ASSURANCE ACTIVITY

2016-2017

Lisa Burn
Quality and Governance Officer

1. Introduction

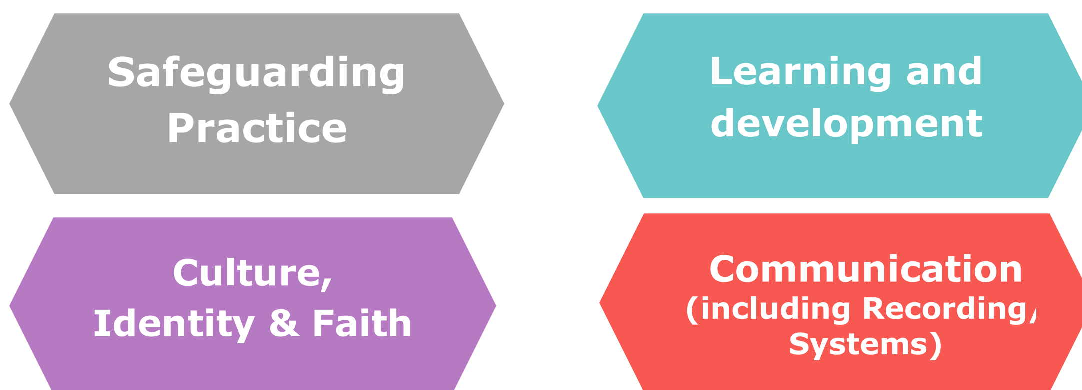
1.1 SSCB is committed to fulfilling the role of being a learning organisation and through its statutory functions and reviews, SSCB scrutinises and challenges local safeguarding arrangements and practice in order to improve services to safeguard and promote the welfare of children in Sandwell.

1.2 As such, one of the key functions of SSCB is to review the quality and impact of safeguarding practice across the wider partnership. Traditionally this is done by a series of quality audits on practice, undertaken on a multi-agency basis but the role of the board in quality assurance is much broader.

1.3 Our overall approach to Quality Assurance in Sandwell is to ensure openness, transparency and create a culture of continuous learning and challenge. This is underpinned by our commitment to establish a culture of cross - organisational learning by;

- Measuring outcomes utilising qualitative and quantitative data
- Undertaking S175 & S11 Audits
- Having a robust audit cycle with identified themes linked to the business plan priorities.
- Learning from both multi agency and single agency audits which includes measuring the impact of this learning
- Undertaking Serious Case, Management and Child Death Reviews
- Service User Feedback
- Workforce Engagement and Development
- Partnership Working

1.4 The following report encompasses analysis drawn from assurance activities undertaken during 2016-2017 along with findings from the Local Government Association (LGA) Peer Review & Audit Validation Exercise carried out in June 2016. The analysis has been collated and the findings organised into the following categories:



1.5 Using these categories, a number of proposed actions have been derived to inform the 2017-18 SSCB Business Plan

2. Safeguarding Practice

2.1 Throughout the 2016-2017 assurance activities, themes relating to safeguarding practice were highlighted. They have been split into the following sub categories:

2.1.1 Multi-agency response to Child Sexual Exploitation (CSE) & Missing Children

- An area the LGA peer review looked at specifically was how SSCB were responding to key safeguarding risk areas, the reviewers stated that SSCB has made a significant contribution to the work of the local authority and partners locally to ensure more consistent understanding and application of thresholds; improving engagement in early help, and in responding to CSE.

- This was supported in the September 2016 Ofsted Monitoring visit of Sandwell Children's services department as reviewers stated that work to address child sexual exploitation at a strategic level demonstrates that partner agencies are engaged positively and that there is appropriate collaboration with regional colleagues to work together, share intelligence, identify victims and pursue perpetrators in most cases.

- In addition to this there have been a number of quality assurance activities undertaken that were assessing operational safeguarding practice in relation to CSE.

- In the CSE & Missing Audit held in September 2016, the focus was to assess how effective interventions are for children who frequently go missing and are at risk of CSE. The audit found that for one child the worker had made the assumption that the child was being sexually exploited when this was not happening. Therefore, a key learning point was for all workers to understand the differences between CSE and Missing including how these cases should be worked on as sometimes children will be both missing and exploited but not always. To respond to this the CSE team will be producing some guidance for practitioners.

- The audit also recognised that for the 5 cases reviewed, MASE meetings were effective at pulling together agency information about a child, and that agencies were engaged in this process. This confirmed a finding in the June 2016 LGA peer review in which it was recognised that 'There is good partnership involvement in Multi Agency Sexual Exploitation (MASE) including identifying risk and responding in keeping children safe.' Additionally, this highlights a sustained improvement since the CSE assurance review (Sept 2015) where it was found that poor multi-agency

attendance at MASE means that partner agencies are not effectively contributing to risk assessment/ management and care planning.

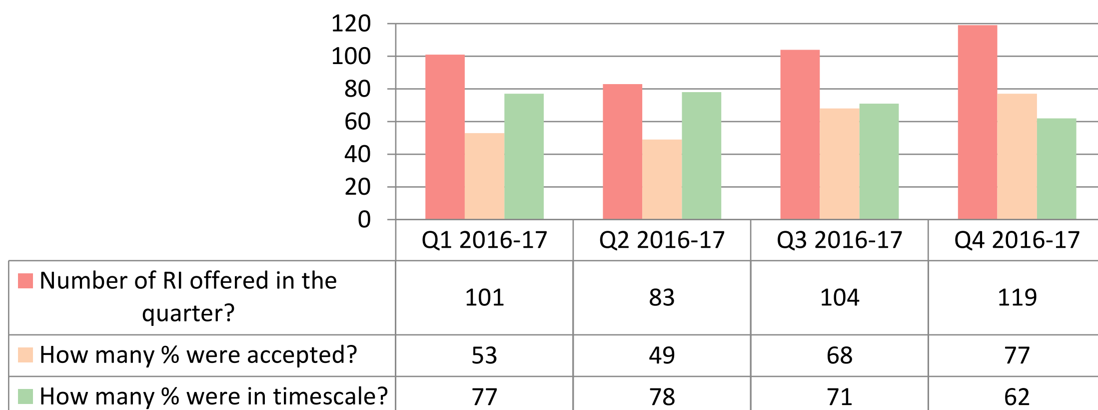
- The audit identified a need for better understanding of why children start to go missing and how we can better protect them not only at an individual worker level but also a strategic level. Therefore, an outcome for the SSCB Missing Operational Group was to ensure there is a multi-agency process for the identification and intervention is as early as possible for children who start to frequently go missing.

- Sustained improvement was also reflected in the Lessons learned review completed in November 2016 in relation to three young people. The review acknowledged that the SSCB YPSE subgroup had undergone significant changes and a shift from a discussion on a case-by-case basis to a more problem solving centered approach. However, the review recognised this has now become fully embedded and preventative links are being made by agencies represented

- Additionally, the review found that much progress had been achieved in carrying out return interviews and effectively sharing them with all partners. However, reviewers were less certain that a similarly effective procedure is in place for children accommodated out of the area and recommended that the positive arrangements in conducting high quality return interviews should be extended to Looked After Children resident outside the Borough.

- The progress made in respect of return interviews is mirrored in the SSCB dataset which evidences an increase in the return interviews being offered throughout the last two quarters of the year along with an increase in the number of return interviews accepted (see figure 1 below). However, this has had an impact on those completed within the 72-hour timescale as only 62% were completed in timescale in Q4 compared to 71% in Q3, 78% in Q2 and 77% in Q1.

Figure 1



	Q1 2016-17	Q2 2016-17	Q3 2016-17	Q4 2016-17
Number of RI offered in the quarter?	101	83	104	119
How many % were accepted?	53	49	68	77
How many % were in timescale?	77	78	71	62

- Support structures for missing children was also a theme within the SSCB Section 175/157 audit with schools during the 2015-2016 academic year (which spanned the 2016-2017 financial year). It highlighted that Schools were effectively engaging with the LA attendance team when pupils were going missing. Persistent absences are closely monitored and acted upon, letters sent out to parents or they are brought in to school for meetings. In some schools, they have an attendance officer employed within the school to undertake this role.

- An outcome of the Section 175/157 audit was that guidance was required for Schools on how they can develop their Personal, Social, Health and Economic (PSHE) curriculum to further encourage Safe relationships at different age groups as Primary schools recognised that more support is required to further incorporate areas such as CSE into the curriculum for key stage 1 (ages 5 – 7) and key stage 2 (7-11). In response to this a facilitated session will be included in the Designated Safeguarding Forum held by the MASH Education Officer.

2.1.2 Coordination of Services

- The effectiveness of coordination of services was a reoccurring theme across the assurance activity in 2016-2017

- Although the September 2016 CSE & Missing Audit found an improvement in agency attendance at MASE meetings, (mentioned above). A finding within the lesson's learned review was the requirement for challenge at MASE meetings in relation to the agreed actions from previous meetings.

- The lessons learned review spoke specifically about the instability in accommodation for young people, either as result of multiple placement moves, or from moving between the home environment and the care of the Local Authority and recommended 'The Director of CSC should over the course of the next planning year, consider a wider range of solutions (including out-sourcing) to alleviate the current shortage of placements for Looked After Children'

- This was echoed in the CSE & Missing Audit held in September 2016 as it was found that all needs of the child are considered with a robust plan about where they will live when they have a significant life change or become looked after.

- Key learning points around coordination of services were also highlighted in the November 2016 Domestic Abuse audit in particular referrals to services; additional support from a clinical psychologist and in two of the cases a referral of the perpetrator to a Domestic Violence Perpetrator programme as an action as part of interventions with the family. Therefore, the audit learning notes included a reminder to all practitioners to ensure both these points were considered during intervention.

- This was mirrored in the February 2017 Early Help and Lead Professional audit, found that agencies were engaging in early help and often were undertaking good work that fits within their service remit. However, it was highlighted in some cases there could have been greater multi-agency coordination which would have ensured that all of the child's needs are met.

- Additionally, in the February 2017 Table Top 2 review for one young person where it was found that it is crucial that a lead professional is identified when a number of agencies are involved with a child and that timely information transfer between schools at transition points is vital.

- However, it was identified in the 2016-2017 Section 175/157 that Schools have good communication and links with other relevant agencies and services.

2.1.3 Quality Assurance & Performance

- During 2016-2017 SSCB partner agencies were asked to submit their internal safeguarding audit schedules and the findings for the audits completed. As at the end of the year 10 of 13 agencies had responded with their audit schedules. However this information has not yet been used to inform other quality assurance work such as multi-agency audits.

- Looking forward to 2017-2018 a key focus area for Quality of Practice and Performance sub group will be to ensure there is a 100% response to the single agency audits which are robustly scrutinised along with ensuring that there is evidence by the partnership of implementing key learning from audits.

- Also during 2016-2017 SSCB partner agencies were asked to submit assurance on the recommendations from their Section 11 Scrutiny Panel held during 2015-2016 to evidence they were discharging their Statutory safeguarding function under Section 11 of the Children Act 2004. However, the responses were not as robust as the previous year therefore in April 2017 SSCB requested that each partner agency

refreshes their audit for 2017-2018 and provides a copy of their safeguarding action plan to SSCB. Following which a challenge day will be held in Autumn/Winter 2017

- Although there has been limited assurance received from partners in relation to the section 11 Assurance request, SSCB have been involved with the regionalisation of the Section 11 Audit which has been endorsed by SSCB and it is envisaged this will be launched in 2018-2019.

- To further improve quality across the partnership; Signs of Safety Child Protection Conferences were launched in Sandwell in July 2016. Children's Services are working to improve the standard of Child Protection Conferences so that good safe decisions are made about Children and young people and offer the right support to them and their families. This work has included developing practice standards, timeliness of Conferences, Outcome focused Child Protection Plans, Social Work Reports and service user feedback. To support this SSCB are offering Signs of Safety awareness courses to all partners within the Leaning and Development Catalogue so that the model is shared by all partners.

- Although there has been significant improvement work, the December 2016 & April 2017 Ofsted monitoring visits for Children's Social Care highlighted that although there have been improvements to quality assurance, the work is not yet making a sufficient difference to overall practice.

- This was also reflected in the Sandwell Joint Local area SEND inspection in January 2017 found that the timeliness, suitability and quality of statutory assessments is a significant weakness. In response to this, SSCB will be undertaking an audit during Q3 of 2017-2018 to identify if improvements have been made.

- Quality Assurance and Performance was also highlighted as a theme during the LGA peer review and it was acknowledged there is comprehensive and regular information within the SSCB dataset. However, although this performance data is a vast improvement from that previously provided to SSCB it was recognised both by the review and QPP that a more refined set of data was now required. This would enable improved analysis, monitoring and challenge to increase clarity and focus. In response to this the QPP group have revised the dataset to make the information reported to the SSCB more streamlined, and the new format was developed after liaising with Good/Outstanding LSCBs regarding the information within their datasets

Actions/Recommendations

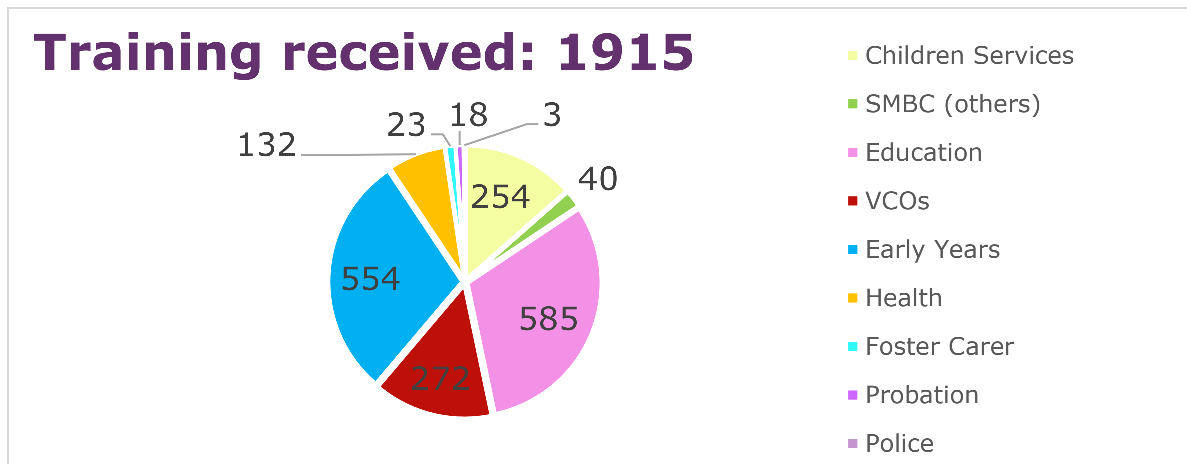
1. Repeat the external audit of CSE Assurance Review during the autumn/Winter of 2017 in order to ascertain the progress made since the Lessons Learned Review in September 2017
2. Ensure agencies are reminded of the need for effective Coordination of Services through increased promotion of audit findings
3. For there to be a robust scrutiny process for Partner's internal agency audits
4. Hold a peer Challenge day for S11 in Autumn 2017
5. To establish closer working relationship with the SHAPE Forum (as well as other forums to elicit the Child's voice/experience)

3. Learning and Development

3.1 SSCB offers a comprehensive multi-agency Learning and Development suite of training to all professionals working in all organisations involving children, young people and their families.

3.2 The training within the catalogue is well attended across the partnership with 1915 multi-agency staff receiving training in 2016-2017. Figure 2 provides a breakdown of training received by agency which clearly demonstrates that Education are the agency that utilise the most courses.

Figure 2



3.3 This was further reflected in the S175/157 audit responses as Schools had reported that appropriate Staff have completed CSE, Domestic Abuse & PREVENT training with the majority attending the courses offered by SSCB.

3.4 Although the training opportunities are regular and well attended, Learning and development was a recurring theme in the assurance activities, in particular, supplementing the courses already offered within the SSCB training catalogue to reflect the assurance findings;

- In the June 2016 Neglect audit it highlighted a need for practice to reflect the impact of Neglect on the child therefore a key finding 'For agencies to ensure that their processes and procedures outline the current risks strengths and safety and the impact for the child'
- A further training need was highlighted in the November 2016 audit for Domestic Abuse of to raise the importance of discussing with the adult victim how practitioners can better support the victim to protect themselves and their children

- During the September 2016 CSE & Missing audit it was recommended CSE training to be supplemented that to ensure missing is discussed as a wider vulnerability than in conjunction with CSE
- As Culture was a reoccurring theme across the multi-agency audits it was suggested that all SSCB training to have a focus on culture and identity and what that means for individual and their family

3.5 To enable a culture of continuous learning and challenge it is important that we measure the difference the training has made to practice. Therefore learning and development sub-group has made some progress to strengthen the impact evaluation process. In addition to the on the day evaluation, 100% of delegates have been contacted 3 months post-training to complete an online survey. Whilst the response rates have been limited they have nevertheless demonstrated that the learning offer is impacting front line practice.

3.6 Looking forward to 2017-2018 the learning and Development Sub group will be undertaking a comprehensive training needs analysis to inform the multi-agency safeguarding training programme and the sub-group has set up a Task & Finish group to focus on the impact evaluation of training courses.

3.7 In addition to the learning opportunities, a key component of the Board's Quality Assurance Framework is Workforce Engagement and Development. To proactively engage with the partnership's workforce a survey was launched on 3 April 2017 for the calendar year. It was specifically designed to proactively engage with staff who work directly with children in Sandwell, along with identifying if learning from Sandwell SCRs and audits is reaching front line practitioners and this has been embedded this into practice. Therefore, the survey has specific questions aiming to measure recommendations from audits following the learning notes being disseminated across the partnership. These questions relate to the following areas;

- If staff are undertaking the role of Lead Professional (**Early Help & Lead Professional Audit**)
- If staff are using eCaf to co-ordinate the services to children and inform themselves as to what other services are involved and what is being provided to families (**Early Help & Lead Professional Audit**)
- If plans and records reflect an understanding of culture, diversity and identity for the child and their family (**Neglect, CSE & Missing and Domestic Abuse audits**)
- If records have direct quotes (or behaviour observed if child is nonverbal) on the system from the child regarding their wishes and feelings (**Domestic Abuse audit**)

Actions/Recommendations

1. Further promotion of eCaf via SSCB website and training catalogue
2. For the Learning and Development to ensure the Impact of learning from Training courses is evaluated
3. For the Learning and Development to ensure the SSCB Catalogue is informed by a multi-agency training needs analysis
4. Analysis of the workforce survey to be undertaken to ascertain if key learning themes from audits have been implemented

4. Culture, Identity & Faith

4.1 Concerns about agencies understanding culture and identity were repeatedly referred to in multi-agency case audits and the lesson's learned review. It was highlighted within the multi-agency Audits undertaken during June - November (Neglect 13 June 2016 CSE & Missing on 23 September 2016 and Domestic Abuse on 14 November 2016) of the need for agencies to identify how they are ensuring staff within their organisation understand culture and identity rather than ethnicity. To respond to this theme, briefings took place for SSCB trainers to ensure the training has a focus on culture and identity and what that means for individual and their family. This change was implemented in June 2016 therefore it was too early for changes to be evidenced in the September & November audits and it is envisaged that improvements would be reflected in future audits.

4.2 This was echoed during the lessons learned report where the case of GS was reviewed again (previously an SCR in 2015) it was recognised that during her time of being looked after, there were few attempts to either identify her personal wishes or manage the case in a way, which was sensitive to her background and culture.

4.3 Additionally, it was recognised in the LGA Peer Review that the Board has commenced work to improve in some key service areas including Faith, Culture, Emerging Communities but it is also aware that these specific work remains underdeveloped as it was highlighted by Ofsted in 2015 Inspection. Therefore, the review recommended SSCB to increase the pace of progress with Faith, emerging communities and acting on the Voice of the Child.

4.4 Although understanding culture was a reoccurring theme during case review activity the SSCB Annual conference held on 5 July 2016 raised the awareness of the abhorrent cultural practice of female genital mutilation with a guest speaker sharing her own experience of FGM. This demonstrates that SSCB are

working towards addressing the improvements required in relation to culture, identity and faith, however it is appreciated there is more work to do.

Actions/Recommendations

1. All agencies within their Section 11 submissions to demonstrate their staff understand culture and identity and what that means for individual children and their family following the Multi-agency Audits in 2016
2. SSCB to ensure they have a grip of the ongoing operational Faith group activities to drive forward the work of engagement

5. Communication (including Recording / Systems)

5.1 Effective communication and recording was a recurring theme in the assurance activities

5.2 The LGA peer Review stated 'Despite the extensive improvement work of the SSCB it was not possible for the peer team to find a clear line between the SSCB and front line practice across all agencies'. To progress this action, following serious case reviews and multi-agency audits, learning notes are written and disseminated to agencies. The Board has been routinely disseminating learning across the partnership from SCRs and audit activity through its quarterly newsletters, coupled with a rolling programme of multiagency 'learning from SCRs' training.

5.3 Additionally, to bridge this gap further all multi-agency audits from September 2016 onwards are now completed with the case practitioners

5.4 It was highlighted in the Section 175/157 audit that Schools are sharing some of the SSCB information to staff through briefings and training however were reminded to utilise the full available resources such as SSCB Newsletters, Audit Findings and Sandwell SCR learning outcomes which all key learning for all agencies. The analysis of the 2017 workforce survey will evidence if this change has been implemented.

5.5 A further area in relation to communication was highlighted around private fostering, in 2016-2017 the SSCB dataset reported that there are only 6 cases of children known to the LA who are privately fostered, however the responses from the S175/157 audit were higher than that which suggests either referrals are not coming in to the Local Authority or perhaps more learning is required around what is a privately fostered arrangement and the process if schools are aware of such arrangement.

5.6 There was commonality across the assurance activities in respect of information recording with the Domestic Abuse Audit evidencing the need for agencies to routinely record information from MARAC on their respective data system and also found there was little evidence of any of the cases audited having direct quotes of how the children are feeling recorded on the system to evidence that agencies understand the child's views of their current circumstances, therefore following dissemination of the audit learning notes it was felt that asking the question in the workforce survey would ascertain if this is now happening across the partnership.

5.7 The Early Help & Lead Professional audit in February 2017 also highlighted a gap in information recording, primarily that the e-caf system is not routinely updated by all agencies to co-ordinate the services to children and inform themselves as to what other services are involved and what is being provided to families. Therefore, in response to this, further promotion of the e-caf system within the SSCB training catalogue and website is required

5.8 Information sharing was highlighted in the December 2016 and February 2017 Table Top reviews whereby it was found

- Records viewed from several agencies were unclear, incomplete and in some cases incorrect
- Multi-agency meetings are needed to ensure holistic support is offered.
- It is important to feed back to the referrer about outcomes of referral and assessment
- Timely information transfer between schools at transition points is vital

5.9 Furthermore, the review of child deaths during 2016-17 identified several modifiable factors which led to the launch/ continuation of several campaigns including

- the development of new of 'Dog, Duck and Cat' booklet containing all recent stories and additional story about safer sleep.
- Contribution to the launch of the Baby Box initiative. 1200 registration cards had been given out and as of January 2017, approx. 500 mothers have registered and completed the programme.

5.10 To enhance this work further the Child Death Overview Panel held a Development Day and delivered to over 60 frontline practitioners looking at modifiable factors, safer sleeping and suicide. Additionally, training was delivered on learning from child deaths to over 400 health and social care students at Sandwell College. This demonstrated SSCB working towards bridging the gap identified by the LGA review as stated in 5.1.

5.11 Looking forward to 2017-2018 CDOP will continue to respond in real time to the emerging issues raised through the collection and review of child death information through campaigns, briefings and dissemination of learning.

Actions/Recommendations

1. For SSCB to further evidence that learning from its own audits are influencing work on the multi-agency front line
2. For the findings of the workforce survey around embedding learning from audits to be used to inform the business plan