LSCB improvement plan 2016-2017				
Source	**Learning**	**Accountable lead for improvement FULL LSCB and exec**		
		What has been done 15/16	**Position February 2017**	**To sustain Improvement**
OFSTED review of Solihull LSCB July 2016	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.	Early Help performance framework for reporting to HWBB complete. Progress report on initial threshold audit complete	MASH review includes early help duty desk. LA has reviewed Engage services.	The exec group to monitor performance and review in March 2018 and provide exception reporting to full LSCB
	Ensure that the board has sufficient capacity to manage SCRs and any related learning reviews or single-agency case audits.	Responsive leadership, management and co-ordination has so far delivered.	Options to be considered by executive group.	A consistent arrangement to be agreed.
	Ensure that, when a child dies unexpectedly, there are adequate rapid response arrangements in place.	Work to assure the board about the effectiveness of rapid response procedures has been scoped and agreed.	An update will be provided to the executive group in Feb.	A final report will be provided to the LSCB in March 2017.

LSCB improvement plan 2016-2017				
Source	**Learning**	**Accountable lead for improvement FULL LSCB and exec**		
Self-Assessment by chair (August 2015) LSCB development day (May 2016) Case audit 2015/2016	"There is an area for development in further enhancing and articulating the way ***the LSCB listens to and responds to children and young people***". "The work on engaging young people needs improved co-ordination and a more strategic approach."	**What has been done 15/16**	**Position February 2017**	**To sustain Improvement**
		Case audit programme evaluates whether the child's voice is heard in practice Officer appointed by LA to work on engaging young people.	CSE training reflects local YP's experience. Case audit programme reported to the LSCB that the child's influence is seen in many of the cases audited. At development day, individual LSCB members made a commitment to ensuring the voice of the child impacts on service planning.	All agencies to account to the LSCB on the impact of the voice of the child on delivery as part of the individual agency accountability to the LSCB. The Case audit group re-auditing in the 2016-2017 cycle. A simple strategy ("texting campaign" agreed in June 2016 has been delivered by young people.
LSCB development day	Need to work with other boards, HWBB, safer Solihull and SAB	Protocol agreed with HWBB and SAB and safer Solihull board. Analysis of SCR's homicide reviews, domestic violence reviews and adult reviews carried out. Workshop held between representatives of each LSCB.	Workstream now producing; • Poster publication on all 4 websites with messages for practice from Homicide, child SCR's and Domestic violence reviews, and adult reviews • Transitions as a common area of interest to all four boards.	Product will be reported to the LSCB and other 3 boards in March 2017. Interim reports to exec in 2017/2018.
	Improve Links between mental health services and the work on children missing from home or care	LSCB has set standards and partners have evaluated against them resulting in a partnership action plan for children missing from home or care.	Action plan needs to include mental health issues. Mental health to be invited to missing work stream group.	Mental health services included in in CSE steering group and in CMOG. BSMHFT meeting with MASH and early help and communications improving.

LSCB improvement plan 2016-2017 DRAFT					
Source	**Learning**		**Accountable lead for improvement; Policy sub-group**		
SCR1	**Learning Point 1**	**Recommendation**	**What has been done;**	**Position February 2017**	**Sustain Improvement**
	Difficulties were identified in respect of the use of a ***range of the 'tools'*** available to professionals for working with children and families across the agencies.	***A review of the 'tools' used in child protection cases*** *should be undertaken on a multi-agency basis focusing in particular on those for the implementation of the 'signs of safety' model and also including Triage processes, Single assessment/risk Assessment processes and Domestic Abuse, Stalking and Harassment (DASH) tools.*	Revision of DV tools has been carried out by the Policy and Procedures sub-group.	The safeguarding learning faculty has identified a training need on the application of tools in addition to existing training.	Application of appropriate tools embedded in training. Bespoke training on the use of tools now being delivered.
			Signs of safety model being delivered in child protection conferences.	Policy and procedures sub-group agreed that this is rolled out to partners 2016/2017.	Embedded in core safeguarding training. Communications to staff who attend child protection conferences will take place in the Summer.
			Briefing seminars by LSCB on use of tools in practice.	Final briefing seminars taking place.	Practitioners toolkit on the website and being used.
			Phase 2 pilot with the NSPCC on the graded care profile is underway.	LSCB and LA now licensed trainers for the graded care profile A pilot group working well.	Pilot/implementation group informing training delivery in 2016/2017. NSPCC evaluating
			Threshold document revised	Threshold document publicised	Produce leaflets and posters to respond to practitioners' demand.

LSCB CB improvement plan 2016-2017 DRAFT					
Source	**Learning**		**Accountable leads for improvement; LA and police**		
SCR1	**SCR Learning Point 3**	**Recommendation**	**What has been done**	**Current Position February 2017**	**To Sustain Improvement**
	The review (SCR1) has identified significant weaknesses in the communication and ***working arrangements between the Police and Childrens Social Work Services***	"*In light of the major review of public protection arrangements in the West Midlands Police Service, the working arrangements between the Police and Social Work Services, in particular the Emergency Out of Hours service (EDT) should be considered as part of that overall review. The review should include a focus on the effectiveness of information systems which can be jointly interrogated by each agency together with the development of clear joint information protocols which are clearly understood and communicated across the agencies."*	A Multi Agency Safeguarding Hub is now operational with representation from Social work, Police, Health, Education and Housing.	There is clear evidence of improved response and speedy information sharing and decision making in MASH.	LSCB multi-agency training improves competencies on communications and information sharing. The LSCB monitors MASH developments with direct reports from social care and police. The LSCB independent chair has made two visits to MASH to observe and challenge directly.
			EDT has been reviewed and processes revised.	The emergency duty team have access to relevant information.	MASH review complete in March 2017

LSCB improvement plan 2016-2017 DRAFT					
Source	**Learning**		**Accountable leads for improvement-Schools sub-group on supervision in schools, case audit group on selected cases and all members.**		
SCR1	**SCR Learning Point 6**	**Recommendation**	**What has been done**	**Current Position February 2017**	**To Sustain Improvement**
And Case audit	The review has highlighted that there was insufficient shared understanding across the agencies involved in safeguarding about what the task of ***supervision in safeguarding*** cases actually was and how it contributed to keeping children safe. It was also difficult to determine through discussions what level of skill and expertise those supervising front line safeguarding activity actually had.	***"Using examples of national best practice underpinned by relevant research the Solihull LSCB should mount an inter-agency development initiative for those supervising front line safeguarding practice. The initiative should include a focus on the importance of shared analysis and challenge within the supervisory relationship process. Those facilitating the initiative should not only focus on improving individuals supervisory skills but also an improved multi-agency understanding of the importance of supervision in its key role in refining safeguarding assessment, planning and review".***	Supervision standards were developed by the policy sub-group in 2014 using national research and have been included on the LSCB website and are used in multi-agency case audit and include minimum frequency, enabling reflective practice and providing challenge.	S11 audit shows agencies compliance with supervision arrangements. Schools have produced a draft supervision policy for comment. The case audit group has found variation in definitions and models of supervision in partner agencies.	LSCB schools sub-group will take supervision forward in schools A training programme for managers on analysis and judgement in safeguarding children delivers training to supervisors and managers on their role in enabling sound reflective practice and providing challenge to front line practice Case audit will re-audit against agreed standards.

LSCB improvement plan 2016-2017 DRAFT				
Source	**Learning**	**Accountable lead for Improvement: LA**		
SCR2	**Recommendation 1**	**What has been done**	**Current Position February 2017**	**To Sustain Improvement**
And Multi-agency case audit	Solihull LSCB, Child in Need (CIN) process needs to be much more robust, which can be achieved by becoming more in line with current CP processes. This needs to be circulated and marketed effectively to relevant professionals to allow proper consistency and commitment of all partners. A process for the distributing of the minutes of the meetings and ensuring actions are swiftly forwarded to the correct agency with a follow up plan is also essential. The development of a meeting template may assist this.	CIN processes reviewed and templates agreed by Policy and Procedures sub-group. Processes for swift distribution of minutes improved and is monitored by the LA Child Protection and Review Unit.	New processes have been delivered	Regular auditing and management oversight by CPRU. Monitored through multi-agency case audit.

LSCB improvement plan 2016-2017 DRAFT				
Source	**Learning**	**Accountable lead for Improvement Policy sub-group**		
SCR2	**Recommendation 2**	**What has been done**	**Current Position February 2017**	**To Sustain Improvement**
	The Solihull LSCB should put in place a process, which takes into account the regional approach that enables the effective use of ***escalation*** and ***professional challenge*** procedures to take place. With particular focus on when step down or step up considerations are being made and there is professional disagreement.	Step up and step down procedures revised by policy and procedures sub-group. Consultation with practitioners on the use of the dispute resolution procedures indicated a need for review and practitioner workshop has produced a new protocol.	Policy sub-group has approved the dispute resolution procedure. Threshold document also reviewed.	Awareness raising about the new dispute resolution procedure and the threshold document included in the LSCB briefings in the Autumn and Spring 2017. included in the impending MASH review. .

LSCB improvement plan 2016-2017 DRAFT			
Source; LSCB SELF ASSESSMENT August 2015			
Learning	**Accountable lead for Improvement; LSCB and Exec**		
	What has been done	**Current Position February 2017**	**To Sustain Improvement**
The Executive should evaluate whether specific performance challenges are fully understood.	LSCB Exec group has agreed on developing individual partner accountability by requesting partner agencies to account to the LSCB on their safeguarding responsibilities	A "Rota" has been devised to ensure each partner presents at least once a year. The police, Local Authority and schools have so far presented.	The "Rota" system will be evaluated by the LSCB. So far LSCB members have found individual presentations useful and informative.
Work should be done to further sharpen the focus on outcomes between the different statutory partners	Case audit programme provides a focus on priorities in practice. Exec has linked this with neglect strategy.	Final case audit report provided to LSCB in March. New audit cycle in progress. The Police DCI lead, Ian Green presented on the perspective of young people experiencing CSE.	Recommendations from case audit work inform this improvement plan below.
The impact of cross Council working and work across geographical boundaries should be further considered for mitigation of risk.	Links to regional developments made through LSCB chairs, DCS and CEO's. Strong links around CSE. .	Regional work on procedures is well developed. Regional training group is well developed.	Solihull will be included in the regional procedures developments.
	LSCB chair requested consultation with the learning faculty to gain practitioners' views.	Faculty consulted and reported to chair	LSCB to continue on cross border issues.
There is a need to discuss and debate what 'good' looks like in ensuring there is an authoritative oversight of the front line by the LSCB.	A sound multi-agency case audit informs the LSCB about practice. S11 audit design complete Rota of individual agency accountability devised as above. Learning faculty routinely consulted.	Case audit embedded S11 audit reported to LSCB in March. Agency accountability rota to LSCB agreed.	Practitioner faculty continues to feedback on learning from practice. Agency rota now embedded in LSCB agenda setting

LSCB improvement plan 2016-2017 DRAFT			
Source; Multi-agency case audit 2015/2016			
Learning	**Accountable for Improvement; LSCB and exec**		
	What has been done	**Current Position**	**To Sustain Improvement**
Timelines and Responsiveness of ***feedback from referrals*** from Childrens Social Work Services needs improvement	Implementation of the MASH and the processes used has improved timeliness and responsiveness of referrals. Auto response upon receipt of online referral form. Referrer informed of outcome within 48hours.	MASH processes observed by independent LSCB chair on 2 occasions and Ofsted MASH review TOR agreed.	MASH review will complete in March 2017.
Continued emphasis on raising ***awareness of the thresholds*** guidance and using this in practice is required	External audit and review carried out on thresholds with resulting action plan and agreement on revising of threshold document.	Threshold document reviewed by policy and procedures sub-group. .	Briefing seminars in the final stages of completion.
Consent around ***information sharing*** and referral needs to be clarified.	Further work identified to promote protocols including consent.	Training emphasising information sharing. Case audit group agreed to re-audit	MASH review Repeat audits Review awareness of information sharing protocols.