertaken by Allan Wood CBE.

The Wood Review's key findings include:

- New requirement on three key partners, Local Authority, Police and the Health Service.
- Expectation on schools and child protection agencies to co-operate with new arrangements.
- No requirement for LSCB with set membership – too large and unwieldy.
- Greater flexibility in developing arrangements to respond to local need and better agency investment.
- Department of Health to oversee the review of Child Deaths.
- SCRs replaced by national and local reviews

Governance Arrangements

The Board provided strategic oversight of partnership activity through implementation of a three year Strategic Plan and annual Business and Improvement Plan. The Board is supported in the discharge of its statutory functions by an Executive Group and seven Sub-Groups. The Board also provides support and direction for the Birmingham Against Female Genital Mutilation Group.

Implementation of the Business and Improvement Plan 2015/16 is delivered through the Sub-Group structure and approved Work Programmes. The Sub-Group Chairs played a pivotal role in directing partnership endeavour in achieving its safeguarding priorities.

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

1. Communications and Public Engagement – Midlands and Lancashire NHS CSU.
2. Child Death Overview Panel – Public Health.
3. Strategic Child Sexual Exploitation – Birmingham City Council.
4. Serious Case Review – Birmingham South Central CCG.

5. Learning and Development – Birmingham City Council.
6. Safeguarding in Education Sub-Group – Birmingham City Council.
7. Performance and Quality Assurance – Birmingham City Council.

The Independent Chair and Business Manager met on a bi-monthly basis with Sub-Group Chairs and Programme Managers to monitor and drive progress on work programmes. The forum identified opportunities for collaborative working, avoid duplication of effort and facilitate debate to improve partnership arrangements and performance.

Board Attendance, Representation and Engagement

Organisational attendance and representation at the Strategic Board (figure 28) is good demonstrating a strong commitment and collective responsibility for safeguarding and promoting the welfare of children and young people in the city.

This commitment is replicated throughout the children's safeguarding from Board level, Executive Group and the Sub-Group structure. The table below (figure 29) provides a pictorial overview of agency engagement and attendance throughout the safeguarding structure. Organisational restructuring has adversely impacted on the attendance and contribution of some agencies at the Sub-Group level. During the next 12 months membership will be streamlined in light of the 'Wood Review' with the Local Authority, Health and Police having leadership responsibility for the multi-agency safeguarding arrangements.

Figure 28 – BSCB Attendance April 2015 – March 2016

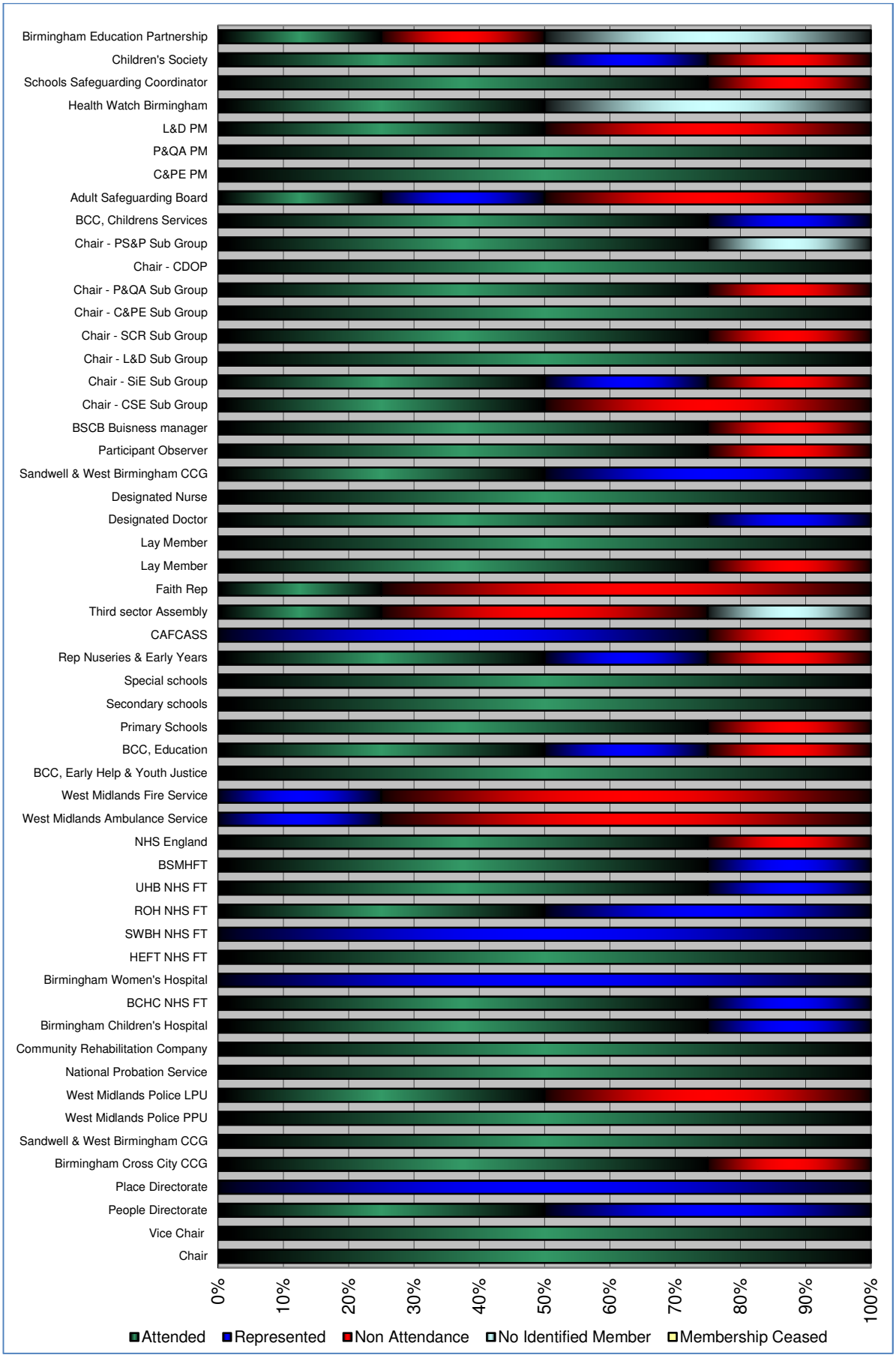
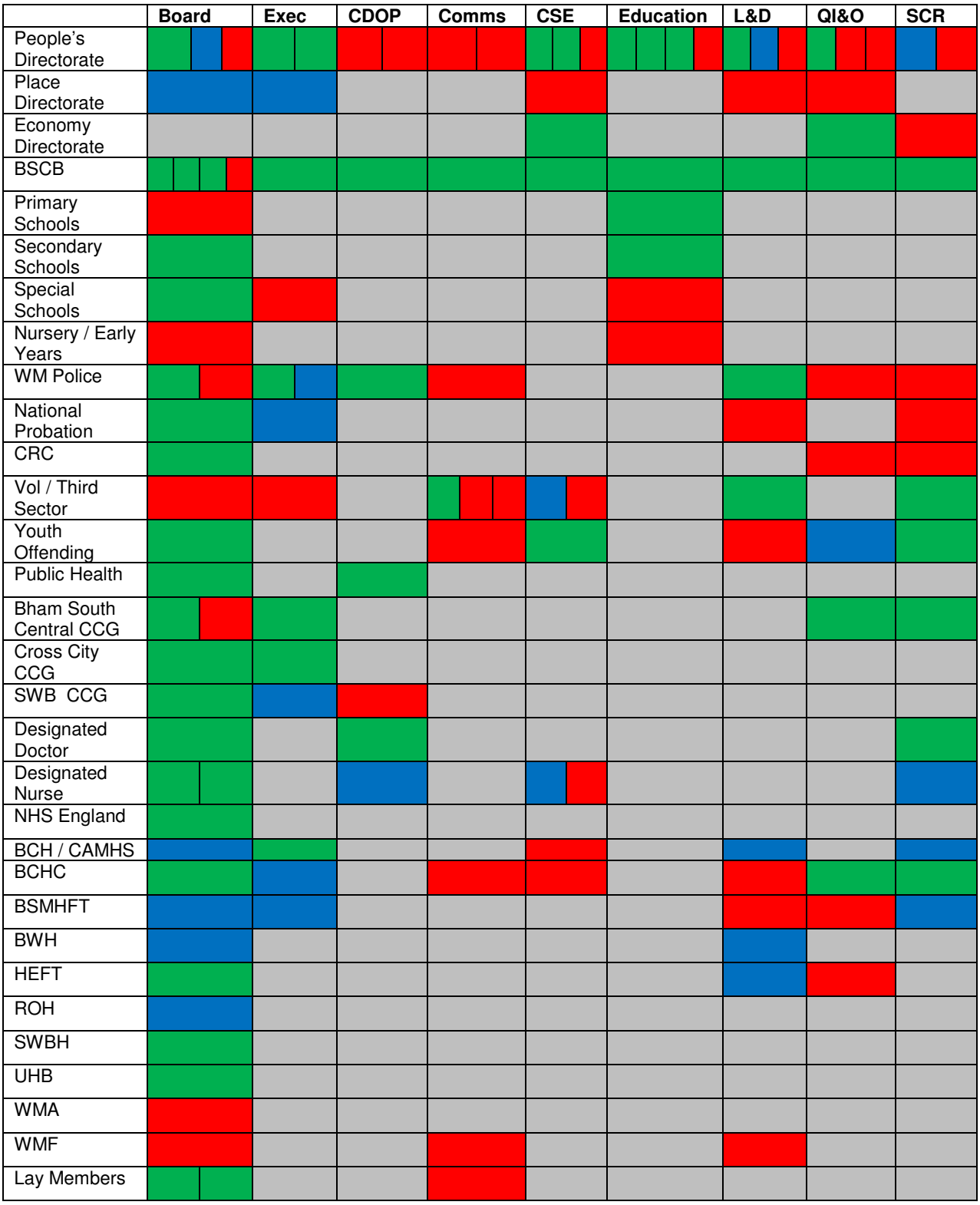


Figure 29 - Agency Attendance by Sub-Group April 2015 – March 2016

- 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



A dedicated Business Support Unit supports the work of the Board and is currently hosted by the City Council, but funded by key statutory partners.

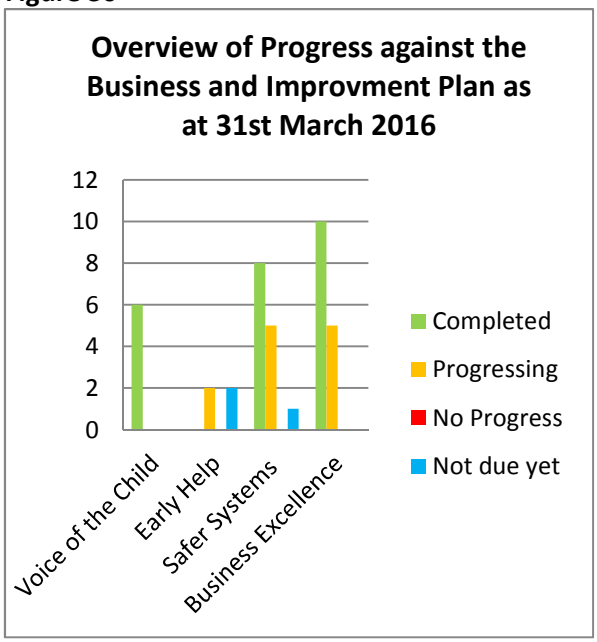
In 2015/16 the Business Support Unit was directly managed by the Independent Chair. The Business Manager provided the Independent Chair with regular performance updates on the efficiency of the administrative systems that impact on the effectiveness of the Sub-Group Structure.

Business and Improvement Plan

The Business and Improvement Plan 2015/16 continued to focus on the four key strategic safeguarding priorities from the previous year. Voice of the Child, Early Help, Safer Systems and Business Excellence.

The Executive Group monitored progress throughout the year, with the outstanding actions informing the business planning cycle and the development of the work programme for 2016/17. Figure 30 provides an overview of progress against each of the priority areas.

Figure 30



Significant progress has been made on the priorities set out in the Business and Improvement Plan during the year, but the Board is cognisant of the further work required to provide the requisite assurance of the impact on frontline practice.

Finance

The BSCB budget for 2015/16 amounted to £788,429, made up of contributions from statutory key agencies and a carry forward of £105,870 from the previous year.
Figure 31 provides a breakdown of the components of the budget detailing individual agencies contributions (£674,409) and income generation (£8,150).

Figure 31

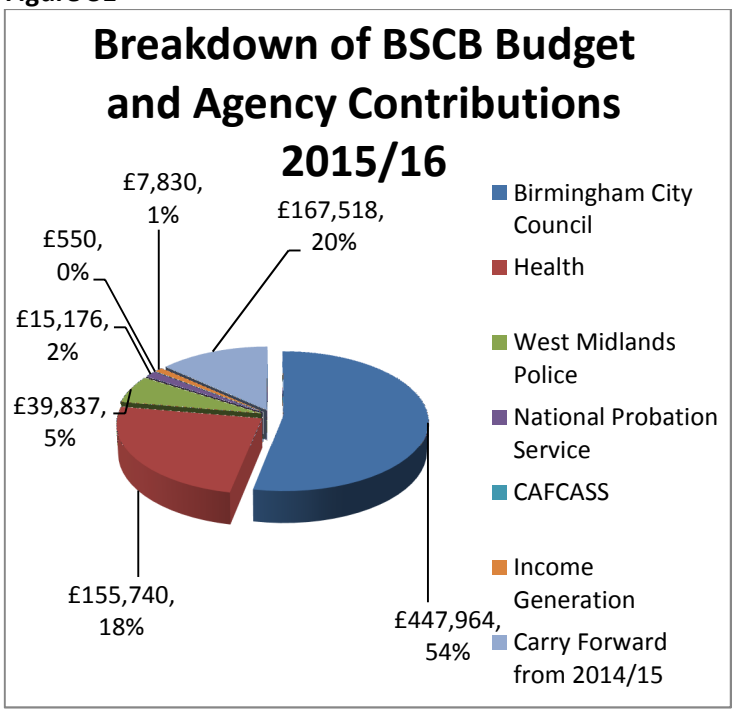
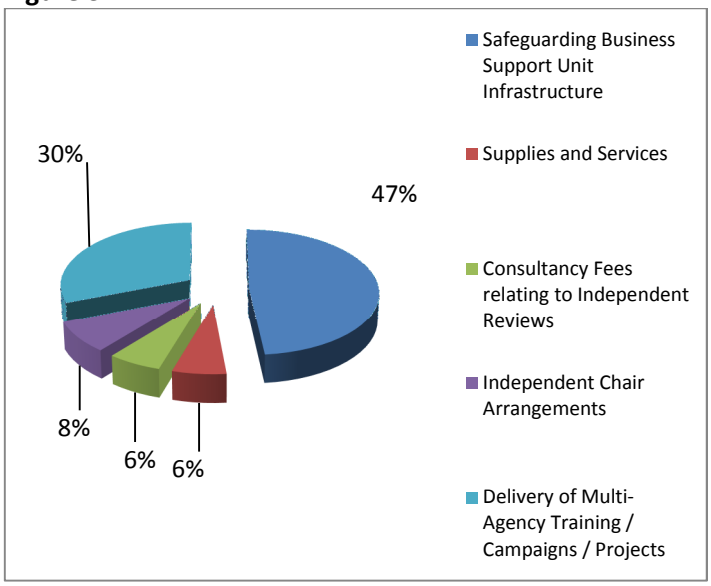


Figure 32 provides details of expenditure during 2015/16 which concentrated on five core business areas.

Figure 32



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. The impact of public sector funding will result in a £79,849 reduction in the budget for 2016/17.

Performance & Quality Assurance Sub-Group

The Performance and Quality Assurance (P&QA) Sub-Group provides a pivotal role in overseeing implementation of the quality assurance and audit programme. A key element is coordinating the annual Section 11 safeguarding audit and peer review moderation process, to validate the audit findings.

The Front Door Reference Group continued to undertake monthly audits of referrals into the MASH. A total of 88 cases were independently reviewed and for the second year in a row there has been an improvement on the overall quality of referrals.

The P&QA Sub-Group completed an audit of Child Protection Cases and a detailed analysis of cases involving FGM and CSE to identify areas for practice improvement. The audit findings have been acted upon and steps taken to implement all the findings.

A CSE case file audit commenced in February 2016 identified important learning which has informed the further development of the CSE pathways and will assist in enhancing consistency of case management through the MASE structure.

WMP and Children's Social Care are leading a review of the Initial Child Protection Conference arrangements aimed at enhancing partnership engagement in the 'Strengthening Families 'model to provide better outcomes for children and families.

Safeguarding in Education Sub-Group

The Board has continued to work 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 Sub-Group provides a conduit between the 526 education establishments and the LSCB.

During the year the group successfully coordinated and evaluated the annual Section 175 self-assessment, which saw a 97% completion rate. The delivery of 'Right Service, Right Time' training is another significant piece of work, with 75% schools having already undertaken the training. Approved lists of supply agencies for Head Teachers have been produced disseminated and the group have contributed to the development of new guidance on children 'Not Picked Up from School' has been endorsed by the group.
In 2016/17 the focus will be;

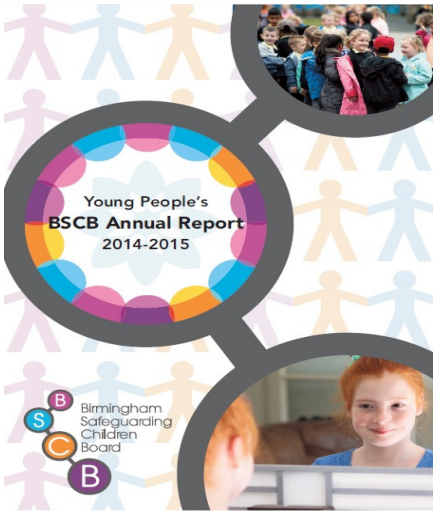
- Undertaking un-announced audits of non-compliant schools in the annual Safeguarding in Education Self-assessment.
- Provide a Peer Support programme to cascade safeguarding good practice amongst schools.
- Strengthen engagement with Further Education Colleges and alternative providers in the city.
- Increase the quality assurance and safety checks in the independent sector and the unregistered/unregulated provision of schools and colleges.
- Develop the registration of out of school educational settings, including quality assurance of safeguarding.

Communication & Public Engagement Sub-Group

During the last twelve months the Sub-Group have gained a much better insight on how organisations are consulting and engaging with children and young people on safeguarding issues, this has identified areas for further work before the Board can satisfied that the 'voice of the child' is being heard loud and clear.

Young people helped to design, edit and produce the first young people's version, of the annual report, which is available to download from the BSCB website. (Figure 33)

Figure 33



The Board launched a Safer Sleeping' campaign from March 2016, focused on reducing the risk of sudden infant death syndrome and the potential dangers of 'overlaying' a persistent feature of a small number of child deaths each year. Health Visitors are providing all new mothers with a 'safer sleeping' resource pack at the28 week antenatal visits which is reinforced following the birth of the child at the first post-natal visit. The campaign evaluation will be presented to the Board later in the year.

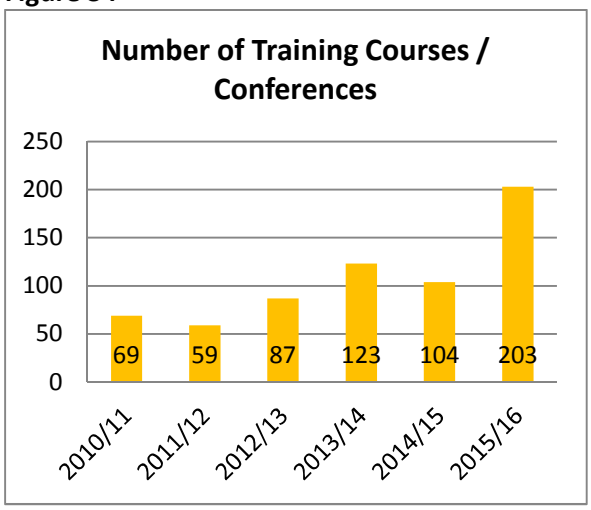
Looking ahead the Sub-Group are planning public awareness campaigns around CSE and FGM. The Board will also continue to expand the use of social media to better target key messages for young people and safeguarding professionals.

Learning & Development Sub-Group

The children's workforce in Birmingham is estimated at 85,000, creating a significant challenge in ensuring the consistency and quality of safeguarding training. The Board therefore prioritises finite resources on the delivery of high quality multi-agency training for those professionals who can make the maximum impact on safeguarding children and young people across the city. The Board's Training Offer aims to compliment and build on each agency's own training.

During 2015/16 a financial carry forward from the previous year was reinvested to deliver additional multi-agency training. This enabled the commissioning of 203 training courses, delivering 4,489 training places, nearly double the number of course and places of the previous year. An extra 55 courses were delivered to help embed new threshold guidance, 'Right Service, Right Time'. Figure 34 shows the increase in training delivery of over the last six year.

Figure 34



The Learning and Development Sub-Group made significant impact during the year:

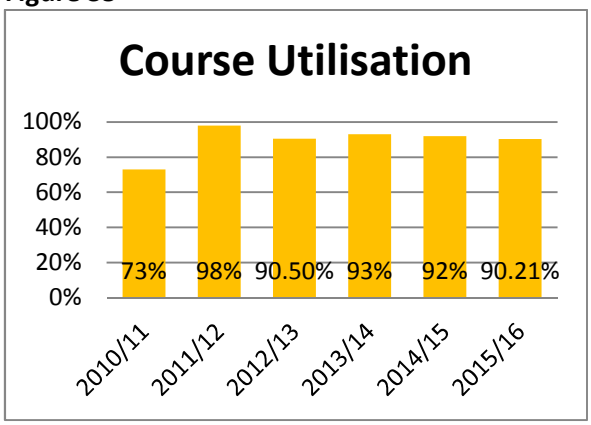
- All commissioned training material incorporated the 'Voice of The Child' practice standards.
- New training modules on CSE, learning form SCRs and FGM have been developed and rolled out.
- Development of a standardised child protection Level 1 and 2 modules for use by all agencies in Birmingham.
- Guidance on the safeguarding content of Induction Programme for the children's workforce.
- Development of 'Right Service, Right Time' training materials/trainer's pack to support the embedding of threshold guidance.
- Robust evaluation of training that informs the development of the training programme 2015/16.

A major step change this year has seen expansion of the partnership training network, with each statutory organisation identifying facilitators to deliver bespoke safeguarding modules designed by the Sub-Group. This approach is improving consistency and quality

of training delivery across the children's workforce.

Overall course utilisation remains high 90%, however there has been a slight decrease on the previous year. Work is being undertaken to improve the marketing and advertising of courses to enhance take up by key professionals. Figure 35 provides an overview of course utilisation in comparison with previous years.

Figure 35



Priorities for the forthcoming 12 months are inextricably linked to the learning and development priorities set out in the three year strategic plan.

Strategic Child Sexual Exploitation Sub-Group

In March 2015 the Board ratified the revised Child Sexual Exploitation Strategy 2015-17 aimed at eradicating CSE.

The strategy is built around four key strands:

- Prevention.
- Protection.
- Disruption.
- Prosecution.

Throughout the year the Board worked closely with the Council's Education and Vulnerable Children Overview and Scrutiny Committee to review and drive progress on the effective implementation of the 19 recommendations from '*We Need to Get It Right*' – A Health Check into the Council's Role in Tackling Child Sexual Exploitation, published in December 2014. Significant progress has been made on taking forward the key findings.

The Group have reviewed the referral pathways for CSE and developed operational guidance to incorporate the development of the MASE during the restructuring of Children's Social Care. Further work is still required to refine the guidance as the new service model is implemented.

The BAIT CSE education resource and teaching plan developed by the Sub-Group for pupils aged between 11 to 17year olds has received recognition as good practice. The resource has now been shared with LSCBs across the region for dissemination to all Secondary Schools and Further Education Colleges. The Sub-Group are undertaking further work to evaluate the impact of BAIT on changing young people's awareness and understanding of risk of sexual exploitation.

A comprehensive programme of CSE training and e-learning is in place for professionals working with children and families at risk of CSE through the BSCB website.

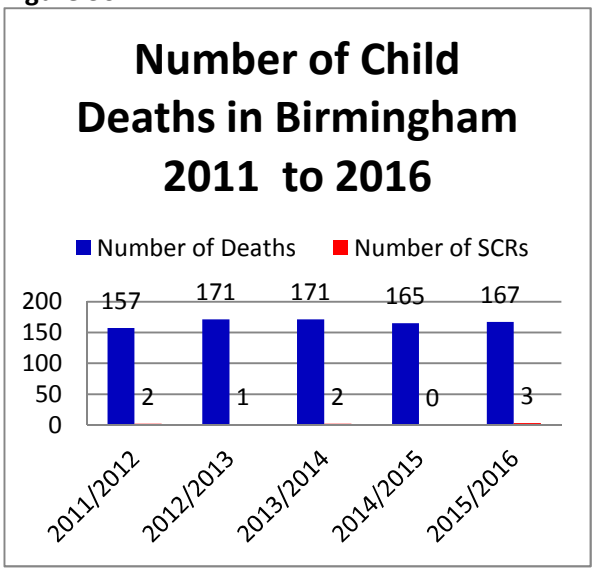
During the next year the focus will be on enhancing the governance and accountability arrangements to ensure the group has the right strategic representation, performance framework and resource to deliver on the year two priories;

- Embed identified learning from Joint Target Area Inspections deep dive of CSE.
- Undertake a public awareness campaign on the dangers of CSE
- Carry out a post implementation review of the MOG arranements.to identify next steps.
- Development of a Joint Strategic Needs Assessment for CSE
- Strengthen the pathways between CSE Operation Group and the Multi-Agency Safeguarding Hub to secure the requisite expertise earlier in identified cases of CSE.
- Expand the programme of CSE multi-agency training to enhance staff skills, knowledge, professional competence and confidence to address CSE.
- Develop outcome based performance framework to evaluate the impact of MASE intervention.
- Evaluate the impact of BAIT educational resource pack raising young people's awareness of the risk of CSE.

Child Death Overview Panel

The 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 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. Figure 36 provides a comparison of the number of child deaths in relation to the number of serious case reviews commissioned each year between 2011 and 2016.

Figure 36



CDOP'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.

A separate Annual Report providing in-depth analysis and learning of why children die is published by the Board each year. The report provides an 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.

The emerging themes from the review of child deaths during 2015/16 are:

a) The high Infant Mortality Rate in Birmingham, particularly the influence of very early births (prematurity) and the impact of life limiting congenital anomalies.
b) Deaths due to Asthma, particularly lessons for the management of asthma and responses to serious changes in health status.
c) The planning and delivery of care at the end of life for those with life limiting and threatening conditions.
d) The systematic provision of bereavement support for families of children who die.

Serious Case Reviews Sub-Group

Serious Case Reviews Sub-Group (SCR) 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 aim is to maximise learning from these tragic cases and identify any improvement in individual agency and multi-agency working to effectively safeguard children. The group ensures that the learning and action plans have been fully implemented.

Serious Case Reviews (SCRs) are not inquiries into how a child died or was seriously harmed or about who is culpable. These are matters for the Coroner and criminal courts.

Published Serious Case Reviews

During the year the findings from two SCRs, the tragic death of Kieron Barley and Fenton Hogan were published. The full reports are available through the Board's website. Kieron died at the hands of his mother and her partner. Kieron's mother was sentenced to 15 months in prison for 'child cruelty' (this was later halved on appeal) while her partner pleaded guilty to manslaughter and was sentenced to eight years. Fenton was given methadone by his mother. In March 2015 she was found guilty of the

manslaughter and sentenced to six years imprisonment.

Key learning from Serious Case Reviews

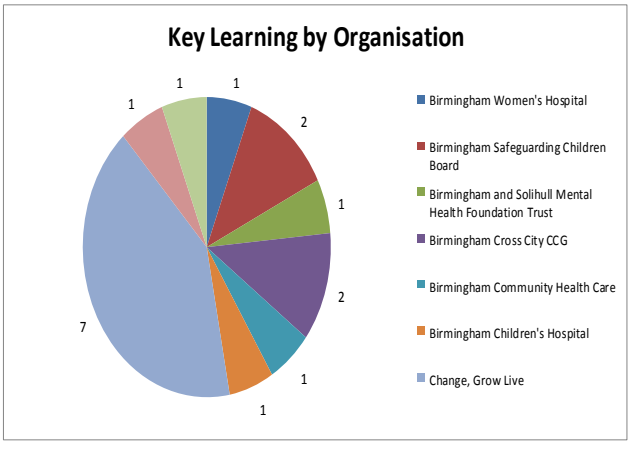
The key learning identified through the review processes inform policy development, training delivery, communication and public engagement and audit activity to evidence learning has been effectively implemented. The key messages are:

- Ensuring that pregnant vulnerable women are identified and appropriate assessments undertaken in respect of any risks to their unborn children and that safeguarding referrals are made when necessary.
- The importance of recognising, listening to, and talking to children and young people living in families where substance misuse is a key part of their daily life experiences.
- The importance of recognising when intervention requires escalation into formal safeguarding processes and ensuring that action occurs.
- Parents should be informed of the dangers of children ingesting methadone or being given it in a misguided attempt to pacify them.
- To consider parenting capacity when parents have mental health problems especially if they are enduring and long lasting. This is particularly important for practitioners who just see the adult.
- The importance of considering both parents' ability to parent a child particularly with a new born baby.
- Ensuring better communication between acute and community staff where parents are being readmitted to hospital and the care of a child needs to be considered.
- Staff need to ensure that they engage with young people especially when there are concerns for their welfare.
- When young people who are potentially at risk of CSE and are approaching 18 years of age, staff should consider how best to support them in the transition from children's services to adult services.
- The importance of recognising self-harm can be a marker of suicide but also other risks to the child.
- Multiple A&E attendances are important in any age in childhood including adolescence and may indicate safeguarding concerns.
- When assessments are made it is important to identify that every risk has been addressed before finalising the assessment.
- If a number of agencies are involved in supporting a young person there should be clear agreement about which agency assumes lead responsibility and this should include the wishes of the young person.
- Whilst interagency working, information sharing and linking of referrals should now be improved with the advent of MASH this should not detract from other responses such as interagency "conversations" and professionals meeting to discuss difficult cases that may not meet a Safeguarding threshold but would benefit from help and support.
- Professionals need to understand and use Think Family Guidance (SCIE30, 2011) and principles in daily practice and in partnership with others.
- Historical information and the need for specialist assessments must be considered when developing a child protection plan.
- The voice and lived experience of children should be evidence in professionals' assessments of both the child and the adult.
- All information, whether gathered by statutory agencies or people in the community, should be considered when looking at risk to women and children where there is domestic abuse.

Ensuring lessons are learnt

The Board closely monitors the effective implementation and compliance with the key recommendations from Serious Case Reviews and Learning Lessons Reviews. Quarterly reports provide reassurance of how learning is being embedded into front-line practice. Figure 37 denotes the identified leaning by organisation, reinforces that safeguard is everyone's business!

Figure 37



Looking forward

The Wood Review published in March 2016 has recommended that the government discontinues Serious Case Reviews, and establishes an independent body to oversee a new national framework for inquiries into child deaths and case where children have experienced serious harm. The proposals require LSCBs to carry out and publish the lessons from local reviews to cascade learning.

The Board will await further guidance. In the interim the Board will continue to progress six ongoing Serious Case Reviews and three Learning Lesson Reviews; when completed the reports will be submitted to the Department for Education, to contribute to national learning and the findings will be published.

Part 4 – Analysis, conclusions, sufficiency statement and challenges

In determining the extent of progress made during 2015/16 the report responds to six key questions that benchmark the effectiveness of the Board's work to safeguard and promote the wellbeing of children and young people.

The five key questions are:

- What is it like to be a child growing up in Birmingham?
- Are children safer in the city?
- Are we making significant progress with our strategic objectives?
- Do we have sufficient assurance about the practice of all statutory partners?
- What impact is the Board having?

The conclusions are informed by the analysis of the outcomes of work undertaken during the year, the identified challenges ahead and how this shapes the priorities for 2016/17.

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

During 2015/16 the Board learnt a lot more about the life experience of children in the city. Building upon the findings of the Children's Commissioners Report, "It takes a City to raise a Child" and the Joint Strategic Needs Assessment, which collectively provided an overview of the issues impacting on children and young people's health and welfare.

The Board had data available to aid understanding of the demographic factors, as well as the social, environment, educational and aspirational ones that affected the Board's ability to promote the welfare of the children of the city and meet their needs.

The report of the Birmingham Child Poverty Commission, set up in the spring of 2015, recognised that not only does it take a city to raise a child, it takes a city prepared to work to lift families out of poverty, increase social mobility, prosperity and aspiration amongst the city's children and young people.

The Board supports the aspiration of Birmingham becoming a ***Family Friendly City***.

Challenge 1: That the BSCB is influential in making the aspiration to become a *Family Friendly City,* a reality.

Are children safer in the city?

The significant progress during the year driven by the Early Help and Safeguarding Partnership has made an impact on keeping children safer, earlier. The work of the MASH, whilst still not as robust as is needed helped focus activity, and develop a better shared understanding of need, risk and what good practice looks like. Partners have more confidence in getting a response from Social Care and Social Care more confident that what is brought to their attention are the appropriate concerns.

Referrals dropped by the end of the year, whilst early help support increased. Cases by year end were allocated by Children's Social Care within timescales and the tools for assessments as well as the child protection processes, using the "Strengthening Families" model of practice were revised, refreshed and clear. The use of the threshold guidance was and is more consistent, and professionals do know what standards are expected of them.

The child protection system was refreshed, the Strengthening Families approach reinforced, simplified and promoted, and the Independent Reviewing Service reviewed, reorganised and stabilised. This brought more challenge and less delay into the system. In addition the approach became more family focused and respectful, with more proportionate and SMARTER child protection and child in need plans.

Despite this it has still not gone far enough, fast enough. The degree of consistency remains a significant concern. There is still a long way to go before every child gets a consistent response and is safely cared for as a consequence. Timeliness remains a concern and whilst the most at risk got a swift response over the year, many others waited for assessments, and support, and help for too long.

Over the year the Board began to move from trying to solve our practice by reviewing systems and reorganising structures to focusing far more on whether the workforce had clear guidance, support and supervision, knew what

was expected of them, had the capacity to do it, in order to ensure practice was good enough. Every partner agency engaged with this, and every partner accepted that far more is needed.

The relationship between partners became more robust and transparent, enabling effective challenge of performance. This was particularly evident at the Executive Group which became more strategic and forward thinking, with a common purpose. This was a big improvement but it also needs to translate from strategic leadership to impact on front line practice.

Challenge 2: The challenge for the BSCB is to move from ensuring there are safe systems in place, to ensuring safe, consistent and sustainable multi-agency practice is in place at every stage of the child's journey to keep them safe.

Are we making sufficient progress with our strategic objectives?

In 2015 the Board reviewed and refreshed it's strategic plan, setting out key safeguarding priorities for next three years;

- The voice of the child – to ensure that everything we do is informed by children and young people's experiences, views, wishes and feelings.
- We provide early help – when problems first arise.
- We run safe systems – to ensure children are properly safeguarded.

At the end of the second year of implementation of the strategy significant progress had been made on addressing and delivering on these strategic objectives.

Although there is better understanding of the extent of consultation and engagement with children and young people, further work is required to provide the requisite assurance that the voice of the child is being heard loud and clear.

Work to drive forward the Early Help arrangements was good. The Board supported and contributed to the establishment of the Early Help and Safeguarding Partnership, and the development of the Early Help Strategy.

In the first two years the 'Safe Systems' work has focused on the continuing development of the MASH and embedding the 'Strengthening Families' model of child protection case conferences, in both areas there is incremental progress. The Board highlighted the need for a whole city and whole system approach to tackle domestic abuse and greater coordination and collaborative working between the key statutory partnerships that impact on children's lives in the city.

Challenge 3: That the BSCB endorses the multi-agency Domestic Abuse Strategy incorporating a whole city, whole system approach and receives a six month progress report detailing the impact on reducing risk for children living in violent households.

There is an opportunity to enhance partnership working, maximise finite public sector resources to deliver better outcomes for children by better strategic coordination and collaboration between the Health and Wellbeing Board, Adult Safeguarding Board, Community Safety Partnership, Early Help and Safeguarding Partnership and the Children's Safeguarding Board.

Challenge 4: The BSCB supports the Strategic Leaders Forum to review the strategic partnership arrangements which discharge the functions of Safeguarding Children and Adults, Community Safety and Health and Wellbeing, clarifying lines of accountability.

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

The Board has in this last year made significant improvements in its assurance systems, performance analysis and quality assurance activity. The annual assurance cycle has been operating for two years providing a far more robust scrutiny and challenge system for the Board.

The BSCB Executive Group took monthly reports on performance and the story behind the data improved through the year. This led to better informed debate and challenge in relation to the evaluation of the three year MASH development programme, as well as the effectiveness of the child protection system including planning and reviews.

Peer challenge events continued which enabled sharing of good practice and verification of organisation's self-assessment judgements, actions and impacts from the previous year's Section 11 audit findings.

Significant work has been undertaken with schools through Head Teachers and the DSL network in terms of safeguarding practice, by the end of the year schools were clearer about what was expected of them.

Progress on developing robust systems in relation to missing children from home, care, education and view was too slow, further work is required to embed the new arrangements for the dissemination of intelligence from return home interviews to support planning intervention to reduce risk.

Despite the prioritisation of CSE throughout the year, progress was slow and agreement about the best approach was not always reached strategically and operationally. In the more serious cases action was coordinated to safeguard victims and disrupt perpetrator activity. However, there was inconsistency in service delivery and practice in lower risk cases.

Challenge 5: The Police and Local Authority to jointly lead a review of the city's approach to Child Sexual Exploitation and missing children. That the findings are presented to the Board to inform development of CSE strategy and practice.

Overall the Board was far better informed about the quality of practice and about how well children and young people were safeguarded. Partners, as well as schools were able to demonstrate their own effectiveness and provide the Board with assurance, and the degree to which gaps and weaknesses were being addressed. However how well applied that understanding was by partners to the areas that needed addressed was variable, and in the case of CSE and missing, ineffective.

It is clear that there is still a big gap between knowing what is not working and doing something about it. At times and that the Board's influence is not as strong as it should be.

Challenge 6: The safeguarding system aims to manifestly become a learning system undertaking systemic audits, assurance work and sharing lessons from individual cases and themed reviews to support improvement and provide evidence for assurance.

What impact is the Board having?

Despite the difficulties set out above, the Board in 2015/16 was a significant and influential part of the improvement journey in Birmingham. The Board had clear impact on the development of Right Service, Right Time, and the work to improve child protection systems. A range of other systems and processes were also developed with support and challenge from the Board, not always proactively enough but always when challenge was needed.

It has also been influential in developing a coherent Early Help Strategy and helped establish the Early Help and Safeguarding Partnership.

Throughout the year the Board engaged the key educational stakeholders, Birmingham Education Partnership, the Local Authority Education Department, Head Teachers and Governors to work together to enhance safeguarding in education. The DSL network has become influential in highlighting weaknesses, and in supporting the roll out of both CSE awareness and Prevent work as well as FGM.

The Board have made a significant contribution to the ongoing development of the MASH, providing robust challenge and support through a monthly case audit programme and commissioning an independent review to inform the next phase of the improvement journey.

Lay Members provided the Independent Chair with feedback on the effectiveness of the Board arrangements. The Practitioners Forum was an important sounding board over the year and was influential in informing the development of a range of Board products. Although relatively small in numbers the forum was an important channel for communicating with the children's workforce.

The learning and workforce development activity undertaken by the Board was extensive and well received, delivering 203 training courses for 4,489 delegates. The successful roll out of 'Right Service, Right Time' threshold guidance was another significant achievement

during the year. However the dissemination of learning from Serous Case Reviews was less effective during this period due to delays in finalising a number of reviews. This did not prevent organisations acting quickly to implement action to address any early learning emerging from the review process. The value of doing the reviews was mitigated by the limitations in being able to apply the learning. The learning was so generic to the whole improvement journey itself that it was hard to distinguish when change was as a result of SCR findings and when it was from a broader programme of change.

The Board by the end of 2015/16 was driving forward a clear, strategic, managerial and operational programme based on its priorities. This was playing an important part in the overall improvement programme, was valued by partners and well supported by them.

Summary, Conclusions and sufficiency statement:

The Board in 2015/16 was maturing, developing and improving at a steadily increasing pace. There was an open debate about the best way to move forward as a Board in terms of an innovative approach to improving the Board's impact and effectiveness. This considered progress made and progress still to make. Partners saw the Board as an essential part of the checks and balances in the safeguarding system with key responsibilities for performance, quality, assurance and applied learning.

Clarity about the functions and responsibilities of the Board was matched with a focus on delivery, and on driving forward a model of partnership assurance based on high support, high challenge and outcomes focused activity.

The deep rooted endemic and engrained challenges faced in Birmingham had a negative influence on the degree the Board could fulfil all its roles, particularly with competing strategic drivers in the form of the Improvement Plans and the Commissioners.

The Board are able to provide substantial evidence of the co-ordination and effectiveness of partnership activity to safeguard and promote the wellbeing of children, young people and families in Birmingham.

We cannot as yet demonstrate that we meet the criteria for a good LSCB; we are still a long way from that. However we can demonstrate further progress over the year 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 and in person contributions to the audit and scrutiny activity.
- 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 influence in informing senior leaders, and our contribution to planning and commissioning activity.
- The provision of a good level of high quality training.
- The degree of cooperation with and support to the Early Help and Safeguarding Partnership (EHSP)
- The contribution to EHSP's first year's work programme.

Looking Ahead – Business and Improvement Plan 2016/17:

The findings of the Annual Report together with the six challenges have helped shape and inform the development of the safeguarding priorities set out in the Business and Improvement Plan for 2016/17, the final year of the current strategic plan.

Throughout the year ahead the Board will closely monitor progress on responding to the identified challenges and ensuring effective implementation of the Business and Improvement Plan. The major challenge for the Board looking forward is having the impact on practice that is needed to improve the quality of safeguarding and the degree to which children's welfare is promoted in Birmingham, making a real difference to children's lives by ensuring the 12 pledges in the BSCB's priorities are more than aspirational and become reality.

Business and Improvement Plan Priorities for the 2016/17 are:

The voice of the child – to ensure that everything we do is informed.by children and young people's experiences, views, wishes and feelings.

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

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 and 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.
4. Families are involved in solving their problems and developing their own solutions in every situation.

We run safe systems – to ensure children are properly safeguarded.

By 2017, we will know that:

1. The number of re-referrals and children made subject to a protection 4 plan for the second time are both reducing year on year.
2. Children and families are assessed and receive the right service at the right time, within relevant statutory timescales.
3. Where children are the subject of a family support or child protection plan the family can tells 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.
5. Whole city and whole system strategy to tackle Domestic Abuse.

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

Appendices:

The below appendices are available to read and download from the BSCB website.

1. Getting to Great – Strategic Plan 2015-17 and Business Improvement Plan 2015/16
2. Strategy for Early Help in Birmingham
3. Birmingham Child Death Overview Panel Annual Report 2015/16
4. Multi-Agency Child Sexual Exploitation Framework & Strategy 2015-17

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