The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board is good

Executive summary

By providing strong leadership, effective coordination and robust challenge, the LSCB is helping to strengthen the work of partner agencies with children and families in Solihull. As well as improving the quality of the services provided, this is leading to better outcomes for children. Ably supported by a very capable business manager, the independent chair of the LSCB provides clear direction and guidance. With good engagement from board members, there is a real sense of commitment and momentum. The work of the LSCB is increasingly focused, coherent and authoritative.

The LSCB makes good and effective use of performance management information and multi-agency audits to 'home in' on its three strategic priorities: children who go missing or are at risk of child sexual exploitation; early help; and neglect. Once areas for improvement are identified, the board provides effective challenge. The board is doubling the size of its case audit sample in 2016–17 to strengthen its overview of the quality and impact of practice and compliance with practice standards, including the use of child sexual exploitation risk assessment tools. The board's improvement plan also includes a clear commitment to strengthen its focus on domestic abuse, and to work with children and young people living in homes affected by domestic abuse.

The board provides effective leadership around work with children and young people at risk of sexual exploitation and those who go missing. It ensures that collective efforts are well supported by a clear governance structure and an appropriate set of up-to-date policies and procedures.

Early help services are being monitored, but the board's challenge to partner agencies does not yet have the same rigour and focus evident in other areas of its work.

Training provided by the board is well-targeted, incorporates learning from local and national serious case reviews (SCRs) and is evaluated. To date, SCR work has been well managed by the independent chair but, looking ahead, she is unlikely to have the capacity to combine this with her primary role as chair of the board.

The child death overview panel (CDOP) is effective, not least in identifying relevant public health and practice improvement priorities. However, the CDOP needs to continue to work with health agencies to ensure that, when children die unexpectedly, a fully staffed rapid response service is available.

Recommendations

111. Strengthen the focus and rigour with which the new early help service is monitored, to enhance the effectiveness of the leadership and challenge provided by the board to partner agencies.

112. Ensure that the board has sufficient capacity to manage SCRs and any related learning reviews or single-agency case audits.

113. Ensure that, when a child dies unexpectedly, there are adequate rapid response arrangements in place.

Inspection findings – the Local Safeguarding Children Board

114. The engagement and commitment of partner agencies to the board is impressive. This is given direction and momentum by strong and effective leadership by the independent chair, supported by a highly capable business manager. The work of the board is supported by a clear and functional structure and effective governance arrangements. Taken together, this means that the LSCB is successfully fulfilling its role as 'critical friend' to partner agencies, providing leadership and challenge in relation to the quality and impact of services for children and young people in Solihull.

115. The LSCB has a small number of sub-groups that are focused on discharging the board's statutory responsibilities and delivering on its three key priorities: children who go missing or are at risk of child sexual exploitation; early help; and neglect. The work of these sub-groups is overseen effectively by an executive group that carefully considers performance data and audit findings, and sets the agenda for board meetings. Board meetings are sharply focused on the most important issues, with a strong emphasis on making a difference. For example, through its monitoring of practice, the sub-group to counter child sexual exploitation identified a number of concerns about the support provided to young people at risk of sexual exploitation once they had turned 18. Having discussed the issue, the executive group took it to the next full board meeting. As a result of this, and robust challenge by the independent chair, the local authority took appropriate action to ensure that young people continue to receive support after turning 18.

116. The LSCB works well with the local family justice board and the health and well-being board. Using the learning from an SCR, the LSCB has provided effective challenge and guidance to the health and well-being board, both on the development of the new education, health and care plans for children who have special educational needs or disabilities, and on the importance of ensuring that safeguarding issues and concerns are appropriately addressed.

117. The board regularly reviews a range of performance data, with particular attention to its three strategic priorities. It has a specific performance scorecard for each. The neglect scorecard is particularly strong, reflecting the LSCB's commitment to implementing its strategy to counter neglect. As well as performance data, the scorecard also covers attendance at LSCB training on neglect and evaluation of the impact of this training.

118. The board has been involved in discussions about the development of the new early help strategy and receives regular updates on the implementation of the new early help offer that started in October 2015. However, the board's scrutiny of early help services does not show the same degree of rigour. While the board collects a range of relevant data, it has not yet focused on the key issues of whether there has been an increase in the number of early help assessments completed or sought to evaluate their

impact. In that sense, the board has not provided the same degree of challenge, not least about the pace of change, as it has in other areas of practice. (Recommendation)

119. The LSCB's multi-agency audit programme in 2015–16 was well managed and focused appropriately on the board's priorities. It identified both good practice and areas for improvement, which were then used to inform the work of the board and to help to shape its priorities for 2016–17. For example, when audits identified a lack of understanding of the thresholds for intervention, the LSCB adapted its existing training courses to include a section on thresholds and decision making. However, although rigorous in their execution, the board's multi-agency audits in 2015–16 were completed using a relatively small case sample of 11. This means that the learning about particular areas of practice, which only featured in some of the children's cases, tended to be case specific rather than representative. For example, the LSCB's strategic priority on neglect includes a particular focus on the impact of the 'toxic trio' of domestic abuse, parental mental ill health and parental drug, alcohol and substance misuse. A larger audit case sample is required to be able to assess thoroughly the quality of practice in relation to these areas of concern. The LSCB is aware of this deficit and has agreed a case sample size of 24 for 2016–17.

120. A section 11 audit of how well partner agencies discharge their responsibilities to safeguard and protect children, which was carried out in the autumn of 2015, was very thorough. It was used effectively, not only to test compliance but also to identify thematic areas for improvement. This is also true of a more recent section 175 audit of schools. An LSCB education sub-group includes representatives from all of the 'collaborative' school groupings in Solihull, as well as from special and independent schools. This means that the level of schools' engagement is strong, both with the audit and with the LSCB.

121. Given the relatively high number of unaccompanied asylum-seeking children in Solihull, the LSCB has also taken the positive step of requiring the UK Border Agency to complete a self-assessment of how well it discharges its responsibilities to children and young people under Section 55 of the Borders, Citizenship and Immigration Act 2009.

122. The LSCB publishes and regularly updates its guidance on the threshold criteria for access to children's social care services. The document covers all the areas required by statutory guidance and is responsive to the latest developments in practice, such as a stronger focus on early help. Concerned that thresholds were not consistently well understood or applied by agencies, the board produced a short summary leaflet that was widely circulated. However, an independent review of the thresholds, which was commissioned by the LSCB and completed in February 2016, has highlighted the fact that the threshold between early help and children in need requires further clarification. As a result, the document is currently being revised, and this work has not yet been completed.

123. The LSCB's learning and improvement framework is clear, succinct and covers all matters expected by statutory guidance. It has a good focus on local priorities, and identifies how learning is disseminated and evidence gathered in order to show that it is making difference. The LSCB's training strategy and training programme are based on a review carried out in April 2015. The review brought together learning from Solihull's most recent SCR and national SCRs, existing local priorities, and feedback from children

and young people in receipt of services. This has resulted in a well-targeted and well-attended programme of training. The board uses an effective online survey tool to gather feedback from course participants and their managers about the impact of training on their practice at three months after they have completed training. Almost all social workers spoken to by inspectors were positive about the quality of LSCB training. They were able to talk confidently about SCR learning and its relevance to their practice.

124. At present, the LSCB does not have a formal SCR sub-group to coordinate its work around SCRs, learning reviews and any single-agency audits that have been commissioned by the board. To date, this work has been led by the independent chair. In the event that further reviews or audits are required, over and above the work that is already underway, it is unlikely that the independent chair would have sufficient capacity to manage this on top of the demands of chairing the board. (Recommendation)

125. The child death overview panel (CDOP) has been effective in analysing information at the individual child and the thematic public health levels. For example, the CDOP has ensured that midwives and health visitors routinely use an assessment tool to identify the likely risk of sudden infant death, and that the protocol on the sudden and unexpected death of an infant is understood and implemented by all of the relevant agencies. However, despite ongoing efforts, including escalation via the board, the CDOP has not yet been able to ensure that health partners provide full 24/7 cover as part of the rapid response arrangements. (Recommendation)

126. Under the strategic leadership and direction of the LSCB, there are clear and appropriate structures in place to identity and respond to the needs of children at risk of child sexual exploitation and those who go missing from home or care. Information about children missing education is well integrated into this process. The child exploitation sub-group advocates strongly on behalf of this vulnerable group of children, has a good oversight and is demonstrably committed to continuous improvement. However, it makes sense to extend the scope of multi-agency audits to ensure a fuller understanding of the quality and impact of practice, and to comply with practice standards. The LSCB monitors data on the prevalence and severity of assessed risks associated with sexual exploitation, on children and young people missing from home or care, and on the completion of return home interviews and the intelligence that they generate. The LSCB provides training, promotes awareness raising and challenges agencies to do better, as and when necessary. For example, at the time of this inspection, the LSCB was challenging the police and the local authority to improve the way in which they collate and analyse information from return home and police 'safe and well' interviews, better to inform their prevention and disruption activities.

127. The LSCB's annual report for 2014–15 is a clear and well-focused document that covers all of the relevant areas. The results of the board's monitoring and scrutiny of practice were used effectively to identify priorities for 2015–16 and to shape the board's business plan. Good progress has been made. Any outstanding actions have been carried forward into the 2016–17 improvement plan, which the board is now working on. The improvement plan encompasses the learning and recommendations from SCRs and areas for development identified through performance and practice monitoring. It sets out clearly the outcomes required, actions that need to be taken and the measures that will be used to monitor and maintain improvement.