SHROPSHIRE SAFEGUARDING CHILDREN BOARD

ANNUAL REPORT

2015 - 2016

Shropshire Safeguarding Children Board annual report 2015- 2016 provides an account of the activities, development and impact of the Board and its partners in fulfilling their statutory responsibility of safeguarding and promoting the welfare of children and young people in Shropshire.

Sally Halls, Independent Chair
Lisa Charles, Acting SSCB Business Manager

September 2016

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2 FOREWORD

I am pleased to introduce this annual report for Shropshire Safeguarding Children Board.

At a national level, the year began with a revised version of the statutory guidance within which all Safeguarding Children Boards operate - 'Working together to safeguard children' - and concluded with the publication of the Wood review of LSCBs, which heralds significant changes in the safeguarding landscape for the future. These changes took place against a backdrop of rising demand, reducing resources, and pressures across the system for partners to do more with less. The implications of these are still being worked out, but have already resulted in and will continue to result in structural changes and altered working arrangements, which bring their own challenges and risks in terms of availability of and disruption to the continuity of services for children.

In Shropshire, the Board has continued to work whilst hard to progress its priorities and achieve consistently good services and outcomes for children, despite the challenge of a business unit which has been below capacity throughout the period. In an analysis of its own effectiveness, the Board recognises the need to strengthen its focus in a number of areas, and be able to demonstrate the impact of its work more clearly.

A major step forward has been the development of a student safeguarding board, which is coordinated through the county's FE colleges. It is early days as yet, but all are excited at the potential for this group to have a real impact on the work of the Board and provide a solid platform for ensuring that children's voices and concerns are heard and responded to.

There has continued to be considerable activity focused on coordinating and ensuring the effectiveness of arrangements to protect children who are at risk of already experiencing sexual exploitation, raising awareness amongst young people and communities across Shropshire, and engaging services such as licensing and taxi operators to assist in keeping children safe.

The Board has maintained its interest in ensuring that early help arrangements are comprehensive, good quality and available in a timely way to families who need them. This has included monitoring the effectiveness of COMPASS - the multi-agency 'front door' arrangements, and there is evidence that this continues to improve, with more consistent decision making and good engagement by a range of partners.

In response to work in previous years on 'compromised parenting', the Board has sharpened its focus on addressing domestic abuse and neglect, working with other partnerships to promote awareness amongst adult services of risks to children arising from the behaviour and problems of adults. Concern about the under identification of DA perpetrators, a lack of focus on repeat offenders, and the lack of availability of programmes available 'voluntary' to address abusive behaviour will all be areas where the Board expects to see improvement in the coming year.

A peer review undertaken by the LGA in June 2015 was helpful in highlighting areas for improvement within the council and across the SSCB partnership. These continue to be addressed, with improvements evident. This has included some reduction in the numbers of looked after children, and the continued development of successful 'edge of care' interventions.

SSCB has worked increasingly closely over the year with the other multi-agency partnerships in Shropshire which are concerned with the safety and wellbeing of children and families - the Health and Wellbeing Board, Safer Stronger Communities Partnership, Safeguarding Adults Board, and Children's Trust - to align priorities, work together on themes of common interest, and maximize capacity. A joint workshop on mental health was highly successful as a first step, and work will take place in the coming year on tackling domestic abuse. The coming year will see further activity to align the work of the boards, including

their back office functions. This work will be informed by the developing thinking nationally, regionally as well as locally to the Wood review.

Overall, the direction of travel within Shropshire is a positive one. Whilst audits, inspections and other quality assurance activity highlight areas for improvement, evidence suggests that the quality and consistency of early help and child protection work is improving, and there are some good examples of effective multi agency working. There is, therefore, much still to do. Within the report, the priorities on which the Safeguarding Children Board will concentrate during the coming year are set out.

What remains constant throughout all this activity and change, however, is the hard work, commitment and dedication of staff who work every day to support families, keep children safe and promote their well-being. I thank them all, on behalf of the Board, for everything they do to keep children safe in Shropshire.

Sally Halls

Independent Chair, SSCB

3 INTRODUCTION

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

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

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

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

This annual report for the SSCB covers the period between April 2015 and March 2016 and evaluates the work and impact of the Board whilst identifying future challenges and priority areas of work for the period 2016– 2017.

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

Chapter 4 sets some context and includes a strategic overview of safeguarding within Shropshire, including local demographics, implementation of the

Children and Young People's Plan, challenges for partners and information about the SSCB.

Chapter 5 focusses on the SSCB's priority areas of work and progress made against these during 2015-2016 set against the SSCB's strategic objectives.

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

Chapter 7 analyses the effectiveness of multi-agency safeguarding arrangements through SSCB's quality assurance processes and the external inspection provided by a Local Government Association Peer Review.

Chapter 8 details the ways in which SSCB engages with children and young people and the recent development of a Student LSCB.

Chapter 9 provides a conclusion and a look to the future of multi-agency safeguarding arrangements and what implications this may have for the SSCB and partner agencies in 2016-2017.

Appendix A is a summary of partner agency assurance reports that have been presented to SSCB throughout 2015-2016.

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

4 CONTEXT AND STRATEGIC OVERVIEW

4.1 CHILDREN IN SHROPSHIRE

Shropshire is one of England's most rural and sparsely populated counties with a large geographic area of 1,235 square miles. Situated in the West Midlands, bordering Wales to the west and Cheshire to the north, the area has a population of 310,100 (ONS, mid-year estimates 2014). Shropshire's population is largely of White British ethnic origin. The number of residents from minority ethnic groups is low; comprising 4.6% of the population (this includes white other, gypsy/traveler and Irish). 40.1% of Shropshire's population live in the main market towns of Shrewsbury, Oswestry, Whitchurch, Market Drayton, Ludlow and Bridgnorth. (Census 2011)

Shropshire has approximately 66,400 children and young people under the age of 19 years. This is 21.4% of the total population (ONS, mid-year estimates 2014). The proportion entitled to free school meals is 10%, which is below the national average but in line with similar local authority areas. Children and young people from minority ethnic groups account for approximately 6.1% of the 0-19 population, compared with the English average of 24.2%. (Census 2011). In January 2015, the number of children whose first language is not English was 1,040. This equates to 2.9% of the school population (figures exclude nursery aged children).

Shropshire has 153 state funded schools: 108 primary schools, 5 infant schools, 5 junior schools, one all through school, 7 secondary schools, and 2 special schools. These are local authority maintained schools. There are also 41 local authority maintained nurseries. There are 23 Academy Schools consisting of 10 primary, 13 secondary, 1 special and 1 free school.

According to the Income Deprivation Affecting Children Index 2015 [IDACI], Shropshire had approximately 12.8% of children (aged 0-15 years old) considered to be living in income deprived families, low compared to national

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

A particular characteristic of Shropshire is the large numbers of looked after children placed with private care providers by other local authorities. This number is rising steadily, and is now more than 700 on record, although the local authority is not always notified when young people move out of area. This has a significant impact on a number of local services, particularly health and mental health services.

4.2 IMPLEMENTING THE CHILDREN AND YOUNG PEOPLE'S PLAN

The vision of the Children's Trust, set out in Shropshire's Children, Young People and Families Plan, 2014, is that:

All children and young people will be happy, healthy, safe and reach their full potential, supported by their families, friends and the wider community.

The SSCB contributes to the fulfilment of that vision by working to hold its partner organisations to account, seeking always to improve the experience and outcomes for children and young people.

The Children's Trust Delivery Plan 2014-2015 achieved the following:

- Strengthening Families Launch in September 2015.
- Strengthening Families Through Early Help Partnership Group established March 2016. (Joining together Strengthening Families Partnership Group and Early Help Leadership Group)
- Identified key issues, potential risks and contingency options for taking forward Health Visitor commissioning arrangements with NHS England.
- Early Help strategy for 2015 – 2018 is being updated.

Further areas for development have been identified for the 2016 refresh of Children and Young People's Plan and these will be reported in the SSCB Annual report 2016-2017.

4.3 CHALLENGES FOR PARTNERS

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

Partner recognize the challenges they face and are working to respond. Many are restructuring their services. Despite the constraints, there remains a clear commitment to safeguarding children, and progress is continuing in the following areas:

- Developing a comprehensive approach to Early Help
- Strengthening Compass (the multi-agency 'front door')
- Gathering service user feedback, including hearing the voice of the child.
- Learning from audit activity, both single and multi-agency.

In this challenging climate, partners have worked hard to develop a range of effective early help services which can support children and their families at an earlier stage, reducing demand for the more specialist and expensive services. The Joint Strategic Needs Assessment continues to play an increasingly important role in assisting partnerships and local organisations to identify and

respond to need. The joint working of the Pentagon of Partnerships[1] is already beginning to make an impact and this is evidenced further in Chapter 6.8.

4.4 SHROPSHIRE'S SAFEGUARDING CHILDREN BOARD

SSCB is a multi-agency partnership that is jointly funded by its partners. The core budget for 2015-2016 was £283,768. A breakdown of this, showing contributors and expenditure is available on the SSCB website, together with further details about Shropshire's LSCB arrangements, including governance and accountability, membership and attendance.

The SSCB carries out much of its work through a number of subgroups and task and finish groups, supported by the SSCB Business Unit. Details of these are available on the SSCB website.

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

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

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

In 2015-2016 the SSCB strengthened its governance arrangements through the development of a Governance Group, made up of partners from the local authority, health, the Police and also including the SSCB Independent Chair and the SSCB Business Manager. The Governance Group considers the SSCB budget, risk register and any partnership wide issues that have been escalated for action by the Board.

5 PROGRESS ON SSCB PRIORITIES

The SSCB set out its intentions for 2015-2016 in a business plan which was published together with last year's annual report. The plan set out a number of areas of activity which were agreed following assessment of the effectiveness of the SSCB and its partners, consideration of information and evidence, and reflecting areas of weakness and challenge set out in last year's annual report. The SSCB Business Plan identifies four strategic objectives:

Strategic objective 1

Ensure quality safeguarding across agencies

Strategic objective 2

Assess the safety of all children

Strategic objective 3

Embed early help

Strategic objective 4

Identify children most at risk across all agencies

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

Within this framework, the Board determined three main priorities for action during the year:

- Neglect
- Domestic Abuse
- Missing children (including child sexual exploitation and trafficking)

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

5.1 Ensure quality safeguarding across agencies

Neglect

What we have done and why?

Findings from a Serious Case Review published in November 2015 indicated that where a child is seen to be at risk of neglect, professionals find it harder to assess the degree of risk, regardless of the impact on the child, because they do not consider that an injury would have been deliberately caused by the parent. The SCR also determined that in cases of neglect is there a tendency to assess risk from the parent's perspective and not to focus on the child's experience, meaning that neglectful parenting is tolerated.

SSCB has begun a review to strengthen Shropshire's response to neglect to make sure that it is fit for purpose. As part of this review consideration has be given to the Neglect Assessment tool, for use by practitioners across each level of need, including Early Help, Targeted Help and Specialist Help. Shropshire will adopt the Graded Care Profile as a practical tool to give an objective measure of the care of children to help identify and intervene in cases of child neglect.

Planning is underway for a multi-agency Neglect Conference in November 2016, where the Graded Care Profile and revised Neglect Strategy will be launched.

What we will do next:

- Launch the revised SSCB Neglect Strategy.
- Deliver Graded Care Profile training and embed this as the assessment tool for identifying neglect in Shropshire.
- SSCB will monitor the renewed response to neglect and report on progress in the 2016-2017 SSCB Annual Report.

5.2 Assess the safety of all children

Domestic Abuse

What we have done and why?

Performance data presented to SSCB in relation to the frequency that children are exposed to domestic abuse has shown an increase in repeat exposure of 3 or 5 incidents or more. This coupled with local MARAC data indicates that reported incidents of domestic abuse are increasing, although Shropshire figures remain low in comparison to national estimations.

SSCB has recently commissioned a multi-agency audit to take a deep dive into a case sample of repeat incidences of domestic abuse and to cross-reference these cases with those presented at MARAC and their status within the safeguarding system.

What we will do next:

- Disseminate and implement learning from the multi-agency audit.

Work with partners via the Pentagon of Partnerships to progress the following agreed actions in relation to Domestic Abuse:

- Community Safety Partnership to lead on review and refresh of the Domestic Abuse Strategy in early 2017, to include impact and support for children who witness domestic abuse.
- Domestic abuse to be the focus of a partnership workshop in March 2017.
- Ensure that the service specification of the 0-25 Emotional Health and Well-being Plan includes the need for therapeutic/support services for children affected by domestic abuse.
- Review the terms of reference of the Domestic Abuse Forum.
- Explore development of closer links between Compass and the Domestic Abuse Co-ordinator.
- Work with the Safer Stronger Communities Partnership to secure resources for a comprehensive Voluntary Perpetrator Programme to address perpetrator behaviour.

5.3 Identify children most at risk across all agencies

What we have done and why?

CSE

Children Services successfully recruited a CSE and Missing Operational Lead in June 2015 to act as the main point of contact for both front line staff and key agencies for consultation, information or support for any CSE or missing children concerns.

In November 2015 the CSE Panel moved into operational services within Children's Social Care to ensure that CSE becomes embedded in day to day safeguarding work.
SSCB has continued to raise awareness of CSE through multi-agency training and local campaigns such as Say Something if you See Something and Chelsea's Choice.

Chelsea's Choice, a nationally recognised CSE awareness raising theatre production was rolled out across all local authority maintained secondary schools and academies in Shropshire reaching an audience of over 8,000 students.

Evaluations were received from 448 pupils attending eight schools and some of their comments are below.

<table>
<tr><td colspan="4">1. How did watching Chelsea's Choice make you feel?</td></tr>
<tr><td>"Chelsea's Choice made me feel sad, angry, annoyed, frustrated and disappointed."</td><td colspan="2">"Angry – how a person who is vulnerable just falls into a trap and how a man can change her. The man (Gary) made me want to scream in his face, like why would you do that!?!"</td><td>"Horrified at what people can do to young adults/children without them realising and the manipulative power they have that change minds in an instant."</td></tr>
<tr><td colspan="4">2. Has it make you think differently or behave differently?</td></tr>
<tr><td>"It has made me more cautious of who I talk to on and offline"</td><td>"Yes I went on Facebook and deleted all the people that I didn't properly know or speak to."</td><td>"It changed the way I think about trusting people I don't know. Makes you more aware of the consequences of having sex too young."</td><td>"It made me more aware of signs and to my general self, and I've made sure that me and my girlfriend have a healthy relationship."</td></tr>
</table>

3. What would you do if your friend needed your help?		
"Talk them through it and tell someone about it to help them with their problem."	*"Tell Childline, teacher I wouldn't feel threatened by anyone who told me not to say."*	*"I would tell the school or the police if I needed to but first of all I would try and help them myself."*

4. Would you like to tell us anything else about Chelsea's Choice?			
"It was interesting to see that sometimes you don't need the internet to not be safe, because most people say only the internet is bad."	*"It made me cry since this has happened to my friend's friend in year 9"*	*"It was really good it showed how easy it is to get into bad things like in Chelsea's Choice."*	*"It affected me a lot because my mum got abused and shouted at and it reminded me of that. But it makes you aware of the things that could happen."*

Due to a number of repeat referrals in to CSE Panel SSCB commissioned a multi-agency audit to review the effectiveness of our response to CSE. The audit looked at 6 cases against criteria from the Ofsted Joint Targeted Ares Inspection. The findings were:

- very good interagency and multi-agency working;
- good use of supporting tools;
- good engagement with the young people, for example, one of the young people wrote an essay on exploitation for school and achieved their best mark.

A recommendation was made for NHS health services to review how they communicate CSE concerns in relation to individual cases to other parties for example CAMHS and GPs and the level of engagement needed from these agencies to safeguard the child.

Partner funding has been secured to build capacity around CSE and commission an independent review of the response to child sexual exploitation in the county. The purpose of the review is to inform SSCB on what more needs to be done to maximise strategic links and address any gaps in CSE service provision locally.

Young Solutions have recently been commissioned to roll out a programme to raise awareness of CSE within the commercial sector to embed the work of the local 'Say Something if You See Something' campaign which was launched in 2015.

Missing

Following HMIC's criticism of the 'unauthorised absence' category in relation to young people when missing West Mercia Police have reviewed the process and have agreed to remove the 'unauthorised absence' category from the Joint Missing Protocol. The 'absent' category has also been removed within West Mercia, whilst this is being reviewed nationally. As a result all children and young people who now go missing are classed as medium or high risk.

SSCB has identified that there continues to be an increase in the number of OLAC going missing. West Mercia Police have been reinforcing and reminding the care homes of the procedure when a young person goes missing. There also remains concern over the number of return interviews not completed for OLAC. The CSE and Missing Operational Lead within Children's Social Care is now tracking all missing notifications for OLAC and sending a letter to the placing

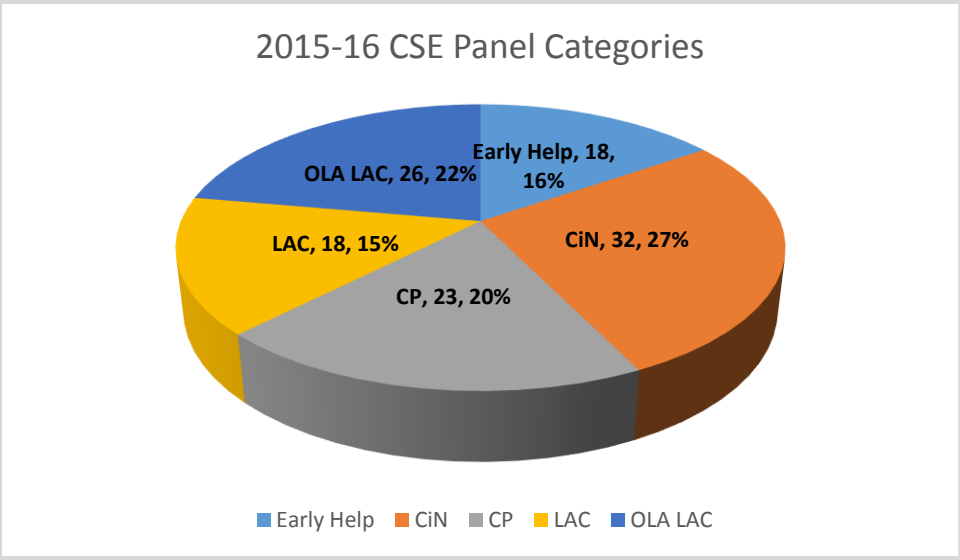
authority and IRO reminding them of their responsibilities in carrying out the return home interview.

e-Safety

Following the e-safety report presented to the SSCB in December 2015 the e-safety survey for young people has been revised to include questions on radicalisation for secondary aged pupils and FE students.

What difference have we made?

There has been a continued increase in the number of CSE referral received year on year. In 2015-2016 more risk identification tools have been completed by our private residential care providers as part of the revised OLA notification system. The increase in numbers more generally suggests that professionals



are more aware of CSE risk indicators and are more confident with the use of the risk identification tool.

During 2015-2016 117 cases were heard at CSE Panel. This comprised of 80 new referrals and 37 repeat referrals or reviews of cases.

The chart below sets out the categories of intervention as last recorded at CSE Panel. These may fluctuate following the case being closed to CSE Panel.

For details of the impact of Chelsea's Choice see Chapter 5.3.

Progress has been made in increasing the number of return home interviews that are being completed for Shropshire children, however completion within timescales still remains a challenge.

What we will do next:

The School's Safeguarding Group will give consideration to commissioning Chelsea's Choice in 2016-2017.
SSCB will monitor progress around information sharing and engagement within Health where there are CSE concerns for children.

Commission the review of key CSE documentation, to include the CSE strategy, pathway and dataset, following the outcome of the CSE independent review.
Establish a project steering group in conjunction with Young Solutions to further embed the Say Something if you See Something campaign.

Address the challenge of completion of return interviews for OLAC through proposals put forward by West Mercia Police and Shropshire Council.

5.4 Embed early help

Thresholds audit

What we did and why?

SSCB commissioned a multi-agency audit of the Thresholds document to review its effectiveness having being in operation for over 12 months. The audit involved a practitioner online survey as well as a deep dive case file audit.

What we learned:

- Almost all of those surveyed (80%) indicated they had access to the threshold document.
- Of those 45% had used the document.
- 35% had not made a safeguarding referral and so had not used the document;
- and a further 15% stated they had not used the document.
- More detailed and written feedback needed to be given to referrers, providing clarity on why the referral does not meet the threshold criteria and what further action can be carried out.
- Information sharing still seems to be a challenge for some agencies in understanding what information can and cannot be shared.
- It was noted that key agencies that hold information on children and families were not always asked for information as part of an assessment.

What we have done:

Letters are now sent to all referrers with an outcome clearly referencing the threshold criteria. This is being evidenced through single agency Children's Social Care audits.

Initiated a review the Thresholds document to ensure that it continues to be fit for purpose and incorporates multi-agency learning.

Audit of children subject of a 2nd or subsequent child protection plan

What we have done and why?

SSCB first audited children subject of a second or subsequent child protection plan in 2014 following an increasing trend being apparent through performance data. SSCB repeated this audited in 2015 as numbers of children subject of a second or subsequent child protection plan continued to rise.

What we have learned:

Following the first audit it was recognized that improvements had been made in the following areas:

- Good quorum at meetings.
- Clear evidence of decision making for a child protection plan using the Threshold guidance along with clear decision making for step-down from a child protection plan.
- Clear rationale and decision making for children to go onto a child protection plan for a second time.

Areas for improvement:

- Evidence of a continued lack of robust step down plans following removal from a child protection plan.
- Child Protection plans needed to be SMARTER.
- There were no clear plans to address non-engagement in service provision.

What difference have we made?

Since completion of the second audit and implementation of actions to address some of the findings SSCB is able to report that there has been a reduction in the number of children subject of a second or subsequent child protection plan.

What we will do next:

SSCB will continue to monitor the number of children subject of a second or subsequent child protection plan via quarterly performance reporting and will be seeking assurances of this improved performance from Children's Social Care.

6 OTHER ACTIVITIES AND FUNCTIONS OF SSCB

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

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

This section of the report refers to wider significant areas of safeguarding children in addition to the priority areas for 2015/16.

6.1 Developing policies and procedures

Shropshire commissions its safeguarding and child protection procedures jointly with the other three West Mercia LSCBs (Herefordshire, Telford and Wrekin, Worcestershire). They are updated regularly. There is work in progress to extend cooperation across the entire West Midlands area, and this will be taken forward in 2016-17.

The Joint Working Protocol (JWP) between Substance Misuse Services and Children's Social Care has been revised during this year ahead of the re-commissioning of the Community Substance Misuse Service.

Shropshire Council as the commissioner of services will monitor the delivery of this protocol and provide an assurance report to the SSCB. Understanding and application of the protocol will be tested through audit activity.

6.2 Safeguarding Disabled Children

A review of arrangements in safeguarding disabled children in Shropshire suggested the following:

- that work with groups of disabled children and young people on their perception, understanding, experience, and thoughts about safeguarding in Shropshire should take place, using the 0-25 Stakeholders group.
- A review of the effectiveness of Early Help in terms of the provision of help and support to disabled children and their families.
- 0-25 Stakeholders group to consider a review of how children and young people diagnosed with an autistic spectrum disorder are supported and protected.

In 2016-2017 the LSCB would expect:

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

6.3 Private fostering

Shropshire Council runs the private fostering service. The SSCB has not received a report on Private Fostering in 2015-2016. However, as previous performance has not been acceptable an assurance report will be commissioned in 2016 with the SSCB expecting to see improved performance and evidence of the voice of the child.

6.4 Case Reviews

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

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

In 2015-2016 SSCB published one SCR, one deep dive audit and initiated a learning review utilizing a Root Cause Analysis methodology. The learning from these reviews is summarized as follows:

6.4.1 SCR Findings and progress against actions:

Are strategy discussions in Shropshire seen as one-off events for social care and police to plan short-term responses rather than an ongoing process involving all agencies for planning and concluding a child protection investigation?

In Shropshire the records of telephone strategy discussions are separately recorded by Police and Children's Social Care meaning that there is no joint record of the decisions reached leading to the possibility of misunderstanding about their content.

- A single record of strategy discussions is now in place.
- Health are now invited to strategy discussions as standard.
- Non-attendees are recorded in the minutes.
- Review strategy requirements are incorporated as a specific question in the revised strategy meeting record.
- Outcomes of all S47 enquiries are fed back in writing to all agencies as part of the S47 CP process.

In Shropshire, where a child is seen to be at risk of neglect, professionals find it harder to assess the degree of risk, regardless of the impact on the child, because they do not consider that the injury would have been deliberately caused by the parent.

In cases of neglect is there a tendency to assess risk from the parent's perspective and not to focus on the child's experience, meaning that neglectful parenting is tolerated?

- A review of the SSCB Neglect Strategy is underway and due to be launched in November 2016.
- The Neglect Developing Practice training module has been reviewed.
- Learning and Improvement briefings in relation to the SCR and Neglect are scheduled to take place in June 2016.
- Early Help assessment tools have been further developed to promote experience and voice of the child.

Is there a pattern whereby members of core groups don't understand their responsibilities for ensuring the effectiveness of the child protection plan and delegate responsibility to the social worker?

- Core group guide has been developed to ensure that all members are aware of their responsibilities and the purpose of the meeting.

- Administration support is now provided for core groups to allow the social worker to focus on chairing, information gathering and reviewing progress of the plan.
- Attendance has improved on the SSCB Case Conference and Core Group training.
- Plans are in place for SSCB members to observe Child Protection Review Conferences to assess the effectiveness of core groups in progressing the child protection plan.

In Shropshire agencies are unclear about who to contact when there are urgent concerns on open cases and the allocated social worker is unavailable.

- Process of referring concerns on open cases has been clarified, strengthened and communicated to all agencies.

In Shropshire re-organisations of services by individual agencies are not planned in a multi-agency way, which means that there may be unintended consequences that can lead to confusion amongst partner agencies, resulting in poor accountability and decision making, which ultimately does not safeguard children.

- West Mercia Business Managers have developed a safeguarding impact assessment template which is being piloted by Shropshire, Telford and Wrekin and the Police. The aim is to ensure that partner agencies consider safeguarding implications when planning restructures or going through organisational change.
- Compass Operations guidance is now in place to support new multi-agency 'front door' arrangements.

6.4.2 Deep Dive Audit

One of the outcomes of the deep dive audit was to review the Children who Abuse Others procedures. Following a MAPPA discretionary SCR this process was already underway in a neighbouring LSCB. The learning from SSCB has been incorporated in this review and the launch of the new procedure will take place in 2016-2017.

6.4.3 Root Cause Analysis Learning Review

The Learning Review was initiated in February 2016 and outcomes will be reported in the SSCB Annual Report 2016-2017.

Overview of themes from Learning Reviews

The Learning and Improvement sub-group has recently worked on producing an overview of themes from all of its reviews over the past 3 years. The findings from each review have been mapped against the SCIE/NSPCC Learning into Practice project themes and will be analysed by the sub-group in order that performance and impact as a result of learning reviews can be measured across the system in a more cohesive way.

6.5 Multi-Agency Training

In total from April 2015 to March 2016 the SSCB has delivered 39 multi-agency Universal and Targeted training sessions to 735 learners. In addition 10 e-learning modules were offered to 1084 learners.

Training pool membership is valued and training is delivered to a consistently high standard which promotes the safeguarding of children and meets the individual learning styles. With the introduction of Standardised Observation Criteria which will promote peer observations further analysis will be possible and reported in 2016/2017

Multi-agency training is valuable in raising awareness of Early Help in Shropshire. Impact evaluations 3 months after training evidence that learners find the training methods applied are effective in increasing confidence, skills and knowledge when working within child protection and safeguarding, increased awareness and changes in practice are improving outcomes for children and families.

Evaluations have demonstrated that SSCB training is valued by the multi-agency learners that attend, the SSCB website and resources are used and referrals have been made into Early Help and Compass following the training which shows learners were able to identify child protection concerns and apply thresholds correctly to access the right services at the right time for children and families.

The SSCB Training Team are working hard to provide a flexible approach to delivering safeguarding training across numerous safeguarding themes, this has continued to develop in 2015-2016 with the introduction of a wider range of e-learning opportunities and taught sessions, including Female Genital Mutilation, Radicalisation, Children with Disabilities and Safeguarding Training for Taxi Drivers and Operators.

From January 2016 all drivers of licensed vehicles, Taxi, Private Hire, Hackney Carriages and Operators will have to attend Child Protection and Safeguarding training as a requirement of their Licensing Agreement. This training includes models of CSE and internal trafficking.

Areas for improvement:

- Increase in the number of completed post course evaluations.
- Post-course evaluation questions will be revised to ensure that it is clear that we want to hear about changes to practice, understanding of thresholds, and accessing services for children and families when they need help.

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

6.6 Child Death Overview Panel

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

In 2015-2016 there were 14 child deaths. This is the same as the average number over the previous five years.

As seen in previous years and nationally the largest numbers of child deaths were in the neonatal period and under 1 year. The CDOP Panel has introduced dedicated neonatal meetings twice a year where a neonatal consultant from SaTH attends the Panel.

In October 2015 a 'Safer Sleeping in Infants' talk was held with over 80 multi-agency practitioners in attendance.

6.7 Managing Allegations against Professionals

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

Working Together to Safeguard Children, 2015

The SSCB receives an annual report from the LADO which this year evidenced that the number of LADO contacts has yet again shown a considerable increase (56%) from the previous year.

The continuing rise in the rates of contact may be attributable to a number of factors.

- The accessibility of a dedicated full time LADO.

- The continuing increasing awareness of employers regarding the LADO process.
- The increased awareness of organisational safeguarding associations / governing bodies, who employers seek guidance from and who encourage referrals to be made.
- An increase in the number of reports being made regarding historical abuse.
- The greater ability of the police / CEOP to detect online abuse and inappropriate internet usage.

Since November 2015 all data is collated on a monthly basis to facilitate an understanding of emerging themes.

The majority of referrals relate to private care providers, with education settings being the second largest referral group. It seems that there has been an improvement in the number of referrals received regarding health colleagues, although referrals still remain low.

There has only been one referral from a faith group in this reporting year. This is an area which remains underrepresented. Referrals regarding social care colleagues are also low.

There has again been a significant rise in the number of police investigations which have taken place (88% on last year's figure). The introduction of the Compass team in Shropshire, has enabled timely and targeted information sharing to take place.

Outcomes

The majority of cases dealt with have an unsubstantiated outcome. Despite this, practice issues are often identified during the process of an investigation.

Eight referrals have been made to the DBS during 2015/16. However, there are an additional seven cases within this reporting period for which police investigations are ongoing and where there is the potential for criminal convictions and DBS referrals to be made.

The additional data collation now also indicates which cases result in dismissal and criminal convictions. This will be reported in 2016-2017.

Areas for improvement include:

Data Collation

Recording systems are being developed to ensure a greater ability to review and analyse the data being produced. Quarterly reports will be generated in order to respond more swiftly to themes emerging.

For 2016-2017 it is proposed that regular meetings will take place between the IRO manager and the LADO to consider key learning from individual cases and how this can be disseminated.

There is a significant issue regarding referrals which relate to serving police officers. There have been seven referrals relating directly to allegations against police personnel, however these cases have been difficult to progress due to difficulties in obtaining background employer information from the relevant department and a culture of dealing with complaints internally.

Private Providers

The number of referrals involving private care providers remains very high. Support from the LADO now needs to be focused on strengthening their confidence in managing matters internally that are conduct or practice issues.

Timescales

Information collated from November 2015 now evidences the timeframe for resolution on each case so that the timeliness can be scrutinised. Systems also need to be introduced in order to pursue organisations for progress reports / outcomes more regularly.

Regional LADO network

Further work needs to be undertaken within the West Midlands Regional LADO network to improve consistency between the different authority areas and assist in enabling LADOs to hold organisations to account. This is particularly important given that many organisations have employees based in a number of different authorities.

6.8 Participating in the planning of services

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

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

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

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

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

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

In November 2015 the Pentagon of Partnerships held a mental health conference which resulted in the following outcomes:

1. To develop rolling mental health needs assessment as part of the JSNA, to ensure the problem and the services available are well understood.

2. To promote the Shropshire Information Sharing Protocol (s); to ensure that all partners understand the legal basis and responsibilities for sharing information (and feel confident to do so)

3. To produce a joint piece of work between Public Health and Children's services to ensure that children of families, experiencing domestic abuse have access to appropriate support

4. Develop Dual Diagnosis – a) through the HWBB develop mental health commissioning arrangements that supports those with substance misuse issues b) through the HWBB develop commissioning practices that ensures both physical and mental health conditions are considered.

5. Through the Children's Trust, develop a working group with Strengthening Families and the Healthy Child Programme to develop 'think family' training.

6. To develop a Mental Health Partnership Working Group to take forward actions and activity to the Health and Wellbeing Board.

Progress against these outcomes will be reported in the SSCB Annual Report 2016-2017.

7 EFFECTIVENESS OF MULTI-AGENCY SAFEGUARDING ARRANGEMENTS

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

Audit

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

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

Oversight and Analysis

- Multi-agency audit;
- Deep dive;
- Audit is undertaken by relevant Quality Assurance & Performance subgroup members and frontline practitioners, file audits per term (September – December, January – April, May– July).

Practice

- This involves evaluating how effectively services are embedding safeguarding practices and integrated working into the delivery of safeguarding children;
- Outcome focused;
- Frequency and numbers of audit: 10 files in September – December, 10 files in January – April, 10 files May– July.

Compliance

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

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

Performance information is included that reflects:

- SSCB's priorities for 2015 – 2018;
- The Children's Safeguarding Performance Information Framework (DfE, 2012);

- Framework for the inspection of local authority arrangements for the protection of children (Ofsted, 2012/13);
- Proposals from the West Midlands Improvement and Efficiency Board;
- Partnership working activity.

Section 11 audit

Agencies are requested to complete the Section 11 audit on an annual basis with the most recent submission of Section 11 audits being reported to the SSCB in March 2015.

Thirty-two agencies were asked to complete the Section 11 audit and 23 (72%) were returned. The majority of returns included self-assessed grades, and most of these grades were 'good'. A few were 'outstanding' or 'Requires Improvement'.

Areas of good practice included:

- The majority of agencies confirmed that children and families are actively involved in the design, development and delivery of services; and different methods of communication are available to children to express their views.
- All those commissioning services confirmed that they are compliant with Section 11 standards and these are monitored through contract monitoring arrangements.
- Engaging children and young people and their families see Chapter 8.
- Learning from (and acting upon) quality assurance activity.
- Proactive approaches to tackling Child Sexual Exploitation.
- All but two agencies confirmed that they have a clear policy on information sharing.

Areas for improvement were identified as:

- A need for five agencies to develop child friendly complaints information.
- A small number of agencies do not undertake any auditing activity where information sharing is considered.
- Awareness raising of safeguarding responsibilities of partners in universal, non-statutory services.
- Learning from, and acting upon the findings from quality assurance activity.
- Evidencing impact on children and young people of safeguarding activity and / or training
- Lack of agency actions identified and little attention given to previously identified actions.
- Outstanding grades were difficult to justify from the evidence provided.

Proposals for quality assurance of S11 audits

SSCB will seek to improve the consistent quality of future Section 11 audits by:

- Improving the return rate of completed audits.
- Strengthening the guidance so that it reads as a set of standards for a good quality s11 audit
- Redesigning the template to include an evidence section for each criterion
- Including best practice evidence examples in the guidance.
- Populating the template with previously identified actions and expecting a specific update of progress and impact.
- Developing a model of quality assurance and peer review assessment of evidence.

Through these developments the SSCB has recognised the need to build capacity to quality assure the audit returns with more rigour. The Board has agreed to commission an online auditing tool to facilitate the ease of completion and analysis of the Section 11 audits, freeing up capacity to focus

on quality assurance. The audit tool itself will be revised so that it is consistent with the approach of other LSCBs in the West Mercia region to provide comparative analysis and potential regional themes and to aid those partner agencies that span more than one LSCB. The next Section 11 audit will take place in autumn 2016.

Quality Assurance and Performance Dashboard

The Quality Assurance and Performance Dashboard continues to enable the LSCB to be sighted on the performance information by exception with regular reporting of a core dataset and themed performance information. Interrogation of the data allows the LSCB to identify points in the system that may require improvement or further exploration and often leads to the commissioning of assurance reports, single or multi-agency audits.

The dashboard has recently needed further work so that assurances can be provided to the SSCB on the effectiveness of safeguarding arrangements.

Information provided through this means about the Child's Journey through the system includes the following (N.B. All England comparisons for 2015 in green, rates per 10k in brackets):

- 545 Early Help Assessments were completed, compared with 577 the previous year (this has dropped slightly because of the introduction of the Webstar assessment)
- As of end of March 2016, 826 children were being supported at a targeted Early Help level
- 1848 referrals were received by Children's Social Care (311.6) (548.3) 11.2% resulted in no further action (13.8%)
- 60.6% single assessments were completed within 45 days 81.5%
- The rate of 'Section 47' child protection investigations has increased from 83.5 in 2014-2015 to 107.9 per 10,000 in 2015/16 (138.2)
- 88% of initial child protection conferences were held within 15 working days (74.4%)
- 267 children were subject of a child protection plan at end March 16, (45), (42.9)
- 1.5% of child protection plans lasted for 2 years or more at end March 16 (2.3%)
- 4.5% of children were subject of a child protection plan for a second or subsequent time within 2 years – a decrease on the previous year's figure of 10%
- There were 283 looked after children a decrease of 8.7% on the previous year's figure (47.7), (52)
- 44 per 10,000 offences against children were reported – a rise from 34.5 per 10,000 the previous year.
- 80 new CSE referrals and 37 repeat referrals or reviews of cases heard at CSE Panel.
- 32 children missing from home or care as of end of March 2016. There has been a decrease in children missing from home and care compared to 2015.
- 42 children had been exposed to domestic abuse 3+ times and 9 children exposed to domestic abuse 5+ times as of end of March 2016.

LGA Peer Review

An LGA Peer Review of safeguarding in Shropshire was undertaken in June 2015.

The review focused on five key themes:

- Effective practice, service delivery and the voice of the child
- Outcomes, impact and performance management
- Working together (including Health and Wellbeing Board)
- Capacity and managing resources
- Vision, strategy and leadership

Overall, there were many positive observations about safeguarding and particularly partnership working.

The Peer Assessors made particular mention of the commitment, passion and loyalty of staff and partners, and recognised that this made a strong foundation upon which to build further innovations, improvements and developments. Importantly, they saw a clear commitment to shared responsibility and multi-agency approach to safeguarding.

The reviewers were impressed with the CSE Panel and saw it as good practice in relation to working with partner agencies. Positive feedback was received across the partnership and the children's workforce.

"The SSCB is well regarded and is going in the right direction; we heard of good examples of challenge in terms of accountability, performance and the direction of travel; sub groups were in general well attended and focussed. The improvements in performance management systems that we suggest elsewhere would be of benefit to the SSCB in enabling it to have greater oversight of key indices and a sound basis for challenge and ensuring increased accountability for performance."

The Peer Review also identified the following areas for development:

- Getting the 'front door' working efficiently
- Cultural awareness is under-developed
- Build on the strength of the Compass brand
- SSCB should have systems in place to check improvement initiatives are getting through to the front line, in terms of both understanding and effective implementation
- Ensure agencies achieve Working Together compliance i.e. attendance at strategy meetings
- Further dissemination of the threshold document
- CSE data to be routinely included in management information reports
- SSCB should satisfy itself that CSE training has achieved the required reach in GP and frontline police areas

Shropshire Council has developed an action plan to address identified areas for improvement for Children's Social Care and has established an Internal Improvement Board to oversee its implementation and effectiveness. SSCB has also developed a Partnership Action Plan in response to the Peer Review.

Agency Assurance reports

Partner agencies are required to produce an annual assurance report to the SSCB to evidence compliance, inform the SSCB of any learning from inspections, case reviews and audits and report on how outcomes have improved for children and young people. An Assurance Reporting template has been developed in 2015-2016 to facilitate reporting on the things that matter and how outcomes for children have improved. This allows the SSCB to challenge the arrangements, identify areas for improvement, monitor that work and then seek further assurance about sustained change.

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

Challenge log

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

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

The Safer Stronger Communities Partnership has reported that as the lead partnership for PREVENT it has delivered WRAP 3 training to all schools and

colleges and a further 23 professionals have been trained to deliver in their own organisations.

The Safer Stronger Communities Partnership has assured the Board of the support available for young people who are at risk of being radicalised through the Channel Panel arrangements and sighted the Board on necessary information in order to keep children safe.

NHS England has responded to a challenge from the SSCB regarding access to Tier 4 beds in Shropshire. NHS England feels that the local CAMHS Transformation Plan will reduce the need for Tier 4 beds, however have not stated how they propose to tackle this national issue. This challenge has been escalated to NHS England via the Shropshire Health and Well-being Board on behalf of the Pentagon of Partnerships as this is a cross-cutting concern.

Shropshire Council have responded to a challenge with regards to the evolution of Compass in that multi-agency engagement will continue to develop with Police joining Compass in early 2016. Health visitor engagement is also progressing.

There have also been improvements in the engagement of Police and Health representatives in strategy meetings and discussions.

Children's Social Care is ensuring that there is connectivity between Compass and the Channel Panel where children are at risk of radicalisation.

The Clinical Commissioning Group responded to issues identified with GP practice in relation to SCR on children A & B. The CCG has communicated to all GP Practices information regarding the taking of photographs for clinical diagnostic reasons and the requirements under the Data Protection Act. Procedures have been put in place to ensure that GPs follow up referral to hospital to ensure that the child has attended.

GP Practices have been reminded of the need to ensure that referrals are made to Compass where there are safeguarding concerns, ensuring that information sharing is necessary and proportionate.

The CCG have also reminded GP Practices of the importance of their involvement in the learning review process.

Shropshire Council Early Years and Childcare Service has considered the Early Years Strategic Inquiry The overall quality of Early Years provision in Shropshire, as judged by Ofsted, remains good compared to local, national and statistical neighbours. The Early Years' service is also committed to carrying out safeguarding reviews with all of the settings on an annual basis which has a positive impact on the overall quality of safeguarding provision within the Early Years settings.

Shropshire Council has been challenged by the SSCB around the poor rate of return interviews for looked after children placed within Shropshire by other local authorities. The LSCB is aware that this group is over represented in the statistics of children missing. Although the responsibility for commissioning return interviews for these children lies with the placing authority, given the numbers of such children placed in Shropshire (more than 400) and their particular vulnerability, together with the need for Shropshire to ensure that it is doing everything it can to ensure the safety of children resident within the area, as well as understand fully any risks there may be the SSCB has asked that this is considered further by the local authority, the Police and the Private Provider's forum. This is being taken forward during 2016-17.

8 ENGAGEMENT OF CHILDREN AND YOUNG PEOPLE

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

8.1 Health Champions

Through the Young Health Champions programme, established in August 2013, Shropshire CCG has trained and supported young people in the County to understand their own health needs, and to help them to make positive choices about their health and wellbeing as well as offering opportunity to work directly with the organisations that provide their health and care services. This has supported the 'rights of the child' to not only to be heard but to be genuinely involved in the co-creation and development of services and have a say in decisions that affect them such as the NHS 'Call to Action' and 'Future Fit' work.

Young people involved in the programme have benefitted as individuals, developing their personal skills, increasing levels of confidence and self-esteem with an infrastructure to ensure young people taking part are safe, happy and achieving their potential.

The Young Health Champions have, in turn, helped the NHS, local authority and all Shropshire people by gifting their time to identify areas of need and generate projects that bring about solutions. Examples of this are an educational video for schools about the needs of young people with diabetes type 1, a helpline set up to provide support for young people with anxiety disorder and a powerful film documenting the experiences of one young person in a clinical environment.

8.2 Section 11 Audits – Hearing the Voice of the Child

Four statutory partners, CAFCASS, the Police, RJAH and SaTH, and one private provider, Branas Isaf, evidenced good and innovative practice in hearing the voice of the child in their Section 11 Audit submissions. Some examples of this are highlighted below:

8.3 CAFCASS

- CAFCASS reviewed the tools used to engage children and young people to ensure that they are effective from the child's perspective.
- The views of children and families are sought to inform case plans and these plans are shared with them where it is safe to do so.
- Cafcass has a *"My Needs, Wishes and Feelings"* Pack which Cafcass workers can use to help a young person share their feelings directly with the court, should they wish to.
- Cafcass has signed a charter with the Family Justice Young People's Board which includes a commitment that all children, who are involved in a case where a report has been ordered and who are of an age and understanding, will be given the opportunity to directly submit his/her wishes and feelings to the court, in written or picture form.

8.4 West Mercia Police

- Police Community Support Officers and engage with children and young people and schools across the community. They provide E-Safety, Drugs Awareness and law input through organising Crucial Crew events and engaging with the Princes Trust and Learning Disabilities Groups. All of these engagements are opportunities to receive back valuable opinion from children & young people on the service provided.
- West Mercia took part in the National Initiative: 'Takeover Day' in November 2015. It puts children and young people into decision-making positions and encourages organisations and businesses to hear their views. Children gain an insight into the adult world and organisations benefit from a fresh perspective about their work. This day was a success and involving 400 to 500 children.

- A dedicated person has been appointed to take on the responsibility in developing an appropriate means of youth engagement with those who are difficult to engage.
- The Cadet Programme provides diversity / equal opportunities training which includes input on safeguarding and domestic abuse, and as well as providing the young people with skills and knowledge around Policing, it also enables West Mercia Police to hear the voice of the child within the community.
- In 2014 a survey of 5000 young people in secondary schools was commissioned by the Alliance to improve engagement. This identified additional ways young people would like to receive communication.

8.5 Robert Jones Agnes Hunt Hospital

- Shropshire Young Health champions assisted with the interviews for a Hospital Play Specialist

8.6 Shrewsbury and Telford Hospital

- The children's ward has "tops & pants" complaints / feedback system for children - if a child thinks something is 'pants', they write it on the pants and if it's tops, they write it on the tops – they are then put on a washing line so others can see.
- Children and Young people have been actively involved in designing the new paediatric build at Princess Royal Hospital. Public discussion and follow up with children and young people has been part of the reconfiguration process.
- Wards ask for feedback from children as well as parents. Children's young champions are used to influence learning from complaints and experiences of children on wards.

8.7 Branas Isaf

- Send out annual questionnaires to young people, families, and placing authorities asking for feedback on the quality of care.
- Hold monthly young person's meetings, at which the residents are asked for suggestions on how to improve the care offered.
- There are also regular Young Person's Forums which involve children from all homes within the Branas Isaf group. All young people are sent a copy of the "Branas Bugle", the magazine produced after each young person's forum.

Evidence of effectiveness from an independent visitor in respect of a young person's meeting:

> *"I must comment on how the minutes evidence excellent consultation with young people, and demonstrate how they can, and indeed do, influence the running of the home".*

8.8 SSCB e-safety survey

The SSCB annual e-safety survey enabled the gathering of valuable information from children and young people regarding how safe they feel when using online technologies and assessed their understanding of online risks.

What makes students/pupils feel safe/unsafe when using the internet:

Reported impact of Cyberbullying:

8.9 Children's Social Care

There continues to be a high level of participation by young people in their reviews.

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

Case file audits highlight good levels of engagement with children and young people and their views are used to inform assessments and decision making. However, the Advocacy Annual Report 2015-2016 demonstrates insufficient take up and poor completion of consultation documents.

8.10 Student LSCB

The SSCB has recently established a Student LSCB which comprises of 10 members from the various further education colleges in Shropshire.

Its purpose is to provide a mechanism for the voice of children and young people to be heard by SSCB. This includes evaluation of the work of the Board as well as having an influence on decision making.

The group have agreed that the most important safeguarding related topics for them to focus on in 2016-17 are:

1. Mental Health (especially related to bullying and how problems in this area are treated in schools)
2. Sex Education (especially related to sexting and sexual abuse)
3. Emotional Abuse

9 CONCLUSION AND LOOKING FORWARD

Evidence suggests that Shropshire agencies are generally effective in keeping children safe across Shropshire, and that more children and families are receiving help at an earlier stage. We have seen a significant reduction in the number of referrals to Children's Social Care as a result of ensuring that children and families receive early help to meet their needs. Overall, however, there is a slight increase in children within the child protection system. Numbers of looked after children have reduced with the development of effective edge of care services. Further development of effective early help services should assist with keeping children safe and improving their wellbeing without recourse to child protection and looked after processes.

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

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

Progress has also been made in working towards the improvements identified from the Peer Review with 100% of the actions being progressed within timescale and the majority near completion.

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

Performance measurement has demonstrated improvements in practice as a result of multi-agency audits and learning. Once the Learning and Improvement Framework is fully embedded the SSCB will be able to evidence impact more effectively.

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

Developing a consistent approach to hearing the voice of children and young people, parents/carers and professionals is an area for development in 2016-2017. Good foundations have been put in place with the development of a Student LSCB and in order to deliver effective safeguarding measures SSCB needs to continue to use this feedback effectively to influence service delivery and provide challenge to partners.

The quality assurance processes of the Board need to be strengthened to allow service user feedback to be coupled with robust data analysis and audit findings. This will provide robust evidence of impact regarding the effectiveness of safeguarding systems and practice in Shropshire. Quality assurance reporting aligned to the journey of the child will build on SSCB's revised performance framework to ensure that SSCB is able to evidence that children and young people receive the right service at the right time.

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

The SSCB has long maintained a focus on looked after children placed within Shropshire from elsewhere. New challenges associated with CSE, FGM and the PREVENT agenda demand that this is further developed. Much work has been done between the Police and the Local Authority with the Private Care Providers and placing authorities which has resulted in improved practice and reduced safeguarding concerns for this population of young people.

Within Shropshire, SSCB is developing collaborative working with a number of statutory and non-statutory partnerships, influencing priorities and commissioning, and identifying common purpose, cross-cutting themes and ways in which the partnerships can 'add value' and improve outcomes for children and families. Areas of joint working include the development of the 'Think Family' approach and tackling the 'hidden harm' of domestic abuse and substance misuse.

At a more strategic level, the Board will need to respond to a number of challenges during the coming year, including those arising from the Wood review of LSCBs and the Government's response.

In addition, the SSCB Business Unit has been working with reduced capacity for much of 2015-2016 and as such has commissioned a number of pieces of work to ensure that it still meets its strategic objectives. A review of the SSCB Business Unit will be commissioned in 2016, alongside a review of the Adults Safeguarding Board Business Unit to explore different models of working.

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

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

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

In relation to CSE, SSCB has recently commissioned a review of Shropshire's strategic response in order to establish the next stages in embedding and mainstreaming activity. Funding has been secured from partner agencies in order to build upon the foundations of this work in 2016-2017.

In bringing together progress against evidencing impact and areas of risk the SSCB has reviewed its activities and identified the need to have fewer, more focused, priorities. This will ensure that resources can be more effectively targeted at embedding learning and evidencing impact. The following priorities for 2016-2017 have been agreed:

- Neglect
- Domestic Abuse
- Child Sexual Exploitation and Missing

These are reflected in the SSCB Strategic Plan for 2015-2018 and will be reported on in the 2016-17 annual report.

Appendix A: A summary of agency assurance reports

The Health Economy

Shropshire's Health economy comprises of Shropshire Clinical Commissioning Group, (CCG), Shropshire Community NHS Trust, Shrewsbury and Telford Hospitals Trust (SaTH), Robert Jones and Agnes Hunt Orthopedic Hospital (RJAH), Children's and Adolescent Mental Health Services (CAMHS) and South Staffordshire and Shropshire Foundation Trust.

During the last 12 months the CCG has been granted full delegated responsibility by NHS England for some primary care services which includes the 44 GP practices in Shropshire. The CCG also commissions and monitors the quality and care of children's services.

Looked After Children (LAC) Health Assessments

In 2015 the CCG led on a review of the commissioning arrangements for LAC health assessments. As a result a plan has been developed to improve the configuration of arrangements for the completion of Looked After Children health assessments and the role of the Designated LAC Nurse. The future model is designed to improve the implementation of care plans following health assessments and improve equity within the service.

The Shropshire CAMHS Transformation Plan

Shropshire has recently started work to transform mental health services for children and young people with the support of funding from NHS England. This funding will be used to deliver the Shropshire, Telford and Wrekin CAMHS Transformation Plan for Children and Young People's Mental Health and Wellbeing.

The Transformation Plan consists of six programmes of improvement and one cross-cutting programme as follows:

- 0-25 Emotional Health and Wellbeing Service
- Redesign of Neurodevelopmental Pathways
- Development programme for workers in universal services
- Eating Disorder Services
- All age Psychiatric Liaison Service
- Improve Perinatal support
- Needs Analysis, Engagement and Transition

Some of the outcomes expected are:

- Improvement in children and young people's emotional resilience and emotional health
- Reduction in hospital admissions for self-harm and mental health related crisis
- Reduction in number of children/young people requiring repeated access to targeted and specialist support
- Improved access into and transition between services
- Improved understanding of the mental health needs and views of children and young people.
- Improvement in skills of professionals in order to better manage the emotional health of children and young people within universal settings

Health Visiting

The CCG report for 2014-2015 highlighted potential challenges given that both School Nursing and Health Visiting have transferred into Public Health. Good

communication channels have been established between Public Health and the CCG with CCG involvement in reviews for the 0-16 pathway development.

General Practitioners

In Shropshire 18 of the 44 GP practices have been reviewed by CQC in 2015-16. The overall findings are outstanding for 5 practices, good for 12 practices in safeguarding, and requiring improvement in 1 practice.

Robert Jones and Agnes Hunt Hospital

Robert Jones and Agnes Hunt Hospital had a CQC inspection in October 2015. The outcome was that some improvements were needed.

SaTH

Shrewsbury and Telford NHS Trust was given an 'outstanding' rating by the CQC in their recent inspection for the Trust Safeguarding Procedures and Policies. The Trust was also deemed to have excellent liaison by having both an on-site Independent Domestic Violence Advisor (IDVA) and a Health visitor co-ordinator on site who liaises with Accident & Emergency and the Children's Ward for health visiting services and schools.

Areas for improvement include:

- Effective information sharing and engagement with child protection processes across the health system (Shropshire is engaged with piloting the Child Protection Information Sharing project. This is expected to improve communication between NHS organisations and the local authority, resulting in improved protection for children).
- For providers of health care to increase the level of safeguarding audits undertaken and share with SSCB.
- For Health Visiting and/or School Nursing to be located within Compass.
- Improvements in access to and impact of CAMHS.
- Health (including mental health) provision for looked after children placed in Shropshire from elsewhere

Public Protection

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

West Mercia Police

By 2014/15 demand in respect of reported crimes with both a Child Victim and a 'Child at Risk' Interest Marker rose by an average of 132%. Due to this increased demand additional resources have subsequently been added to Protecting Vulnerable People (PVP) departments to balance resources with current demand.

In response to the HMIC PEEL Vulnerability Inspection in 2015, work is ongoing to up-skill staff around multi- agency safeguarding / assessment of vulnerability and risk. A bespoke training programme is being designed for delivery to all staff responding to threat risk and harm, encouraging them to demonstrate professional curiosity, and do the right thing at all times.

West Mercia Police have improved outcomes for children in the following ways:

- Improved oversight and governance arrangements for incidents and crimes involving vulnerable children and increased coverage of specialist investigating officers 7 days a week.
- Commitment to enhance the awareness of officers and staff when dealing with vulnerable children by improved training with partners.
- Implementation of a Multi-Agency Safeguarding Hub (MASH) structure across the force area assisting in more effective joint planning and better oversight of child protection and safeguarding incidents.
- CSE teams support investigations by providing expert advice and initial risk management plan to assist officers in safeguarding children.
- Improved timeliness of investigation of online CSE offences.
- Reduction of the number of children in custody (569 to 451 across the Alliance in last 12 months) by use of alternative investigation pathways.

Areas for improvement include:

- A commitment to ensure referrals received by the police are allocated to officers and teams with the skills, capacity and competence to undertake that investigation, whenever that referral is received.
- Increase appropriate 'vulnerability training' to staff who are involved in protecting children from harm.
- Ensuring a robust multi-agency approach is implemented for all incidents of CSE.
- Complete the transition of the Harm Assessment Unit to Compass.
- Continue to reduce the number of children and young people within custody suites and improve the experience for children and young people when it is necessary for them to be in custody.

National Probation Service

Since the inception of Shropshire's Compass service the timeliness of safeguarding checks has improved (95% within 24hours, 100% within 48hrs).

Areas for improvement include:

- A need to engage with Police on their change programme review of public protection and Integrated Offender Management and the inclusion of repeat domestic violence perpetrators, CSE and other risk /threat areas.
- Develop and implement plans for co-location within Compass.

Community Rehabilitation Company (CRC)

The thematic inspection in 2014 identified poor quality in assessments of risk to children in domestic abuse cases. This was the basis for an audit undertaken by the CRC in spring 2015.

Despite some good practice across the organisation, the findings largely reflected those of the thematic Inspection.

Areas for improvement as a result of these findings include:

- Ensuring safeguarding and domestic abuse are seen as priorities.
- All staff will have safeguarding and SARA training.
- Ensure home visits are made in accordance with safeguarding policy

Youth Offending Service (YOS)

West Mercia YOS has identified that the findings from a HMI Probation thematic inspection in other LSCB areas draw parallels with practice across West Mercia. The inspection identified weaknesses in information sharing and joint planning between YOTs and Children's Social Care. This is an area that could also be improved upon across West Mercia. As a first step in this a joint workshop

between YOS and key managers and staff from Children's Services, was held in Shropshire in October 2015.

Across West Mercia 24%, of young people on YOS caseloads are looked after children. In September 2015 34% of the Shropshire team case load comprised looked after children from other local authorities. These young people often have complex needs and tend to be high risks in terms of vulnerability or posing risks to others. As a result the YOS Management Board has established a LAC and Care Leavers sub group of the Board.

Work being pursued by the group includes agreeing a multi-agency protocol to reduce the criminalization of LAC and promoting the use of restorative approaches to managing behaviour within children homes.

The YOS will be joining the Shropshire Corporate Parenting Board in 2016.

Over the past year the YOS has been screening all young people for indications of CSE and where relevant referring to the CSE pathway. In addition YOS has been working on a short screening tool for spotting indications of potential perpetrators amongst the young people known to YOS. A joint learning event between the Police CSE teams and YOS practitioners and managers was held in October 2015.

Shropshire continues to have a low rate of custodial sentences. For the year ending June 2015 the rate for Shropshire was 0.13, compared to a national rate of 0.43.

The proportion of young people receiving a youth justice caution in 12/13 that went on to re-offend within 12 months in Shropshire was 37.1% compared to a national rate of 37.2%. In mid-2015 the YOS implemented a re-offender tracker which monitors all young people subject to a YOS intervention to re-assess and intervene with young people who re-offend at the earliest point.

During 2015 the service has developed a new service user feedback process and established a service user participation group.

West Mercia Youth Offending Service was subject to a Short Quality Screening (SQS) inspection in March 2015. The inspection considered the assessment and planning work undertaken by YOS at the first stages of any intervention with a young person.

Identified improvements were required in vulnerability planning and the management oversight of these and other cases where this is not addressing standards and service improvement.

A SQS improvement plan and monthly quality audit process has since been put in place.

Areas of risk/challenge:

- Potential future budget pressures
- Increasing numbers of first time entrants to the youth justice system
- High proportion of looked after children from other authorities requiring intensive intervention

The SSCB Annual Report 2014-2015 referenced further work to understand the extent and nature of sexual offending. Capacity issues have prevented an in depth study being undertaken to date; however, a proposal has been put forward to resource work to review the YOS approach to responding to Harmful Sexual Behaviour. This will be reported in the SSCB Annual Report 2016-2017.

Multi-Agency Public Protection Arrangements (MAPPA)

The MAPPA Annual Report 2014-2015 identifies 1,402 MAPPA eligible offenders as of 31st March 2015. This figure is across the whole of West Mercia, (Shropshire, Telford & Wrekin, Herefordshire and Worcestershire) and currently no local data is available for analysis. The 2015-16 report is still awaited.

The MAPPA team has engaged in multi-agency based training during the course of the year to support front line staff in the jobs they have to undertake, and the decisions they are required to make.

There have been two Discretionary Serious Case Reviews, and the commissioning of the first Mandatory SCR (none of which were Shropshire reviews).

Multi-Agency Risk Assessment Conference (MARAC)

In January 2016 Safelives published a report on MARAC data across West Mercia.

By December 2015 referrals to Shropshire MARAC were still below the national average (33 cases per 10,000) at a concerning low of 17 cases per 10,000.

Interestingly in Shropshire the majority of referrals to MARAC do not come from the Police. This is in contrast to other areas in West Mercia, however the fact that a higher number of referrals come from other sources in Shropshire indicates that awareness of domestic abuse and MARAC is good amongst other agencies. There is concern that there may be some screening of cases ahead of MARAC by the Police and that some high risk cases then do not receive a multi-agency response. This will be investigated further during the coming year.

Recommendations identified in the report were as follows:

- Ensure there is adequate strategic governance for MARAC.
- Each MARAC to conduct a full review.
- Consider doing regular audits of MARAC cases.
- Commissioners need to consider how they can support to sustain the Independent Domestic Violence Advisor.
- Continue to raise awareness and have clear referral pathways for frontline practitioners.
- Measure outcomes form MARAC to ensure effectiveness.

A West Mercia wide strategic group has since been established to begin to take some of the recommendations forward. Shropshire County Domestic Abuse Forum, which acts as the steering group for MARAC locally, will be required to report on progress to the SSCB.

During 2016-17 the LSCB expects to see evidence of:

- A reduction in offences against children and young people
- Effective support and intervention with young people who pose a risk to others
- Evidence of effective contributions by all public protection agencies to the 'hidden harm' agenda.
- An increase in referrals to MARAC by the Police.
- Domestic Abuse Strategy to give consideration to children and young people who may perpetrate or experience domestic abuse.

Shropshire Council

As a 'top tier' local authority, Shropshire Council has particular responsibilities under Section 11 of the Children Act, and the Director of Children's Services has a statutory leadership role across the multi-agency system.

Shropshire Council reported the following performance information to the SSCB for 2015-2016:

- More advice and support is being provided through Early Help staff in Compass. There has been an increase in the number of referrals moving

to social work assessment, 77.4% in April 2015 up to 85% March 2016, which suggests a better understanding and application of threshold criteria by partners.

- More children receive the right service at the right time. Repeat referrals have dropped from 25% April 2015 down to 18.5% in March 2016, which is lower than the England average of 24.0%
- There has been improved joint decision making in Compass to agreed and shared thresholds, and an increase in the number of Joint Section 47 enquires following strategy discussion as a result of an audit and co-location. Joint investigations increased from 21.6 % in 2014-2015 to 26.3% in 2015-2016.
- The number of children in the care of the Local Authority has fallen from 313 in March 2015 to 285 in March 2016. At a rate of 47.3 per 10,000 at the end of March this is below the national average and below the rate of statistical neighbours at 51.4.

As a result of the Edge of Care strategy to support children at home where it is safe to do so, Shropshire Council has also seen a significant reduction in the number of children entering the care system, with 83 new accommodations in 2015-2016 compared to 138 in 2014-2015.

During 2015-2016 approximately 90 individual children received planned short breaks and a further 35 crisis short breaks. Of these, 22 children were subsequently received into care with 68 being successfully supported at home, representing an 80% success rate of preventing children becoming looked after unnecessarily.

A Support Prevention Panel was introduced in March 2015 to manage all voluntary 'Section 20' care requests from parents and / or young people. The aim of the panel is to challenge and support parental responsibility in caring for children in the family home where it is considered safe to do so. Parental and young people's engagement with the process has been high and feedback from those who have used the service is that support is positively received. Overall, only 9 young people have become looked after following the Support Prevention Panel during the period March to December 2015, demonstrating that this has supported the ongoing reduction in Section 20 admissions due to family breakdown.

The number of children achieving permanency outside the looked after system continues to increase, with improvements seen in the rate of children leaving the care system exceeding the new entrants.

Special Guardianship Orders rose from 5% in 2014-2015 to 20% in 2015-2016. Adoptions increased from 15 in 2014-2015 to 19 children adopted in 2015-2016.

The overall number of looked after children placed outside Shropshire is decreasing, from 80 in March 2015 to 73 in March 2016.

There has been a decrease in the number of children with a second or subsequent child protection plan, reducing from 21.8% in 2014-2015 to 11.2% in 2015-2016.

The service has made improvements in finding out the experience of the child and parent. A service user feedback project was commissioned in January 2016 to gather and analyse direct service user feedback from parents who have received a social work intervention. The aim will be to build service user insights to inform future process.

To date, eleven face to face interviews have been completed with a variety of service users with different experiences.

Other developments in 2015-2016 include:

- Development of a Workforce Strategy

- Embedding a robust Quality Assurance Framework
- Case file audits have been undertaken and feedback provided to practitioners. An action plan is in place setting out how key learning from the case file audits undertaken in 2015/2016 will be addressed and practice priorities for 2016-2017 have been identified.

Areas for improvement include:

- Recruitment, retention and stability of the workforce.
- Effective use of Early Help in 'step up and step down' to maximise the use of the professional social work resource.
- Improved levels of removal of child protection plans where effective interventions have reduced risk.
- Timeliness of social work assessments being completed in the maximum 45 day timescale.
- Shared priorities and outcomes for children and families across partner agencies.
- Evolution of Compass to include partners from Health and Probation.

Independent Reviewing Officers (IRO):

The independent reviewing service is run by the local authority, and oversees the conference and review process for both looked after children and child protection. The Board receives an annual report from the service. Developments during the year have included:

- Splitting the independent chairing functions between the chairs so that they have specific roles and responsibilities.
- Introduction of a dispute resolution process.
- Developing the quality assurance role of the independent chairs and introducing a RAG rating system. Noticeable improvements in practice have been evidenced particularly in relation to child protection conferences.
- Completion of exit interviews for children and young people when they move placements or leave care.

It is pleasing that 99% of review child protection conferences are taking place within timescales.

Areas for consideration and improvement:

- Improve the timeliness of initial child protection conferences (only 88% undertaken within timescales).
- Consider how to evidence the added value that the IROs and Independent Conference Chairs (ICCs) make to improving outcomes for children
- Ensure the child's voice is heard and used to inform decision making.
- Reports to be produced on a monthly basis setting out practice issues and where improvements have been made in relation to child protection conferences and statutory reviews and the effectiveness of the multi-agency system
- Develop practice standards for the IRO's/ICC's
- Introduce and develop IRO specialisms and champions of specific areas of practice
- To develop a service user feedback form to be completed by IRO/Conference chair

- To develop a partner agency feedback form to be completed by all agencies at the conclusion of a child protection plan to ascertain the effectiveness of the safeguarding system
- To review LAC consultation documents and introduce child protection consultation documents for children subject of a child protection plan

Education

The Education Quality Assurance Framework ensures safeguarding compliance of all schools and Early Years settings since September 2015, assists with identifying areas for targeted support and providing appropriate safeguarding challenges to schools.

Schools Safeguarding Group

This group has recently identified the following areas of development:

- To improve the sharing of information to all schools.
- Development of a termly Safeguarding Newsletter focusing on Education updates and amendments.
- To ensure that the Independent Schools' Safeguarding Group has access to the same information and agenda items to improve cohesive and consistent practice throughout the county.

Independent Schools

The report to the Children's Services Scrutiny Committee in October 2015 confirmed the current safeguarding arrangements in Independent education settings and made the following recommendations which are being progressed:

- Strategic Management: Clear strategies for feedback following the completion of the section 9 and section 11 audits needs to be developed to ensure schools modify their safeguarding practices and are compliant with statutory regulations.
- Improved Compliance: Development of a strategic process that holds schools to account if they are non-compliant.
- Improved cohesive working: Forge closer links with Independent Schools in the County and raise the awareness of safeguarding regulations.
- Child Protection Training in Schools: Develop more capacity to deliver Child Protection Training in schools to meet increasing demand and update on statutory changes from government.
- Prevent Strategy: To ensure Independent Schools have accessed current Radicalisation and Prevent Training in line with National Prevent Government strategy.

School attendance

The combined attendance for primary and secondary schools in 2014-2015 is 95.6%. The overall attendance of Special schools has decreased by 0.5% to 90.9%.

Exclusions

School exclusions have been historically low in Shropshire. Early indications for this academic year are that exclusions are reducing in recognition of the significant intervention by the Education Access Service team.

Children Missing from Education (CME)

In March 2016 there were 198 CME cases (102 are not Shropshire children) on the CME register, this is a decrease of 25% on the same period last year.

The CME Strategy Group will pilot a protocol with Severnside Housing which will see Neighbourhood Tenancy Officers ask for assurances from new tenants that their children are enrolled in a school or being educated otherwise. They will liaise with Education Welfare Officers if it appears any child is not in school or in receipt of a suitable education.

Elective Home Education

In Shropshire it is usual to have up to 200 electively home educated pupils on our EHE register, we currently have 230, but it is likely there are more who are not registered with the Local Authority.

In 2015 four School Attendance Orders were breached in Shropshire. The resulting action (the first in Shropshire) brought before the Magistrates Court in September 2015 resulted in fines and costs totaling £5,074.

Ofsted Inspections

Out of the 26 schools and academies that were inspected from January 2015 to 2016, 96% of parents agreed that children were safe in school. In 25 inspection reports it conveyed that children felt that they were safe whilst in school and knew how to report their concerns to staff.

Of the 26 schools that were inspected:

7 were graded as requires improvement however only 2 of these required improvement in Behaviour and Safeguarding

1 school was inadequate and did not meet the statutory safeguarding requirements.

The Education Improvement Service safeguarding team implemented targeted support as required.

The SSCB will be seeking assurance during 2016-17 regarding the safety of children outside mainstream education provision.

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

www.safeguardingshropshireschildren.org.uk