Coventry City Council

Agenda

Education and Children's Services Scrutiny Board (2)

Time and Date
2.00 pm on Thursday, 21st July, 2016

Place
Committee Rooms 2 and 3 - Council House

Public Business

1. **Apologies and Substitutions**

2. **Declarations of Interests**

3. **Minutes** (Pages 3 - 6)

   a) To agree the minutes of the meeting held on 16th June, 2016
   b) Matters Arising

4. **Serious Case Review** (Pages 7 - 50)

   Report of the Independent Chair of the Local Safeguarding Children's Board (LSCB)

5. **Early Help Strategy Progress Report** (Pages 51 - 76)

   Briefing Note of the Director for Children's Services

6. **Improvement Board Progress Review** (Pages 77 - 84)

   Briefing Note of the Director for Children's Services

7. **Outstanding Issues** (Pages 85 - 86)

   Briefing Note of the Scrutiny Co-ordinator

8. **Work Programme** (Pages 87 - 92)

   Briefing Note of the Scrutiny Co-ordinator

9. **Any Other Business**

   Any other items of business which the Chair decides to take as matters of urgency because of the special circumstances involved.

10. **Meeting Evaluation**

To discuss and evaluate the effectiveness of the meeting.

Private Business

Nil

Chris West, Executive Director, Resources, Council House Coventry

Wednesday, 13 July 2016

Notes: 1) The person to contact about the agenda and documents for this meeting is Michelle Rose, Governance Services, Council House, Coventry, telephone 7683 3111, alternatively information about this meeting can be obtained from the following web link: http://moderngov.coventry.gov.uk

2) Council Members who are not able to attend the meeting should notify Michelle Rose as soon as possible and no later than 1.00 p.m. on 21st July, 2016 giving their reasons for absence and the name of the Council Member (if any) who will be attending the meeting as their substitute.

3) Scrutiny Board Members who have an interest in any report to this meeting, but who are not Members of this Scrutiny Board, have been invited to notify the Chair by 12 noon on the day before the meeting that they wish to speak on a particular item. The Member must indicate to the Chair their reason for wishing to speak and the issue(s) they wish to raise.

Membership: Councillors N Akhtar, S Bains, G Duggins (By Invitation), D Gannon, S Hanson (Co-opted Member), K Jones (Co-opted Member), D Kershaw, M Lapsa, A Lucas, P Male, K Maton (By Invitation), C Miks, M Mutton (Chair), R Potter (Co-opted Member), E Ruane (By Invitation) and P Seaman (By Invitation)

Please note: a hearing loop is available in the committee rooms

If you require a British Sign Language interpreter for this meeting OR it you would like this information in another format or language please contact us.

Lara Knight/Michelle Rose
Telephone: (024) 7683 3237/3111
e-mail: lara.knight@coventry.gov.uk michelle.rose@coventry.gov.uk

Coventry City Council
Minutes of the Meeting of Education and Children's Services Scrutiny Board (2)
held at 3.30 pm on Thursday, 16 June 2016

Present:

Members:	Councillor M Mutton (Chair) Councillor N Akhtar Councillor S Bains Councillor D Gannon Councillor D Kershaw Councillor R Lancaster Councillor M Lapsa Councillor P Male Councillor C Miks
Co-Opted Members:	Mrs S Hanson, Mrs K Jones and Mr R Potter
Cabinet Members and Deputy Cabinet Members:	Councillor Maton Councillor Seaman
Employees (by Directorate):	J Gregg, People Directorate G Holmes, Resources Directorate M Rose, Resources Directorate
Apologies:	Councillor E Ruane

Public Business

1. **Declarations of Interests**

There were no Disclosable Pecuniary Interests.

2. **Minutes**

The minutes of the meeting held on 14th April, 2016 were approved.

Further to minute 72/15 'Children's Social Care Performance Report' members had received information about Barnados return home interviews and children who had had 3 or more placements but were awaiting other information they had requested.

3. **Improvement Board Progress Review from 11th May, 2016**

Further to Minute 74/15 the Scrutiny Board noted a joint briefing note which detailed progress on the Children's Services Improvement Plan, reported to the Children's Services Improvement Board on 11th May, 2016 based on data from March, 2016.

The progress report included an update on the six themes aligned to the Department for Education (DfE) Improvement Notice including an update on the Local Safeguarding Children's Board.

The Scrutiny Board questioned officers on the following:

- Government Initiative to increase the number of student placements in social work
- Whether the current successes in recruitment were in the areas where we most needed them
- Support to retain staff and creative thinking
- Task and finish group support
- Inspiring middle leaders
- Celebrating what we are good at and championing children's services
- Comparisons with other local authorities
- National and regional concerns about lack of social workers
- Alternative models of delivery
- Ofsted
- Social workers working with schools

4. **Establish a Task and Finish Group to Consider the Recruitment and Retention of Social Work Staff**

Further to Minute 74/15 the Scrutiny Board considered a report of the Scrutiny Co-ordinator which sought to establish a task and finish group of the Education and Children's Scrutiny Board to consider recruitment and retention of social work staff.

Members discussed with officers whether there could be useful recommendations resulting from focussing on these issues. Officers were supportive of a member investigation into improvements that could be made to stabilise the workforce.

RESOLVED that the task and finish group be established and membership be sought from Scrutiny Members

5. **Draft Work Programme**

The Scrutiny Board considered the draft work programme and requested that the following areas of interest be considered during the year:

- Educational performance including vulnerable groups and especially those home schooled and excluded
- Connecting Communities
- Special Educational Needs and short breaks
- Prevent
- Child and Adolescent Mental Health Services (CAMHS)
- Multi-Agency Safeguarding Hub (MASH)
- Young People and Anti-Social Behaviour/Police school panels

RESOLVED that the work programme be updated

6. **Any Other Business**

There were no other items of business.

(Meeting closed at 4.35 pm)

This page is intentionally left blank

Coventry City Council

Briefing note

To Education and Children's Services Scrutiny Board (2) **Date 21st July 2016**

Subject Serious Case Review

---

1 Purpose of the Note

1.1 The purpose of this note is to update scrutiny board on the outcome of the serious case review (SCR) published by the Coventry Safeguarding Children' Board on 11th July 2016.

2 Recommendations

2.1 Scrutiny Board are asked to note the recommendations arising from this report.

3 Information/Background

3.1 The primary aim of a SCR is to help agencies learn lessons from these events, and to use this experience to improve practice.

3.2 Following the police commander referring the case to the Independent Chair of Coventry Local Safeguarding Children Board (LSCB) it was agreed this case should be the subject of a Serious Case Review in March 2015.

3.3 Each agency may make recommendations to support improvements in practice within their organisation. The on-going implementation and monitoring of these actions is the responsibility of the individual agency. Evidence of progress is regularly provided for the LCSB. This process enables the LSCB to fulfil its responsibility for monitoring progress, and to be assured that these recommendations have been delivered in practice.

3.4 Recommendations that are multi-agency are the responsibility of the LSCB, and an action plan to address these recommendations is currently being progressed.

Appendices

1 – SCR Report

Hardeep Walker
Job Title: SCR Coordinator for Adult and Children Safeguarding Boards
Contact Details: Hardeep.Walker@coventry.gov.uk 024 76831528

This page is intentionally left blank

Coventry Safeguarding Children Board

SERIOUS CASE REVIEW

Child G, Child H, Child I, Child J, Child K

CONTENTS

1. INTRODUCTION

1.1 The circumstances that led to this Review

1.1.1 In the autumn of 2012 West Midlands Police initiated a major investigation, as a result of information that several teenage girls were victims of Child Sexual Exploitation perpetrated by a group of men in Coventry. Five men were subsequently convicted of a number of criminal offences, including physical assault, witness intimidation and the supply of drugs and were given custodial sentences. The men had also been charged with a number of sexual offences, but these charges did not result in any convictions.

1.1.2 Following the investigation the Police provided a briefing to the Safeguarding Children Board regarding the investigation. The Coventry City Police Commander referred the cases of these five young people, who previously or at the time of the abuse had been in receipt of services from agencies in Coventry, to the Board's Serious Case Review Sub Group for consideration. The Independent Chair of Coventry Safeguarding Children Board formally made a decision to undertake a Serious Case Review on 2nd March 2015, as this case had met the criteria for a Serious Case Review as identified in Working Together to Safeguard Children 2015[1] in that there was information that:

(a) abuse or neglect of a child is known or suspected; and

(b) either (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

1.1.3 Irrespective of the outcome of the criminal proceedings, what is absolutely evident to this Review is that the five children under consideration have experienced appalling violence, intimidation and sexual exploitation over a considerable period of time.

1.1.4 The 5 children subject to this Review were between 13 and 15 years old at the start of the time period under consideration and were from different racial and ethnic backgrounds. Information about the individual children within this Review is limited in order to minimise the risk that they could be identified.

1.1.5 A conscious decision has been to refer to the individuals subject to this report as **children**, in clear recognition of their age, legal status and vulnerability at the time of these events. It should however be acknowledged that at times and in some settings the use of the term young people is quite appropriate for this age group, indeed referring to teenagers as children in direct work with them can be actively unhelpful. This will be referenced further in the body of the report. As all five are now over the age of 18, references to them in the present will use the term 'young people'.

[1] Working Together: HM Govt 2015

1.1.6 An Independent Chair and Author were appointed in June 2015. The Independent Chair is David Peplow. Mr Peplow is the Independent Chair of two Local Safeguarding Children Boards and also has experience of chairing and authoring SCRs. The Independent Author is Sian Griffiths. Ms Griffiths has significant experience of authoring Serious Case Reviews including a previous high profile SCR regarding Child Sexual Exploitation. Ms Griffiths has no previous involvement with any of the agencies involved with these children. As Chair of a neighbouring LSCB Mr Peplow has contact with some of the Health Trusts concerned in this context, but has no involvement with any of the agencies which would impact on his independence.

1.1.7 The date for completion of the Review was initially hoped to be in six months' time, with the intention of the Report being presented to the Board in January 2016. However, an extension was subsequently agreed due to the complexity of obtaining adequate information relating to the identified timescale and the report was actually presented to the Board in June 2016.

1.2 Methodology

1.2.1. Statutory guidance within Working Together requires Local Safeguarding Children Boards to have in place a framework for learning and improvement, which includes the completion of Serious Case Reviews. The guidance establishes the purpose as follows:

> *'Reviews are not ends in themselves. The purpose of these reviews is to identify improvements that are needed and to consolidate good practice. LSCBs and their partner organisations should translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children.' (Working Together,* 2015:73)

Statutory guidance further requires SCRs to be conducted in a way which:

- *recognises the complex circumstances in which professionals work together to safeguard children;*
- *seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;*
- *seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;*
- *is transparent about the way data is collected and analysed; and makes use of relevant research and case evidence to inform the findings*. (2015:74)

1.2.2. The methodology used for this Review was underpinned by the principles outlined in Working Together, including the need to use a systems approach. The author of this report is familiar with a systems based methodology. In particular this approach recognises the limitations inherent in simply

identifying what may have gone wrong and who might be 'to blame'. Instead it is intended to identify the work context and systems that supports good practice, as well as the work context in which poor safeguarding practice is more likely to take place. This allows us to achieve a focus on the underlying reasons as to why there may be problems with practice when we look back and examine it in detail.

1.2.3. A proportionate methodology focussed on future learning was designed to take into account the historical nature of the events under consideration; the importance of not identifying the young people concerned; the body of learning about CSE already identified as a result of a number of recent reviews and reports; and the significant changes to policy and practice that have taken place in Coventry since these events.

The primary focus for this Review was to consider the response of agencies in Coventry to the Child Sexual Exploitation of five children. Child Sexual Exploitation (CSE) can be defined as follows:

> *Sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them, sexual activities.*
>
> *Child sexual exploitation can occur through the use of technology without the child's immediate recognition; for example being persuaded to post sexual images on the Internet/mobile phones without immediate payment or gain. In all cases, those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the child or young person's limited availability of choice resulting from their social/economic and/or emotional vulnerability*[2]

1.2.4. The Review was not required to work to prescriptive Terms of Reference, instead 3 Core questions were posed:

i) What can we learn specifically about these cases, as well as more widely around responses to troubled young people?

ii) Why did it happen and could it have been prevented?

iii) Could it happen now? If yes, what do we need to change?

The Review was also specifically asked to consider:

[2] National Working Group 2015

- **the voice of the children, their understanding of their own situations and the implications for what disclosures they make**
- **Professionals' relationships to the children**

1.2.5. The starting point for the Review's time frame was determined by the Safeguarding Children Board to capture adequate information about the children's involvement with services prior to the point at which it was recognised that they were experiencing CSE. The time frame ends at the point that the police investigation was identified as a major incident and a multi-agency response was initiated. That is:

January 2010 to end September 2012.

1.2.6. The Chair and Author worked with a core Review Team made up of Senior Safeguarding representatives from the key relevant agencies as follows:

Children's Society (responsible for the projects known as Reunite and Streetwise)	Programme Manager Birmingham, Coventry and Solihull
COMPASS (drug and alcohol service)	Assistant Director Young Peoples Services
Coventry City Council Children's Services	Children's Social Care Lead
Coventry and Warwickshire Partnership NHS Trust	Safeguarding Lead
Coventry City Council (Education)	Head of Student Services
Coventry & Rugby CCG	Designated Nurse Child Protection & Lead GP
University Hospitals Coventry and Warwickshire NHS Trust	Named Doctor for Safeguarding
West Midlands Police	Detective Chief Inspector, Coventry and Solihull Domestic and Child Abuse Lead
YMCA Coventry and Warwickshire	Chief Executive
Youth Offending Service, Coventry City Council	Service Manager

1.2.7. The review process included:

- Consideration of chronologies and learning summaries produced by 10 key agencies.
- 5 meetings of the Review team.
- Meetings with a range of key professionals

1.2.8. The following agencies provided chronologies and Agency Reflection and Learning Reports - focussed reports identifying the key lessons from each agency:

- **West Midlands Police**
- **Coventry Children's Services** (CSC), including Adoption Support, Looked after Children[3] (LAC), Referral and Assessment (RAS), After Care team.
- **Streetwise** – a project run by the Children's Society (previously known as Reunite) which initially worked with young people who had been missing from home, but later focussed on work with children experiencing CSE
- **Compass** - Charity commissioned by the Local Authority to provide Drug and Alcohol services for young people
- **Education**
- **GPs**
- **Coventry and Warwickshire Partnership NHS Trust** (including CAMHS, School & LAC Nurses, sexual health.
- **University Hospital Coventry and Warwickshire, NHS Trust**
- **YMCA Coventry and Warwickshire**
- **Youth Offending Service**

1.2.9. Individual meetings took place with 17 practitioners who had been involved with the children at the time, including 3 who no longer worked in Coventry but who had significant involvement with the children. The author also had conversations with some key managers and professionals currently involved in CSE work in the multi-agency partnership.

1.2.10. Towards the end of the Review a meeting of practitioners who had either been involved with the children or were currently working with those at risk of Child Sexual Exploitation across services took place. A total of 28 front line staff and managers attended the meeting and contributed to the information gathering and the analysis aspects of this Review. The Independent Author and Chair, supported by members of the Review team facilitated the event.

1.2.11. The Independent Author also attended meetings of the following groups to learn more about the way in which CSE was understood and responded to in Coventry:

- Young People's CSE participation group
- Supported Housing accommodation Providers group

[3] Looked After Children (LAC). A child is described as 'looked after' by a Local Authority if provided with accommodation under the Children Act 1989.

1.3 Contributions from the children concerned

1.3.1. All the young people concerned were informed that the Serious Case Review was taking place and asked if they would wish to contribute to the Review. Only one of the young people said that she would like to contribute, but a change in her circumstances meant that she was not able to do so before the report was completed.

1.3.2. As a result it was not possible to gain a first-hand understanding of the experience of those who were subject to the Review and it was not felt to be appropriate to attempt to identify and meet with other young people who had been subject to CSE. In the absence of such direct feedback, the perspectives provided by the young people from the CSE consultation group regarding the general experience and understanding of young people within the city, were of particular value.

1.3.3. All the young people were provided with the opportunity to read the report prior to publication and make any contributions at that time. The young people were overwhelmingly concerned that their privacy was not compromised as a result of this Review and this was a significant factor in the level of detail about individuals contained within the final report.

2. SUMMARY OF THE CHILDREN'S EXPERIENCE

2.1. This section provides a brief combined summary of what is known about the 5 children and their involvement with agencies. The level of detail about the children's lives has been carefully considered during the Review, but has not been included here in order to minimise the risk of identifying the individuals concerned. The decision not to describe full details of each child's individual experience is purely for their protection.

2.2. The five children were from different racial and ethnic backgrounds, with three identified as White British and two dual heritage (Asian/White and White/Black African Caribbean). No information has been provided to this review regarding issues such as disability, faith or religion in relation to the children. The Review recognises that this means there may be gaps in our understanding of their experience.

2.3. All of the children had experienced contact with a range of statutory and voluntary services during their lifetimes, including health, children's services and the police. All had experienced some form of disruption or difficulties within their birth families, for example allegations of domestic abuse or parental mental health problems. Two of the children, who had been adopted, experienced family breakdowns during their teenage years which led to the involvement of the Local Authority Post Adoption Support Team. However for neither family was it possible to prevent the breakdown and the child left the home to move into foster care or semi-independent accommodation. By the time at which it became understood that the children were experiencing

abuse, they were all living away from their homes, one in a Local Authority residential home, the others in semi-independent accommodation. All of the children had very limited personal support.

2.4. Whilst each child's story is unique to them, they all had a number of needs and problems which led them and their families either to seek help or to be referred for help and assessment. There was evidence of significant neglect with one of the children which did not at an early stage lead to her being identified as a child in need or at risk, although she did later become looked after by the Local Authority. The children at times showed very clear signs of distress at their situations, with substance abuse identified as a concern as well as self-harm and in one case involvement in a serious offence. Often the children or families did not take up services that were offered to them, and as a result their cases were closed to health and social care services.

2.5. With all of the children there were identified concerns about sexual activity. This included being sexually active at a young age, allegations about possible sexual abuse in the home and direct referrals to the police regarding possible sexual offences against them outside of the home. One of the young people was subject to a Strategy Meeting[4] as a result. Other allegations were also investigated by the police but none resulted in criminal charges prior to the autumn of 2012.

2.6. Despite their difficulties there was also positive information about the children. Individual workers spoke with warmth about them and, for example, one of the children achieved good academic grades despite her highly disrupted personal circumstances and absence from school.

2.7. By early summer 2012 four of the children were living in a housing unit run by the YMCA which provided semi-independent accommodation. In the first half of 2012 it was being specifically recognised by the Voluntary Sector organisation, Streetwise, and by the Looked After Children Nurse that there was a pattern of sexual exploitation taking place, with some of these children involved. It was also becoming increasingly apparent to the police and staff at the YMCA, that a group of men at a house close to the YMCA were involved in anti-social behaviour, with both drug use and '*inappropriate sexual activity'* being reported. Some of the children living at the YMCA were involved with this group and concerns were growing about them as they often returned distressed, intoxicated or with injuries.

2.8. In June 2012 a neighbourhood police officer began to investigate the activities at the house. Initially some children made allegations but were reluctant to make statements due, not least, to concerns about repercussions against them by the men. However, ultimately the children were supported to make statements leading to the eventual prosecutions.

[4] A Strategy Meeting/discussion is required whenever there is reasonable cause to suspect that a child is suffering or likely to suffer significant harm. This should include Children's Services, the police, health and any other appropriate body.

3. THE LINKS BETWEEN CHILDREN AND THOSE ABUSING THEM

3.1 A significant difficulty in Coventry, as has been the case with other Local Authorities is that initially the agencies struggled to understand the links both between the children and with the network of men in which CSE was taking place. The following is a summary of the key events which agencies (singly or collectively) were aware of at this time.

Key dates table

January 2010	**Child H**: Allegation of sexual abuse by older males. No prosecution deemed viable as she withdrew allegations.
March 2011	**Child K:** Moved into YMCA.
Dec 2011	**Child G**: CAMHS records noted she was at risk of sexual exploitation
August 2011	**Child J**: Social Worker for Child J's younger sibling concerned that both were at risk of CSE. **Child J** became Child in Need and Streetwise involved to discuss CSE with her.
Sept 2011	**Child J**: CSC recorded concerns about possible CSE/grooming (not specific).
Oct 2011	**Child G** admitted to hospital due to self-harm. Referred to CAMHS and CSC, allegations of abuse within the family noted.
April 2012	**Child G** moved into YPDA (Young Persons Direct Access housing)
May 2012	**Child J** identified by statutory agencies as visiting a house where she was at risk of CSE.
May 2012	**Child I** moved into YPDA.
June 2012	Neighbourhood police officers identified concerns about anti-social behaviour, including drug misuse and inappropriate sexual activity at a house close to the YMCA (House A).
10th June 2012	YMCA staff noted concerns about some of the residents, including three of the five subject to this review visiting a house , where there was believed to be drug use and sexual abuse of them by the men who were described as '*preying on the girls in the project*.' On police advice YMCA staff began to log any incidents connected to the address and inform the police. YMCA gave letters to the residents to pass on to the 'lads' at House A telling them they were banned from the premises.
12th June 2012	Information from one of the children concerned stating that another of the children was staying at House A
23rd June 2012	**Child G:** CAMHS made referral to CSC regarding history of sexual vulnerability and possible exploitation. Around this time CSC were making links between the girls and the men at House A and a Strategy Meeting was planned.
26th June 2012	Social worker identified that 3 of the children concerned were friends.
28th June	LAC nurse concerned about the presence of men outside the YMCA

2012	and the intimidating effect. She and Streetwise then ran a group health session attended by some of the children. There was discussion in the group that further increased their concern.
5th July 2012	**Child I:** referred to Streetwise by social worker as at risk of CSE. A Strategy Meeting took place with regard to three of the children concerned and one other young person.
10th July 2012	**Child G:** CAMHS made a further referral to CSC.
16th July 2012	Strategy Meeting regarding another young person at YMCA.
19th July 2012	Information from the police to YMCA that men at House A appeared to have moved to a different address.
8th August 2012	Sexting workshop at YMCA run by Streetwise worker. One of the children concerned attended
16th August 2012	Prostitution workshop at YMCA run by Streetwise & Kairos with a YMCA worker present. One of the children concerned attended.
22nd August 2012	**Child G:** CAMHS escalate concerns to CSC team manager, who took the view that Child G was not at risk. Police called by YMCA due to an incident when two men were being aggressive to staff and residents. Police also dealt with a large group of men outside the building.
23rd August 2012	**Child H** made allegations to Police re sexual abuse, interviewed, but not willing to make a statement due to fear of repercussions. One of the children concerned barred from YMCA as considered a risk to the other girls**.** Incident when five men break into her B&B to find her, police called and CSC informed.
24th August 2012	**Child I:** Safeguarding meeting **–** Child I allocated a Streetwise worker.
3rd September 2012	**Child G** referred to Streetwise by Social Worker identifying that she was believed to be at risk of CSE.
7th September 2012	Streetwise and Kairos ran a group at the YMCA. One of children made a disclosure of CSE and police informed. Kairos worker accompanied the child to an ABE interview. She attended a second ABE interview later in the month.
11th Sept2012	**Child K:** Social Worker made a referral to Streetwise.
18th September 2012	Three men arrested by the police in connection with CSE following allegations by one of the children concerned and another young person. The men subsequently bailed. The police investigation was recognised as likely to be complex. Strategy Meeting regarding a number of young people, including three of the children concerned. Police believed the arrests of the men could put them at risk. Two of the children concerned agreed to talk to the police.

4. APPRAISAL OF PRACTICE

4.1 Introduction and context

4.1.1 This section will analyse the quality of the most significant features of the services provided to the children during the time period under consideration. Where practice appears to have fallen short of what either at the time, or now, we consider to be good practice, it will seek to explain why this was the case. Section 5 will then consider if, and to what extent, current practice has improved and what this identifies about the need for future practice development and improvement.

4.1.2 Prior to September 2012, neither the multi-agency partnership nor the key statutory agencies in Coventry had experience of identifying or responding to complex episodes of Child Sexual Exploitation. Whilst awareness of CSE was being highlighted at a national level, at this point in Coventry the development of a multi-agency approach to CSE was at a comparatively early stage and this was reflected in frontline practice. The Local Safeguarding Children Board (LSCB) had established a CSE Focus Group in February 2012 in response to the publishing of the significant report by CEOP of 'Out of Mind, Out of Sight'. By September 2012 the CSE Focus Group had established a work plan including:

- Developing procedures and protocols
- Setting up an operational multi-agency group to manage children and young people at risk
- Awareness raising
- Training of workforce, parents and carers
- Taking part in West Midlands Area CSE Strategic group to develop best practice.

As such, the group's work reflected its purpose to '*scope out and gain an understanding of the scale of the problem in Coventry*'[5] rather than to work as an operational group.

4.1.3 Knowledge and information regarding Child Sexual Exploitation was considerably less well known during 2010-2011 than it is today and in Coventry, as was the case in many authorities, was not recognised as such a priority issue at that time. Nevertheless there was a growing national awareness of the phenomenon and agencies could reasonably be expected to have had some early awareness and begun to consider potential strategies and ways of working. There were some key documents that should have been made available to practitioners working with children and young people, particularly the 2009 Supplementary Guidance to Working Together regarding Child Sexual Exploitation and the Barnardo's report of 2011, Puppet on a String. Other information was also available regarding investigations into CSE, including the Derby Serious Case Review (2009)

[5] Coventry Safeguarding Children Board Annual Report 2011-12 and Business Plan 2012-2015

and the convictions of nine men in February 2012 following a major police investigation in Rochdale.

4.1.4 It should also be noted that during the time period under consideration within this Review, there is reason to believe that the quality of children's safeguarding in Coventry was not consistently reaching good enough practice standards. In January 2014 both Children's Services and the Safeguarding Children Board[6], were judged by OFSTED to be inadequate. None of the contributors to this review have suggested that practice during the period under consideration here should be assumed to be fundamentally different. The OFSTED inspection referred to '*key weaknesses in children's social care*' and many of these are mirrored within the experience of the children subject to this report. As a result of the OFSTED inspection the Local Authority has been working to an Improvement Plan[7] overseen by the Department for Education.

4.1.5 Since 2012 major changes have been made in Coventry in the way that agencies respond to CSE and these will be referenced more fully in Section 5.

4.2 January 2010 - May 2012

4.2.1. All five of the children subject to this Review were known to a range of services prior to June 2012, the time which effectively marked the starting point that culminated in the police investigation. All of the children had been in contact with Children's Services and three of them became Looked After Children as they had been accommodated by Children's Services after their parents were no longer either able or willing to look after them. Referrals had been made to Children's Services about each of them identifying a range of concerns including possible sexual abuse within the family, neglect, placement breakdowns, drug use, mental health problems and self-harm.

Safeguarding response to the children's identified risks and needs.

4.2.2. Setting aside whether or not these concerns might have indicated there were vulnerabilities for Child Sexual Exploitation, what could reasonably have been expected was that they would result in wider concerns about the children's welfare including the need for a safeguarding response. Whilst different agencies did identify concerns it was often this holistic approach to assessing and managing the risks to the children both at home and in the outside world that was either delayed or absent.

4.2.3. The quality of the response by Children's Social Care to four of the children prior to CSE being identified gives cause for concern. There was very worrying information being forwarded to CSC about the circumstances of all

[6] The Local Safeguarding Children Board is the key statutory mechanism for agreeing how the multi-agency partnership works together to safeguard children. For further information see Working Together 2015, chapter 3.

[7] The Improvement Plan is a high level plan designed to address the areas for improvement identified by the statutory Improvement Notice from the Government.

four children. Both the written records and the contributions of staff to this Review suggest too often there was a lack of meaningful assessment and a failure to recognise the seriousness of some of the risks facing these children. For example, Child I was subject to two referrals to CSC in 2010, but there is no evidence that a good quality assessment took place, or whether either Child I herself or her school were spoken to, it is simply recorded that these allegations were unsubstantiated. When in May 2012 the Young Person's Direct Access housing provider made a referral to Children's Social Care (CSC), an Initial Assessment was completed. However, the actions that followed appear to have been almost entirely focussed on practical issues, that is, her financial situation and accommodation, rather than reflecting her complex emotional and psychological needs and the resulting vulnerabilities.

4.2.4. 14 year old Child G 's presentation to hospital on three occasions in as many months during 2011 demonstrates the problems in ensuring that safeguarding concerns are recognised in the A&E setting. It was not until the third occasion that a referral was made by a consultant to the police and CSC, despite the fact that this was the third injury, the previous two being of a similar nature. Without detailed information about the circumstances of these two injuries and the context in which she was treated, it is not possible to reach a conclusion about the quality of individual practice episodes. However it highlights once again the limitations of A&E as an opportunity for identifying abuse or neglect in children. It is likely that the referral to CSC was made possible on this occasion because Child G was not just treated in A&E but admitted to a ward, which provided greater opportunity to respond to safeguarding concerns, not purely the presenting injury. On this third occasion there was good communication from the hospital to the police and social care and it also led to the involvement of CAMHS.

4.2.5. The response of CSC to the referral again raises questions about the way the needs and risks of older children were understood. The hospital were concerned that given the circumstances of the injury Child G might be '*in danger'* at home. She was also known to be self-harming, using drugs and to have witnessed domestic abuse, there was also a (disputed) history of sexual abuse within the family setting. What is therefore surprising is that this did not reach the threshold for any assessment by CSC whose involvement was brief. Similar to the response to Child I, Children's Social Care did become involved with Child G at the point when aged 16 she was required to leave home and moved into Direct Access accommodation and therefore needed to be assessed for financial support. There is no information to suggest that her wider needs other than the financial needs were assessed at this point.

4.2.6. The assessment and intervention in relation to Child J during this period was particularly worrying and will be considered in more detail. In March 2010 Child J's school attempted to initiate a CAF but only one meeting took place as it is understood that Child J's mother would not agree to take part and a CAF requires consent from the family. The school's concerns at that meeting led them to make a referral to CSC and there was also an anonymous referral specifically referencing CSE. It was good practice that

the school escalated their concerns, first to the CSC Referral and Assessment Team Manager, subsequently to the police. However, CSC's ultimate decision remained as no further action. Given the family history, the school's serious concerns about missing episodes and the direct reference to CSE, and in the absence of any explanation for the decision, this would not appear to be good practice.

4.2.7. The next referral to CSC just a few months later regarding specific and serious issues of neglect also did not appear to have resulted in a comprehensive assessment and was not considered to meet the threshold for intervention by CSC. instead the case was referred to the Family Intervention Project (FIP). It is of note that FIP themselves referred Child J back to the Referral and Assessment team as they were concerned about the reasons behind Child J's behaviour, particularly the frequent running away from home and felt it needed a '*more comprehensive assessment and intervention'*. Whilst the actions of FIP were appropriate, the need for such an assessment should have been apparent to the Referral and Assessment team based on the information that was available at the time.

4.2.8. It is also revealing that the vulnerabilities and risks to Child J's younger sibling seem to have been acknowledged earlier than those to Child J. In 2011 there appears to have been a Core Group relating to Child J's younger sibling. But although there is no immediate evidence that the risks to Child J whether of neglect within the family, or vulnerability outside it, were any less, the response to her needs was noticeably slower.

4.2.9. Throughout her time at school, there is evidence of persistent attempts to support Child J by school professionals including the Education Welfare Officer, who visited frequently, arranged transport to collect Child J and take her to school, informed police of missing episodes and had contact with other agencies involved with the family. It has now been recognised that there also needed to be a more strategic approach to ensuring that Child J's persistent periods of being missing from home and school were always reported, rather than sometimes relying on the mother to do so. One explanation for the school not always contacting police or social care when Child J was missing, could be their experience that whenever they contacted CSC it was '*batted back'* to them.

4.2.10. Given the quality of information available to this Review and the fact that these events took place between 4-6 years ago, it has not been possible to achieve a detailed understanding of the decision making at the time. The conclusions of the OFSTED report in 2014 however are likely to be pertinent:

"Social workers in the referral and assessment teams have very high caseloads and this means that they cannot do their job properly… (they) do not always receive the right level of supervision from their managers to enable them to discuss cases fully and make the right decisions for children and young people to improve their outcomes and ensure their safety and welfare"

4.2.11. The pattern of response to these children, before CSE was explicitly identified, reflects what has now been recognised as a common feature in

safeguarding. That is that the safeguarding needs or neglect of adolescents is less likely to be recognised or meet the thresholds for intervention than that of young children. Members of the Review Team reflected that in common with the wider national picture safeguarding in Coventry was much more focussed on the neglect of young children than it was on the neglect of adolescents. Coventry's policy on neglect which has been in place since 2011 does draw attention to this common tendency, but there is no supporting information to evidence that this was prioritised in frontline practice at the time:

> *"There is a tendency for professionals to underestimate the effect of neglect on older children and adolescents and to judge any concerns around neglect in relation to this group as less serious".*

Significance of adoption breakdown

4.2.12. Two of the 5 children had been adopted and had lived with their adoptive parents for a number of years. The children had left their adoptive homes prior to the timescale of this Review, but given the potential impact of their life experiences on their later vulnerability to CSE, the Review considered this merited consideration as part of the Review.

4.2.13. As the adoptions had been arranged outside of Coventry there was no requirement for the involvement of Coventry Children's Services in the early years. However, the response by CSC when the parents did request help with both children in 2005/2006 was appropriate. Both families were referred to the Adoption Support Team and there is clear evidence that significant attempts were made by that team to provide help and support to both the children and the parents.

4.2.14. During that period the Post Adoption Social Worker allocated to the families had both a good level of specialist knowledge about adoption breakdowns and the time and resources to work with the family. There was also an informal collaborative working arrangement with a Consultant Child Clinical Psychologist from CAMHS who had specialist knowledge in this area and worked with one of the children. As a result these professionals developed a proper understanding of the difficulties facing the families, the level of early life disruption that the children had experienced and the impact this now had on their relationships with their adoptive parents.

4.2.15. Despite their involvement, the Adoption Support Team was unable to prevent the breakdown of these two adoptions. Both professionals contributed to this Review and demonstrated a significant level of knowledge about the difficulties arising out of their early experience that face some children living in adoptive families, as well as considerable empathy towards the adoptive parents. Whilst CSE had not specifically been named as a risk by them, both these professionals identified that the children were highly vulnerable, with significant problems in making healthy attachments and in regard to their sense of identity. The Clinical Psychologist described one of the children as: "*vulnerable to abusive experiences, particularly because she already takes responsibility for the behaviour of people who have not treated her appropriately and fails to report abusive behaviour"*

4.2.16. It would be wrong to ascribe statistical significance to the fact that two of the five children had experienced adoption breakdown. Nevertheless the similarities between the two and the very particular emotional vulnerability that is linked to adoption breakdown is striking. As in the case of these two children, families who experience adoption breakdowns typically do not come to the attention of the safeguarding agencies at an early stage and this limits the opportunity for early intervention with these children and makes successful intervention considerably more difficult.

4.2.17. Figures regarding adoption breakdown are limited but the most recent research in the UK[8] concludes that approximately 2 to 9% of adoptions break down, with age at the time of adoption (i.e. over 4 years old) being the strongest indicator for breakdown[9]. The research also confirms the degree of vulnerability of young people moving after an adoption breakdown into supported housing which is so clearly reflected in stories of the children in this review:

> *"Young people, who left their adoptive family aged 15 years or older found it very difficult to access Children's Services and were signposted towards housing or benefit advice. They had no entitlement to leaving care services and were financially poor, lonely, and vulnerable to further abuse."*

4.2.18. Given the significance of adoption breakdown that has been highlighted in this Review, a recommendation has been made to the Board as follows:

Recommendation: The Board to ensure that learning from this SCR regarding the vulnerabilities following adoption breakdown are shared with relevant professionals and the implications for pre and post adoption support in Coventry considered.

Looking beyond the behaviour: recognising CSE

4.2.19. Child Sexual Exploitation was explicitly recognised by some of the professionals prior to the events of summer 2012. Although CSC intervention with Child J was slow to start, by summer 2011 she was specifically identified as being at risk and a Child in Need Plan put in place. The decision not to place her on a Child Protection plan, as was the case with her younger sibling, was at this point a conscious one in recognition of her age. The intention was nevertheless clear at the Initial Child Protection conference that the concerns for Child J were as great as they were for her sibling and their plans should be reviewed together. There was evidence of a strong chairing of this conference, one of a number of occasions when conference chairs and IROs have provided a good steer in decision making.

4.2.20. The professionals who appeared to identify CSE most quickly in relation to the other children were those staff working for Streetwise and Kairos, and the Looked After Children Nurse. Streetwise is a Children's Society project initially funded by Comic Relief to conduct return home interviews with young

[8] Selwyn, J et al (2014 : 275)
[9] Selwyn J et al (2014:19)

people who had run away or gone missing and help reunite them with their families. Over time as they worked with the children Streetwise began to identify a repeating pattern which they recognised as Child Sexual Exploitation. In September 2011 the project, which consisted of a manager and two part time workers shifted its focus entirely to Child Sexual Exploitation, working to raise awareness amongst other professionals and to support children and young people at risk. However, despite attempts by the manager to formalise their role, Streetwise was not a member of the key multi-agency networks, including the LSCB and the Missing Children Panel, nor had it been commissioned by Health or Social Care and as such, despite several attempts, found it difficult to influence policy or the approach to CSE at the strategic or higher operational levels.

4.2.21. The School Nursing service was also involved with some of the children, all of whom were to some degree difficult to engage. In early 2012 the school nurse who had contact with Child J was very concerned about her. She clearly understood that Child J was being exploited, but although she tried to develop Child J's trust was unable to get her to speak to her about what was happening. The school nurse's description of her own frustrations at being unable to help Child J is something that was reflected by a number of the professionals: "*I could see it happening, but felt powerless to help".*

4.2.22. Whilst some individuals clearly did recognise that the children were at risk of sexual abuse it was also the case that this was not always recognised as CSE. The indicators and warning signs of CSE, which with hindsight and greater familiarity we can now identify, were often not recognised as such. At times they were seen more as a feature of the children's behaviour or something they need to just take responsibility for. What is apparent is that too often agencies and professionals seemed unable to look beyond the behaviour of the girls and recognise the full reality of what they were experiencing.

4.2.23. A recurring feature with several of the children is that they were identified as being sexually active at an early age including having contact with men online. For several of the children there was information about previous sexual assault or allegations of sexual assault which were later withdrawn. It is evident for example that both social workers and foster carers were concerned about one child's safety following allegations in 2010 of '*sexual incidents'* with older teenagers and men as well as in relation to men she had contact with on social media. However it is not evident that this represented a conscious recognition that this child might be experiencing CSE or be at significant risk for the future. It was also the case that at times the language used about the children, for example, references to promiscuity, was highly judgemental and demonstrated a lack of understanding of the degree to which they were in control of what was really happening to them.

4.2.24. All of the children were known to be going missing from home or school, sometimes for quite significant periods of time, including overnight or for a few days. The police have now identified that there were at least 96 occasions in which these children were reported to them as missing and it is

likely that the actual figure was actually much higher. Information about the police response to the children in 2010 and 2011 is very limited as due to software problems with the recording system in early 2012, all the previous missing records were removed from the missing person system, with the result that the only information available to the Review from the police prior to 2012 relates to one of the young people, Child J. However, there is nothing to suggest from the records of other agencies that the Police had prior to 2012 identified any link between the children's missing episodes and the possibility of CSE.

4.2.25. Education staff were particularly concerned about Child J's frequent absences and worked hard to ensure she was in school in order to complete her education, with the outcome that despite her difficulties she was able to achieve a number of qualifications before leaving school. However, the absence of the children from school also limited their schools' opportunity to engage with them and to achieve a better understanding of what was happening in their lives.

4.2.26. There were a number of occasions prior to June 2012 when the children either made direct allegations that they had been sexually assaulted or spoke of historical sexual assaults that had taken place. Some of these were subject of Strategy Meetings between the Police and Children's Services and led to the Police beginning investigations, although it was not until the major police operation in 2012 that any of these investigations led to criminal charges. On more than one occasion allegations were made by the children and then withdrawn and there existed a level of scepticism about the allegations within the police. One of the children gave a description of sexual assault by a number of men after she had gone missing, which with hindsight, looks like a 'text book' description of CSE. However what is recorded is that she had been sexually active since she was 13 and that she '*admitted she had lied'.*

4.2.27. The withdrawal of, or unwillingness to, pursue allegations does create a genuine difficulty for a police investigation, particularly when the allegation relates to events that happened some time ago. Whether there was the basis for prosecutions on these occasions is not something that this Review is in a position to judge. However, the lack of any prosecutions prior to the events of summer 2012 at the very least raises questions about the level of understanding and persistence the police showed in investigating the allegations. The fact of a delay in reporting, or withdrawal of a report is not in itself indicative of a false allegation. There is now a much wider understanding of what can appear contradictory behaviour by children in relation to reporting sexual abuse or being willing to make statements.

4.2.28. Another common feature was the way in which the children presented for health, including sexual health treatments. Often presentations would be via acute services, such as A&E rather than through their GP which can have the effect of masking any pattern of attendance. The Hospital Trust has identified at least 15 attendances at A&E for these children during the time period. On a number of these occasions the child concerned had been drinking and the approach as described was to allow them to '*sober up and*

go', demonstrating a failure to recognise that these were children who needed a safeguarding response. On one occasion a Sister from A&E did inform CSC when one of the children said that she was drinking a bottle of vodka a day. However, there is no information that any action was taken as a result of this. One of the children attended A&E with bruises and 'love bites', and other presentations were with possible pregnancies or miscarriages, but the potential significance of these was not understood. At the time the screening processes at A&E did not include an alert to the possibility of CSE, although this has now changed.

4.2.29. Individual presentations at A&E should at least on some occasions have raised concerns about the children's welfare and this has been recognised by the Trust and action taken to raise awareness and improve systems. However, it would not be reasonable to judge that an average of three presentations per child over the 2 year period should or could have been seen as a pattern by A&E staff. The key relevant contact between GPs and these children was in relation to requests for contraception. Information within the children's medical records, as well as documented attendances at A&E, would have identified them as vulnerable with complex social histories. However, there is no evidence that the doctors questioned the children about the circumstances in which they were sexually active. Frequently there was no information recorded about who the child's sexual partner was and there appears to have been an inherent unquestioned presumption that they were consenting to sexual activity. The Named GP for the Clinical Commissioning Group, who provided a report for this Review, described this as being absolutely in line with current professional practice. This will be considered further in Section 5.

4.2.30. There were many other signs amongst the children indicating either vulnerability to CSE or that CSE was actually taking place. These included deteriorating physical appearance and self-care; self-harm; substance misuse; being given gifts including mobile phones; socialising with older peer groups; tiredness; being collected in cars by older men. These often gave cause for concern, but as has been described above, professionals did not always understand their potential significance.

Multi-agency working

4.2.31. As is so frequently the case with Serious Case Reviews there were at times problems and weaknesses in working across agencies and sharing information effectively. Many of the practitioners involved with these children were unaware of other services or individual professionals who were also involved. The underlying problems are very familiar, ranging from: difficulties with databases; limited resources; individuals not recognising the significance of information they held; assumptions that other agencies would be dealing with the identified problems. One example of how this manifested itself was in the involvement of the school nurse in formal child protection procedures. The school nurse was not provided with information about Child Protection Conferences or other multi-agency meetings regarding one of the children she worked with. Neither did she get a response when she followed this up. Practice now is that the MASH

identifies the relevant practitioners to be invited to Conferences. However it was common practice at that time for school nurses or their service not to be invited to CP conferences. This both reduced access to information about an individual child, but also in the context of CSE meant that a potential source of information that might link individual children being abused within a network, was lost.

4.2.32. Other multi-agency meetings also effectively excluded some professionals and organisations who could have provided helpful information. This was particularly keenly felt by the voluntary sector organisations, such as Streetwise, who felt strongly that their role was not understood or taken seriously. The manager at the time spoke about her frustration that Streetwise was not represented on Coventry's Missing Children Panel, which reviewed those children who were going missing, despite the obvious role they played in working with this group of children. What this reflected was the absence of a clear strategic approach ensuring that information was shared with the right organisations, based on an understanding of CSE and the often complex links between the victims and perpetrators.

4.2.33. Those workers who did identify and raise concerns, felt frustrated at what they experienced as a lack of response from Children's Services, this can be seen in their actions and records. Whilst there is evidence of one occasion when a school professional attempted to escalate matters with little success, it would appear that services felt unable to influence CSC's decisions. Since this time regular meetings have been established between schools and other agencies such as the police and CSC which provide an opportunity for raising concerns at a senior level. What is more difficult to assess is the degree to which front line professionals, including managers, feel able to challenge colleagues from their own or other agencies.

4.3. June 2012: Identification of CSE and the multi-agency response

Identifying and investigating what was happening

4.3.1. Although Child J had already been recognised as being 'at risk' of CSE and was by March 2012 on a Child Protection Plan for sexual abuse, this had not led to any of the perpetrators being identified, nor to a decision to investigate whether others were also at risk. 15 year old Child J was living in a Children's Home where she was being assessed, but she continued to cause concern to staff and social workers. When in May 2012 after her social worker called the police because Child J had been assaulted by her boyfriend, she was described in police records as '*prostituting herself'* and the alleged assault was not recorded. This, like other similar episodes demonstrated a failure to understand that Child J was a child who required protection, or that she might be being exploited.

4.3.2. The fundamental shift in the safeguarding response to these five young women came during the summer of 2012 when the activities at the house close to the YMCA where three of them were living were becoming increasingly visible to different agencies. It was also becoming apparent that

more than one of the children was involved. Although there was some very good individual work, the subsequent response by the agencies was not without its problems. The lack of any agreed multi-agency process for managing such a situation or a shared professional understanding of CSE and its impact on victims undoubtedly contributed at times to a disjointed approach, some delay in intervening to protect the children and a sense of intense frustration for some professionals. In the words of one of the professionals involved:

> "*We followed established rules at the time, but the perpetrators didn't follow our rules*."

4.3.3. By May 2012 the LAC nurse had met with two of the children. The LAC nurse was experienced in working with children in care, she had undertaken training in gang based violence and had made a point of following developments nationally in order to develop her own knowledge about CSE. The LAC nurse became aware of the number of children that were going missing and began to be concerned that there was something worrying taking place in Coventry. She consciously made efforts to make lots of visits to the children she was responsible for in an attempt to build trust. What is evident here, and will be a repeated feature, is the degree to which the system was reliant on individual workers who had educated themselves about CSE, to identify what was happening.

4.3.4. The LAC nurse provided a powerful picture of her first visit to one of the children at the YMCA in June 2012. There were a number of Asian men '*hanging around'* outside and although they were not directly abusive, she described it as an '*intimidating atmosphere'*. During her meeting she could hear the doorbell constantly ringing, but when she spoke to the staff about it, she felt they were not particularly aware that there was something wrong about this and that the behaviour felt like it had become normalised. As a result of her concerns she contacted Streetwise in the hope that they might work together with some of the children and young people in the YMCA. Staff at Streetwise had been concerned about CSE in the city for some time and had been involved in providing awareness raising and training both to young people and to other professionals. It was following one of these awareness meetings run by Streetwise and Kairos that one of the children told the Kairos worker that she was experiencing exploitation and agreed to give a police interview. Although she subsequently withdrew due to fear of repercussions, this direct statement from one of the children was a crucial step in the overall investigation. The support of the Kairos worker for the child during the process and as long as she wanted it subsequently was an example of the good practice that did exist.

4.3.5. At around the same time the Community Police Sergeant was also becoming aware of anti-social behaviour, various allegations of drug dealing, parties and sexual activity in the house close to the YMCA. He identified that this might be CSE and agreed with his inspector to make more inquiries, including visiting the YMCA and making checks on some of the men concerned. Within a week he had collated information which was forwarded to the Public Protection Unit of the police, ultimately leading to the major

investigation being established. Prior to this there had been no proactive attempt by police to seek intelligence about what was happening in the area and surprisingly little contact from local residents about the unusual activity. The officer concerned described his response to what he saw as being a result of instinct combined with specific intelligence.

4.3.6. The response of this individual officer, in contrast with some previous police officers, highlights both the strength and a weakness in policing and wider safeguarding. What was very positive was that the Community Sergeant, supported by his Inspector, drawing on personal skills and awareness was able to identify what was taking place and effectively set in motion the subsequent police operation. The weakness however is the reliance on some particularly able individuals, in picking up an issue of concern that is not a particular focus for the overall system. In this case it did result in a much quicker response than has been seen in some of the other high profile CSE cases. Nevertheless by not having an established proactive approach to the possibility of CSE the police within Coventry may have missed an opportunity to intervene at an earlier stage.

4.3.7. National guidance on investigating complex child abuse had been in place since 2002. The guidance is based on the expectation of an early multi-agency approach:

> *"Complex abuse investigations should be undertaken as a joint operation involving the police and social services, with the Crown Prosecution Service being involved at an early stage as appropriate"*[10]

This however was not put into effect at as early a stage as possible in this point in Coventry and this created problems. The Police experienced difficulties for example in not initially having a single point of contact within Childrens Services, which itself is likely to have contributed to wider communication problems with other partner agencies. There was a three month delay before a Major Incident Room was set up, which is understood to be as a result of resourcing difficulties. The strengths and weaknesses of this investigation, which have been very apparent to this Review have been candidly analysed by the Senior Investigating Officer who provided a debrief to the Safeguarding Children Board and included:

- Early safeguarding Strategy Meetings not being focussed enough.
- An initially slow acceptance by senior management in CSC and the police that what was taking place was CSE
- Lack of good communication from the police and CSC to other organisations about the significance of the information they had provided.
- Initially a lack of knowledge around 'Organised Abuse' Strategy Meetings and the need for a tailor made approach

4.3.8. Whilst CSE was now being recognised, it took some time to establish a comprehensive process examining how the perpetrators and all the victims, not only these five children, might be linked together. Staff at Streetwise

[10] Home Office and Dept of Health (2002:5)

described their frustration at the lack of co-ordination across services in the early weeks and their concern that the complexity of the abuse was still not being recognised. A decision was made, led by the manager at Streetwise to put into place fortnightly meetings of the 4 key voluntary sector organisations working directly with the children. These were :

- Streetwise,
- Kairos, a small project in the same building as Streetwise, which worked with adult women involved in prostitution and shared an understanding of the significance of CSE.
- a project working on trafficking
- CRASAC, the Coventry Rape Advisory service.

Other agencies such as the police were invited but never attended.

4.3.9. This group arranged for each young person identified as a victim of CSE to be allocated a worker in one of the organisations, but also began a process of collating the information that they were beginning to see and building a coherent picture of what was happening. They started, what is now a familiar process within specialist CSE investigations, of identifying and mapping out as much information as possible that might be relevant: names, nicknames, venues, car registrations, links between individuals both perpetrators and victims. This information was eventually physically taken to the Police PPU as the group felt they were not being heard in any other way. That small, poorly resourced third sector agencies were taking on this task rather than the Police reflected the lack of senior leadership and resources during these early stages, not the commitment of the individual investigating Police Officers.

4.3.10. The Community Sergeant met with staff at the YMCA and asked them to record information about any activity or allegations regarding the house they were visiting. It is evident that staff at the YMCA were routinely recording information and allegations from other residents as requested. Whilst this was important in itself, there is less evidence that the YMCA staff viewed themselves directly as having a wider role in safeguarding. There is no doubt they were worried about the children and were trying to deal with a very difficult situation but the YMCA's activity seemed to be focussed primarily on identifying the criminal and anti-social behaviour on behalf of the police. YMCA staff did not routinely become involved in these particular group events organised by the LAC nurse and Streetwise. There are contradictory perspectives on why this was the case, but given that the events took place in YMCA premises it is surprising that they did not take a more active role.

Responding to the children's needs during the period of investigation

4.3.11. By the end of June 2012, it seems to have been understood across the various agencies that there was a significant problem of abuse and exploitation. The Police investigation was transferred from the neighbourhood team to the Police Protection Unit and safeguarding plans began to be put in place for 4 of the children. At this point no connection had

been made between what was taking place at the house close to the YMCA and with Child J's experience. Staff at the children's home where Child J was living had however not long previously contacted the Police and reported that they suspected that Child J was being groomed as she was very frequently collected by an unknown 'asian man' driving a BMW, alongside other indicators.

4.3.12. What is evident over the next 3 months is that many of the services and the professionals continued to have limited understanding of the impact of CSE on the children, or how best to respond to what was happening. Examples of this included:

- CSC responding to a referral from CAMHS about Child G by referring her on to Compass for advice work rather than considering that this was evidence that she was at risk of significant harm and considering Child Protection processes.

- Professionals focussing on telling the children that they should keep away from the men, or instructing parents of their responsibility to keep their children safe.

- YMCA giving letters to the children to take to the perpetrators telling them they were banned from the premises, despite staff themselves being uneasy at having to ask the men to leave the site.

What this revealed was that many of the professionals did not understand the degree to which the girls were controlled by the men, emotionally, physically, through supplying them with drugs, through physical abuse and threats.

4.3.13. The social work response was very mixed. Some social work staff and managers appeared to have limited understanding of the level of risk the children faced. For example in August the social worker, with management support, concluded that Child G was no longer at risk because she was '*working with professionals'* and so closed the case. A recording at the time is revealing: "*Child G is 16 and therefore capable of making decisions about consensual relationships….social care can only advise and make recommendations.*" Irrespective of whether she might or might not still be subject to abuse, this was a 16 year old child who was understood to have been sexually exploited and had no meaningful family support. A supervision note relating to one of the other children around the same time stated that she was someone who:

> *'lies convincingly…for some reason she seems to love the way of life she is carving out for herself, but she will disclose nothing"*

4.3.14. Other social workers, although they may have struggled to make progress, evidenced greater awareness of the risks and vulnerabilities of the children they worked with. An example was a social worker responsible for Child J towards the end of the period under consideration who evidenced a good understanding of Child J's history and vulnerability. Child J was to be moved

to a different residential home. The social worker recognising that Child J, whose safety remained fragile, was likely to be unsettled by the move, intervened to try to enable her to stay. She was frustrated that the system was not flexible enough to allow this to happen and clearly recognised the significance of stability of both placements and relationships for this child.

4.3.15. The lack of active senior management involvement for many of the agencies meant that front line practitioners who were facing a complex and at times highly distressing set of circumstances often lacked support or direction. As the seriousness of the situation became clear there was little evidence of this being recognised by agencies or the safeguarding partnership as a critical incident that needed an urgent joint response at senior levels. A social worker spoke of the impact of feeling that she had to 'fix' everything but feeling isolated and lacking effective support or structures in which to work. The same social worker felt that the managers who were trying to be supportive were really 'muddling through' themselves.

4.3.16. For a period of a few months some workers, particularly, but not uniquely, the voluntary sector workers appear to have held a disproportionate amount of responsibility for the children. The two workers from Streetwise and Kairos, provided a powerful description of the emotional and professional toll on them of working with these children in the absence of clear and robust support from the statutory partnership. Both professionals were very experienced in working with vulnerable young people and gained excellent support from the manager at Streetwise and the informal group which met fortnightly. Nevertheless continually hearing about highly disturbing abuse of these children and knowing that they were continuing to experience this abuse, was extraordinarily difficult for them and for others. One of the voluntary sector workers who was a trained social worker, reflected that her professional training made her painfully aware that she was carrying a level of risk which given her role at the time, she was not in a position to manage. One of the social workers who was given a particular role with a number of children experiencing CSE, despite having very limited experience, described this as a highly damaging experience. The description given reflects the lack of a structural understanding of the nature of what was taking place, and the potential impact this could have in the absence of a very robust structure for individual workers For a while there was evidently a lack of recognition of the degree of organisational responsibility not only for the children, but for the wellbeing of practitioners working with this type of abuse.

4.3.17. The central role of the YMCA Coventry and Warwickshire requires some consideration, both in the service it provided at the time and because of the implications for commissioning of such services. Staff have been subject to criticism by a number of professionals who felt they should have been much quicker to recognise the problem and more proactive in working with the children and young people in the project. It should be noted that the YMCA does not entirely share this perception. It is the conclusion of this Review however that there is some reason to conclude there were weaknesses, although it is important to see these in the context of the organisation as a whole.

4.3.18. The YMCA found itself at the centre of what became a major CSE investigation, for which it is clear it was not prepared. Some staff told the review they had no training in CSE and limited safeguarding training, although it is the case that the YMCA did have in place training for staff as required by their commissioners. The building was made up of self-contained flats and the role of the Housing Co-ordinator, who was effectively the day to day manager, was dealing with all the practicalities from staff rotas to health and safety. The interim YMCA Housing Co-ordinator at the time said she was not having supervision and there was no safeguarding supervision. She was required to attend Strategy Meetings which she felt unprepared for and where she was not in a position to make key decisions.

4.3.19. The location of the building and range of residents meant that it could be a demanding and stressful place to work and it would appear that staff had to some extent become used to behaviour which was felt by other professionals visiting the building to be much more concerning. At the time the Housing Co-ordinator's line manager had responsibility both for operational issues and safeguarding. With hindsight this meant there was no-one in a position to take a step back and ensure there was a more questioning or strategic view of what was taking place or to provide more of a specialist safeguarding perspective. Since this time a new system has been put in place to ensure there is a manager who is able to fulfil this role.

4.3.20. The YMCA project in Coventry is part of the national YMCA Federation but is not directly managed by YMCA England. YMCA England itself runs a number of housing projects, but others, such as the project in Coventry are self-governing and managing. YMCA England has established advisory policies and procedures, including safeguarding policies, and these were in place at YMCA Coventry and Warwickshire. Although it was not a requirement, YMCA Coventry and Warwickshire could have approached YMCA England for advice or support, but did not do so at this time. What this has highlighted is the potential to find more effective ways of sharing support and information across the YMCA Federation, particularly when a member project is facing a complex safeguarding situation. As a result of this Review discussions have taken place between YMCA Coventry and Warwickshire and with YMCA England and it is a recommendation of the Review that the final report is shared with YMCA England and consideration given to any wider learning for the Federation as a whole.

Recommendation: This SCR to be shared with YMCA England in order for the lessons to be considered within the wider organisation, including access to safeguarding support for members of the Federation.

4.4 The longer term approach to working with victims of CSE

4.4.1. The time period set for this Review has meant that there was less evidence available about the nature of practice in working with the victims of CSE in the longer term. However it was apparent to the Review that this is one of the particularly complex challenges for agencies and required some

consideration. At the time of these events the focus was predominantly on identification, investigation and arrest, but there are clues even within this limited time to the difficulties that were being experienced and pointers and what this might mean for future involvement with young victims of CSE.

4.4.2. Only one of the children, Child J, was subject to a longer term plan of intervention after it had been identified that she was at risk of CSE. From August 2011 she was a Child in Need, although this changed in November 2011 to when she was placed in Foster Care under S20 of the Children Act, making her a Looked After Child. Also in March 2012 she became subject to a Child Protection Plan on the grounds of Sexual Abuse. What can be seen over this period is a predominantly reactive approach to crises rather than a clearly laid out plan of work.

4.4.3. It is widely recognised now that working with children and young people who are subject to CSE is extremely complex and success is rarely something that can be achieved, if at all, within short time frames or by single agencies. The vulnerabilities that often allowed children and young people to be groomed at the outset can be very complex, as can be seen from the limited picture drawn of these five children. Those vulnerabilities often continue to be used as a hook by the perpetrators even when children are subject to Child Protection Plans or Looked After by the Local Authority. Whilst there were undoubtedly some workers who were skilled and committed, it is difficult to judge whether they had adequate organisational support including access to managers with the skills or knowledge to properly support them and enable them. It is of interest that one of the IROs at the time commented that LAC Reviews should not be being used as analysis and decision making forums, suggesting that this was not taking place as part of normal management oversight and supervision.

4.4.4. Child J's experience also reflected the difficulty in establishing effective placements for children experiencing CSE. Child J spent a brief period in foster care, but this quickly broke down because she immediately and repeatedly went missing. Whether this was a suitable placement is not something that this Review can judge. However it does raise the question as to how effectively placements for a young person were assessed, whether a family based placement was most suitable and if so, what skills, training and support would the carers need to have had in place. What Child J's experience also demonstrates is the inability of the system to accommodate the individual needs of each child.

4.4.5. A foster placement for a child such as Child J would need to manage the behaviour that led her to be accommodated in the first place, as the behaviour, which was directly linked to her vulnerability and abuse, could not be expected to change in the short term and might not change during the period a child is in care. This may require a shift in thinking for both the those arranging the placement and the foster carers who will need to show persistence in the face of continuing risks; '*seeing past challenges to the need for compassion and unconditional acceptance*'[11]

[11] Shuker, L (2013:94)

4.4.6. For all of the children accessing appropriate, long term safe accommodation was a significant issue and it is not easy to detect a clear strategy for housing them. All fve eventually found themselves in semi-independent accommodation, which they were poorly equipped to cope with. Supported accommodation such as the YPDA (Young People's Direct Access) accommodation or the YMCA in reality did not have the skills and capacity to meet these children' needs. Some of the children because of their circumstances were unable to maintain this type of accommodation and faced eviction because of their behaviour. The challenges that applied to Child J in foster care equally applied to the children in semi-independent accommodation and at times they struggled to meet the requirements placed on them. When Child J was found a placement in which she showed signs of settling, she was only able to stay there short term as its purpose was assessment. The system did not have the flexibility to allow her to stay.

4.4.7. Although none of the children had reached the age of 18 by the end of the period under review, this would have been a point for those not Looked After by the Local Authority when access to support would have come to an end. For those Looked After children the support from the Local Authority would have continued until 21. The absence of any meaningful transition into adult services for children who are likely still to have significant problems beyond the ages of either 18 or 21 is a cause for serious concern. We know from experience elsewhere, that some of these young people will still be involved with individuals who have been suspected of abusing them; they may be in long term relationships with them and possibly have children with them. We also know that CSE can impact on the victim's wellbeing into the future and can also affect children they may have. The impact of having been exploited can also re-emerge later in life [12] when those who are now adults may struggle to access appropriate services. This was a concern repeatedly identified by practitioners and senior managers in Coventry and results in a recommendation to this review:

Recommendation: The LSCB share this SCR with the Adult Safeguarding Board and review options for joint working or commissioning of services for the victims of CSE.

4.5 How the children's voices were heard and how they engaged with the professionals

4.5.1. An important aspect of this Review was to gain understanding of the children's perspective on their experience. That we have not been able to achieve contributions directly from the young people concerned represents a significant gap in our understanding. The Review has, as far as possible, attempted to understand what the children might have been trying to say to professionals about their experience from what we know of their stories and

[12] Research in Practice (2015: 79)

the stories of others who have had similar experiences. The review has drawn on three other key sources of information to supplement what was available regarding these five children:

- Meeting with the Coventry Young People's CSE Reference Group
- National research
- Published Serious Case Reviews

4.5.2. Limited research has as yet been undertaken in relation to children and young people's perspectives on CSE[13]. The Cascade research which heard directly from a small number of young people who had experienced CSE identified a number of key issues including:

- Vulnerability to CSE arising as a result of other issues and feeling 'invisible' to practitioners and their families
- Instability in their care.
- Difficulties with family and relationships
- Risky activities (including alcohol and drug use) representing a way of asserting themselves and feeling in control
- Exchanging sex for some young people being the least worse option

4.5.3. Direct information about the children's views is hard to identify within the records that are available and where it is available it is of a mixed quality. Some positive information can be identified, for example, one of the children wrote a thank you letter to her school for their support after she left, and there is evidence within the children's records of some professionals working hard to gain their trust, seeking to hear their views and attempting to understand what was happening to them. The worker from Streetwise described being surprised at how much one of the children was willing to say about the abuse she was experiencing, evidencing that the children were at times willing to speak to trusted professionals given the opportunity and time to do so. Conversely there is evidence of poor practice regarding one of the children on two very significant occasions in that she was moved from her foster placement without consultation or discussion after disclosing sexualised incidents and secondly required to change school without any evidence of her wishes being taken into account.

4.5.4. What is very apparent from both the records and the information provided by the professionals was that the children's '*voice*' could predominantly be detected through their behaviour, requiring a level of awareness and skill on behalf of individual professionals. Some professionals demonstrated a strong sense of what the children were telling them - '*reading between the lines'* where the child could not talk openly. One of the children was described as being *'desperate for help*' but at the same time refusing to talk to any of the agencies about what was happening to her. However, as has already been noted in this report, frequently the signs and symptoms of what was happening to the children went unrecognised, and even when disclosures were made this did not result in a positive outcome for them.

[13] Hallet, S (2015)

4.5.5. A thread that can be seen running through much of the response to the children is too great a reliance on direct disclosure from the children as to what was happening to them. In reality less than 1 in 10 disclosures are made to professionals[14]. This study by Cossar and others on behalf of the Children's Commissioner suggests that there is a '*spectrum of disclosure*' with four aspects: **hidden**; **signs and symptoms**; **prompted telling** and **purposeful telling.** The study identified that **prompted telling** could follow a sensitive response from a professional recognising a sign or symptom, or a gradual building up of trust with a professional over time. **Purposeful telling** required the young person to understand what was happening to them and deliberately approach someone, which was likely to be extremely difficult for most young people. It further identified that the personal qualities of the individual professional, rather than the agency, were crucial and included: *"reliability, privacy, continuity and power to act and change the situation*."

4.5.6. The central role of the relationship that is developed between a professional and a young person receiving help or care is widely recognised and supported by a range of research. There is evidence that some individuals were working hard to achieve trusting relationships with the children and also evidence that some of the children were developing trust in those relationships. An example of this was one of the children specifically requesting to have contact with her previous adoption support worker. However, this is again focussed on individual workers, whereas from an agency perspective it appears only to have been the voluntary sector group led by Streetwise that took a strategic decision to prioritise relationship building and consistency during this period. Outside of the timeline for this Review it is the case that individual police officers working on the investigation regarding these children as well as on subsequent investigations, have often developed into being a very significant professional for some of the children. However this is recognised as being an unsustainable model given the police's role and their need to withdraw following completion of an investigation or trial.

4.5.7. Whatever the skills and qualities of individual workers, in the absence of a strategic approach from their agencies, these professionals could only make limited progress. Problems for professionals needing a more strategic solution included:

- Lack of confidence and skills in working with this age group and/or in relation to CSE.
- Frequent changes of allocated worker
- Agency roles and demands limiting opportunities to build relationships over time
- Children with significant attachment problems being required to work with large numbers of professionals affecting the ability to build relationships "*it was doomed to fail*".
- The children being unable or unwilling to speak to professionals because of the risks from the perpetrators of them making disclosures

[14] Cossar, J et al (2013:v)

4.5.8. Whilst the young people subject to this review were not able or did not wish to contribute, another recent SCR[15] which did benefit greatly from the young people's involvement provides some powerful messages, which clearly resonate with evidence from this Review including:

- *Recognise that it is very hard for us to see ourselves as victims and therefore to have any insight into what help we need. When we are displaying difficult and challenging behaviour, we want professionals from all agencies to have a greater awareness of this, especially schools.*
- *Know it is embarrassing to talk about sex – really important that you must not look embarrassed or go red, this just shuts us up.*
- *It is hard to say what is happening - we worry that it will get back to our families or to some of the people who did this, who might hurt us.*
- *If you want us to share, do stuff with us; find places that are comfortable out of your offices.*
- *Children need a safe place to go – this is very important.*
- *The public need to be aware of what can happen and report things*
- *There should be services on demand and at night when we really need you[16]*

Whilst it is crucial that each young person's needs are assessed and responded to individually the voices of these young people from Bristol offer an important addition our understanding of CSE.

4.5.9. A further important contribution to this review came from the Coventry Young People's CSE Participation Group. This is a group of young people who have agreed to work together with youth work staff from the Horizon team to contribute their views to the multi-agency approach to CSE in Coventry. These young people were generous in the way they gave their time and thoughtful in sharing their views with the Review. In particular they were able to give a perspective on how young people more generally might view CSE. There was a widely shared view that most young people still know very little about CSE and that education within schools was not really working. Whilst, for example, they could remember seeing a performance of Chelsea's Choice, a theatre production designed to raise awareness of CSE with young people, it seemed to have had little impact on them. Their analysis was that it took place in front of a large year group and no-one would want to be seen showing an interest in front of their peers.

4.5.10. This group of young people all felt that more could be done in schools to get young people thinking about '*healthy relationships*' so that they might recognise when they were not in a healthy relationship. All felt that there were not enough lessons about personal and social issues and that lessons on sexual and intimate relationships should begin in Year 7. In particular they felt quite strongly that Child Sexual Exploitation is not a useful term as far as young people are concerned. Their perspective was that the reference to '*Child*' meant that teenagers would not see it as something that

[15] **The Brooke Serious Case Review into Child Sexual Exploitation, Bristol LSCB, 2016**

[16] Messages from young people adapted from the Brooke SCR.

referred to them. Evidence has been provided to this Review that there is some very positive work taking place in some schools, however, the messages from these young people remains an important one.

4.5.11. When asked about who they would talk to if they had a concern about CSE, there was a strong collective view that they would find it difficult to talk to a parent and probably would not tell a teacher. They identified that the person they would speak to would be the youth worker working with them on the group, but also mentioned particular community police officers who they had got to know. This reflected many of the lessons from research which is that it is individuals that young people develop trusting relationships with that are key to any disclosure. Finally they spoke of the importance of peers who could offer support and suggested a confidential helpline might be useful – although there were different views about this.

4.5.12. To summarise, the strongest themes emerging from this analysis are in relation to the importance of relationships with key professionals and for all professionals to have a much better understanding of how and why young people may disclose their concerns. These issues are subject to a recommendation:

Recommendation: That the LSCB and partners consider how to promote and develop a relationship based model of working with older children who present as vulnerable and at risk.

4.6 Summary

4.6.1. In assessing the overall experience of the children in this case, it must be acknowledged that ultimately their needs were not adequately met and they remained at risk and vulnerable for too long. However, the picture of services is a mixed one, with evidence not only of poor or ineffective practice but of good, determined practice by some individuals and agencies. The police investigation when it was fully initiated was treated seriously and within three months it took the form of a full Major Incident Inquiry. For the children and those supporting them, this did represent a difficult period of delay, but it did not represent the entrenched failure to take these offences seriously that has been a pattern familiar from some other CSE investigations nationally.

4.6.2. It is evident now that all the children had experienced significant problems prior to the summer of 2012 when it was recognised that they were either experiencing CSE or were at high risk of CSE. The full extent of the children's problems and vulnerability would not have been apparent to all of the agencies or professionals at the time. Neither would it have been a simple matter of predicting that these children would be subject to CSE. Nevertheless there was enough information about each of the children which had it been collated and properly assessed could have led to a very different response.

4.6.3. Where there were weaknesses in the practice, these were often related to underlying issues now very familiar when we review historic CSE. These included:

- Lack of practitioner knowledge
- Lack of agency knowledge
- Critical or judgemental attitudes which reflected a lack of understanding of the impact of CSE.
- Skill and knowledge base in working with adolescents
- Resource pressures – for police investigation
- Resource pressures - social care
- Availability of suitable long term accommodation.
- Absence of a strategic multi-agency approach

4.6.4. In the absence of a strategic approach to CSE at Service or Board level at this time it is not entirely surprising that front line practitioners were often slow to identify that what was happening was CSE or struggled to respond despite recognising the signs. Practitioners informed this Review of the lack of information and training provided to them about CSE and some described themselves as '*gleaning*' what knowledge they could from the press. Several of the agencies have explicitly recognised that their knowledge base and experience of working with children who were at risk of CSE was quite limited and that this had an impact on the way they and their staff were able to work with them. For example, Compass, whose primary role was working with substance abuse have identified that this in effect meant they were working within quite a narrow focus and that their staff did not have the confidence or understanding to explore information given to them, which could have identified that CSE was an issue.

4.6.5. It has been a feature of this Review that the quality of the information available from some agencies, but particularly Children's Services has often been of a poor standard and therefore judgements about the actual quality of practice have at times been difficult. Nevertheless what is clear is that there was quite variable practice on an individual level and little evidence of clear management oversight or direction. To at least some degree the experience of this Review appears to reflect the conclusions of the OFSTED inspection in January 2014 about the quality of safeguarding practice more generally.

5. CURRENT PRACTICE AND THE IMPLICATIONS FOR FUTURE WORK

5.1 Introduction

5.1.1. Given the passage of time since the events analysed in relation to these five children, a key purpose of this Review was to consider:

- Could the same thing happen now?

- Has the approach of agencies evolved and what is there that still needs to be done?

5.1.2. No safeguarding partnership can be in a position to say that it is able to prevent all incidences of the abuse of children whichever form it takes. The nature of child sexual abuse and exploitation means that it is particularly difficult to eradicate and those who are determined to exploit and abuse children will find different means to do so, as the authorities become more successful in responding and detecting CSE. There is clear evidence however that the police, Children's Social Care and other key partners now have considerably more intelligence about the risks of CSE in Coventry and are proactively identifying and investigating cases. The Partnership has significantly more information about the numbers of children at risk, the potential perpetrators and how they link together. Evidence of intervention for example includes an increase in the number of harbouring notices over time and the undertaking of more forensic medicals for children who are believed to have been subject to abuse. A case audit undertaken in October 2015 concluded that:

> *The professionals involved in working with children and young people at risk of CSE work well together and are engaged and dedicated to their work. Individually and as a group they held vast amounts of information on these children and were working often in very challenging circumstances to engage and protect those young people***.**

5.1.3. Since 2012 there have been fundamental shifts in practice and approach to CSE both at a national and a local level. In Coventry this includes the development of a multi-agency CSE strategy and the setting up of a specialist multi agency team - the Horizon team - with dedicated workers who have established a good level of understanding of the complexities of working with CSE and an ever increasing knowledge base regarding the potential areas of risk for children and young people living in Coventry. It is also evident that there has been a significant reappraisal of the way in which complex CSE cases are now being investigated by the Police and Children's Social Care with a specific Complex Abuse Procedure for CSE now in established use in Coventry. The effectiveness of this approach is demonstrated by the fact that Coventry is currently running a number of serious and complex CSE operations across the city. There is also evidence from the increasing use of the required screening tool for CSE and subsequent referrals that there has been a cultural shift by front line practitioners in recognising the early signs.

5.1.4. The CSE Strategy is based on the three themes of Prevent, Pursue and Protect, it is regularly reviewed and gaps in the work plan identified. The CSE Strategy appears to be a dynamic strategy with strong leadership and good participation from agencies. A comprehensive toolkit has also been developed for professionals working with children and young people covering both procedures and practice. With regard to wider safeguarding practice Coventry Local Authority and LSCB has also been working to an Improvement Plan for the last 2 years following the OFSTED Inspection in

February 2014. Whilst this is not yet finalised, evidence of relevant improvements have been provided to this review.

5.1.5. The following section provides a number of examples of the developments in Coventry since September 2012. Whilst this cannot provide a comprehensive description of all the work that is taking place it does offer a picture of the range of changes that have taken place during the last 4 years. What becomes evident is that those significant weaknesses identified during the timeline of this review have all been considered by the relevant agencies and many changes resulted. This is not to suggest that practice is now perfect, that there may not be gaps in services or areas for improvement; however it does evidence that Coventry's response to CSE is crucially different to the response in 2010-2012.

5.2 Changes in practice

5.2.1. A crucial area is that of **early intervention services** provided to children, including older children and young people as these are a fundamental contributor to the future prevention of CSE. The approach to early intervention can be considered to have two different aspects. Firstly early intervention with children who are already known to be experiencing difficulties within their families. Secondly, preventative strategies for children and adults across the community.

5.2.2. The formal structure for Coventry's early intervention services is the Children and Families First Service within the Local Authority. This service works in partnership with schools, in particular providing the response to problems with attendance and provides a named worker to each school. The Service also co-ordinates CAF activity. All the staff in the service have now been trained in CSE and risk assessment and some workers have undertaken specialist training in Protective Behaviour Programmes. The senior manager is a member of the CSE Strategic Group. A detailed analysis of the role or effectiveness of the early help service provided within Coventry is beyond the scope of this Review. Its strategic role and approach is evidently actively reviewed and discussed at a senior level.

5.2.3. The quality of decision making within Children's Social Care regarding assessments and intervention with the children concerned has been a significant feature of this review. It has highlighted questions about the understanding of and focus on neglect in adolescents and whether good enough decisions were being made about thresholds for intervention, such as Child in Need or Child Protection procedures. Although there is evidence that children are now being referred to the Horizon team when CSE is identified, the Review is still left with questions about the consistency of practice regarding CSE across the neighbourhood teams and this remains a challenge to Children's Social Care. A multi-agency case audit was undertaken in October 2015 with future audits planned and these should provide an important contribution to measuring the quality and consistency of work over time.

5.2.4. Secondly is the issue **of preventative strategies** which are focussed on both children and adults within the wider community. Considerable work has been undertaken to raise awareness across Coventry and this represents one of the key facets of the CSE Strategy. Schools have a significant role to play in prevention with children. The research undertaken by Research in Practice in 2015 particularly identified the role of schools who they state *"represent an ideal forum for addressing attitudes and knowledge gaps"*[17]. Whilst there is evidence of considerable activity in some schools, the comments of the young people's participation group raises some challenges about effectiveness. One area for potential development across the strategy is in relation to assessing impact of the activity. This is subject to a recommendation within this review.

5.2.5. Amongst the developments are

- Targeted work with proprietors of bed and breakfast accommodation, hotels, clubs and pubs, taxis, transport providers, shopping centres and food outlets, sports and recreational centres
- Mandatory CSE training for taxi drivers
- High profile CSE awareness week in 2016
- Over 800 children taken part in awareness training sessions delivered by Streetwise
- Use of social media to reach wider community and young people, including See Me, Hear Me website
- Radio and TV advertising and other presence
- Range of CSE training for practitioners by LSCB and across individual agencies

5.2.6. The improvement in the **investigation and identification of CSE** within Coventry is marked and is most apparent in the approach adopted by the Police alongside the specialist multi-agency Horizon team. West Midlands Police now has a dedicated Police CSE team in Coventry, although the resources available to the team are fully stretched. The Horizon team was established in May 2015 and consists of an experienced Social Work Team Manager, 2 Social Workers, a Police CSE co-ordinator, 2 Children and Family Workers, 2 detached Youth Workers and a Health Worker. The team has a high workload including mapping and investigation, providing awareness training, working directly with high risk children and young people, undertaking and supporting others doing risk assessments, working on safety plans. High priority is given to providing good quality supervision and also access to other support as necessary in recognition of the demands on team members and to avoid 'burn out' of staff. The balance of the team's work is continually under review and there is a conscious awareness of the risks connected with providing a specialist service and the potential for this to deskill other workers.

5.2.7. The management of children missing from home or care had been an area of particular concern for the Board and partner agencies. The

[17] RIP (2015:67)

Board now receives regular updates on missing children as well as analysis of wider trends.

5.2.8. There is evidence of **improved information gathering and sharing**. This includes the use of a '5x5x5' intelligence form by which professionals can inform the police of any information of concern which then contributes to the overall police intelligence regarding CSE. The Horizon team also collects soft intelligence and are regularly refreshing their own knowledge regarding areas where children and young people gather and may be at risk. Two standing groups, the Missing Operational Group (MOG) and the CSE Operational Group (COG) ensure a multi-agency response to individual children and young people who go missing or are at risk of CSE. Other developments include:

- Training of a wide range of professionals in the CSE screening tool
- Developmental work underway on working with boys and young men
- A Multi-Agency forum in place for the management of perpetrators.
- Commissioning of supported accommodation for children and young people now includes requirements relating to CSE
- Range of disruption activities
- Clear pathway for referring children where an agency has a concern about CSE through the MASH team and from there to the Horizon team.
- Active focus on work with residential homes.
- Specific targeting of work with Looked After children.

At an anecdotal level practitioners who contributed to this Review also described a number of important improvements, including a shift in culture and a wide 'buy in' at senior levels of the priority given to CSE. They described better inter-agency communication and spoke of how valuable the Horizon team was as a resource to staff.

5.2.9. One other area where there has been a significant development with the potential for future impact not only locally but at a national level is in regard to the approach taken by **GPs when in consultations with sexually active children**. What was identified by the Named GP for Coventry was that the advice established for GPs when providing contraception to children (known as the Fraser Guidance) had for many years led to the common unintended consequence of directing GPs to focus exclusively on the protection of unwanted pregnancies in children, but without any corresponding focus on the safeguarding risks which a child may be facing.

5.2.10. As a result a new Guidance Document has been issued by the Local Medical Committees in Rugby and Coventry advising GPs not only to consider the appropriateness of prescribing contraception, but also asking a number of questions which might identify if the child is being exploited and with a clear statement that if this is the case there is a professional obligation to report this to the police. As well as launching the guidance and including it within IT systems, it has also been forwarded to NHS England for further

consideration. CCG Commissioners have also ensured that the contract bids for termination of pregnancy services include a specific requirement to engage with the CSE agenda.

5.2.11. Whilst this Review has not been in a position to comment in detail on the approach to **long term post abuse work**, this has nevertheless been raised on numerous occasions by practitioners and managers during the course of the Review. Provision of services in the medium to long term, for young people who have been exploited, represents one of the hardest challenges for partnerships. Significant changes have already been made to the commissioning of Supported Housing for children and young people, which now incorporates a specific focus on CSE. Similarly there is a recognition of the need for specialist fostering placements for older children. What is less apparent is whether there is a planned strategy for meeting children and young people's wider therapeutic needs. It is therefore the recommendation of this Review that work is undertaken to identify best practice in relation to longer term work and consider the implications for providing appropriate services to young people who have experienced exploitation in Coventry.

Recommendation: The Board to co-ordinate a task and finish group to consider the longer term needs of those children and young people who have experienced abuse and how these can be met within Coventry.

6. CONCLUDING COMMENT

6.1. The purpose of a Serious Case Review is to learn from the case in order that improvements to practice can be put in place and more effective help offered to families in the future. It is apparent that the services provided to these five children and their families fell short of what is understood to be good practice both now and also at the time. The children's vulnerability was not recognised and adequately acted on at an early enough stage making effective intervention increasingly difficult to achieve as they became more vulnerable to exploitation. Working with CSE is extremely complex and requires a high skill and knowledge base, which evidently was not consistently in place prior to 2012. Nevertheless there was also evidence of committed and positive practice which should not go unrecognised.

6.2. Significant changes to practice have however been made in the intervening 4 years. The conclusion of this Review is that these changes can reasonably be expected to have had a genuine impact on prevention and reduction of CSE in the city, although inevitably there will continue to be challenges for services in maintaining and improving the services to children and young people and identifying new risks.

6.3. Any number of detailed recommendations could be made for consideration as part of the current CSE strategy, from the nature of the training programme to enhancing the role of the third sector within the strategy. However a conscious decision was made at the outset of this Review to take a

proportionate approach, which reflected the level of work already being undertaken. This proportionate approach therefore includes the making of recommendations, the focus of which will be a small number of key areas arising out of the learning.

7. RECOMMENDATIONS FOR THE BOARD

7.1. **Recommendation:** The LSCB to ensure that assessing the impact of Coventry's CSE strategy on outcomes for children is identified as a priority including giving consideration to the option of commissioning a research led project to identify the outcomes.

7.2. **Recommendation:** That the LSCB and partners consider how to promote and develop a relationship based model of working with children who present as vulnerable and at risk.

7.3. **Recommendation:** The Board to co-ordinate a task and finish group to consider the longer term needs of those children and young people who have experienced abuse and how these can be met within Coventry.

7.4. **Recommendation:** The LSCB share this SCR with the Adult Safeguarding Board and review options for joint working or commissioning of services for the victims of CSE.

7.5. **Recommendation:** The Board to ensure that learning from this SCR regarding the vulnerabilities following adoption breakdown are shared with relevant professionals in order for the implications for post adoption support in Coventry to be considered.

7.6. **Recommendation**: This SCR to be shared with YMCA England in order for the lessons to be considered within the wider organisation, including access to safeguarding support for members of the Federation.

REFERENCES

Cossar, J et al (2013). It takes a lot to trust (Office of the Children's Commissioner)

HM Govt (2015) : Working Together to Safeguard Children

Hallet, S (2015)**:** Child Sexual Exploitation: Problems and Solutions from the perspectives of young people and professionals

Munro, E (2011) The Munro Review of Child Protection: Final Report a child-centred system

OFSTED: (2011) Ages of Concern: Learning Lessons from Serious Case Reviews

Research in Practice (RIP): (2015) Working Effectively to address Child Sexual Exploitation

Selwyn, J et al (April 2014) Beyond the Adoption Order: challenges, interventions and adoption disruption

Shuker, L (2013): Evaluation of Barnardo's Safe Accommodation Project for Sexually Exploited and Trafficked young people.

This page is intentionally left blank

Coventry City Council

Briefing note

To: Education and Children's Service Scrutiny Board **Date: 21st July 2016**

Subject: Early Help and Partnership Working

1 Purpose of the Note

1.1 To bring the Education and Children's Services Scrutiny Board up to date with progress on Early Help and Prevention.

2 Recommendations

2.1 The Education and Children's Services Scrutiny Board are recommended to:

1) Consider the content of the briefing note and appendices
2) Receive further progress reports as requested
3) Identify any further recommendations for the appropriate Cabinet Member.

Appendices:

Appendix 1: Early Help Strategy

Appendix 2: Early Help Action Plan

3 Background

3.1 At the last education scrutiny committee – members received a paper outlining the significance of Early Help in supporting families and children at the earliest possible point/transitions in children's lives, and before problems escalate, needing acute, and costly services. The Early Help Strategy outlines key strategic objectives below which supports and strengthens the collaborative working arrangements and partnership of agencies and organisations across Coventry – to focus on improving outcomes for children and young people with a range of specific measures aimed at evidencing progress.

Strategic objectives:

- ✓ To identify the needs of children, young people and families across a continuum of need – 0 – 19, to understand and respond quickly to that need
- ✓ Supports the refocusing of resources from crisis intervention to prevention
- ✓ Supports families to achieve their full potential and thereby mitigate the impact of issues such as child poverty and health inequalities
- ✓ Supports an action learning approach that ensures that learning and evidence informs future service design and delivery. This includes listening to what children and families have to say about what helps them to prevent problems from occurring or escalating
- ✓ To provide the context for multi-agency partnerships to work together to improve outcomes for children, young people and families

4 How will we know Early Help is working?

4.1 The overall aim is to develop a cohesive Early Help offer embedded within a Whole Family approach, that builds protective factors and family resilience, (enables families to help themselves) and reduces expenditure of costly reactive services. Our ambition is that families, particularly those with multiple and complex needs will have access to co-ordinated Early Help in accordance with need as soon as difficulties are identified.

4.2 The offer is personalised, multi-agency, and evidenced based. Children and young people in those families will live safe, healthy and fulfilling lives and develop into responsible adult citizens, thereby breaking the intergenerational cycles of risk and vulnerability. Families will become more resilient and develop capabilities to prevent and resolve problems. The aim is to reduce demand for higher cost specialist services and achieve greater use of community based universal preventive services.

4.3 Social capital and resilience within local communities will be identified and enhanced.

5 Early Help measures

5.1 There are a wide range of important measures that are indicators of the effectiveness of early help. We have identified the following measures that we will particularly focus on to measure the effectiveness of our combined efforts:

- Maximise school readiness
- Maximise School attendance
- Minimise the numbers of referrals to social care
- Maximise the numbers of assessments completed to support the family when a need emerges
- Minimise the number of parents and children involved in crime and Anti-Social Behaviour
- Minimise the number of Looked After Children
- Minimise the number Child Protection Plans

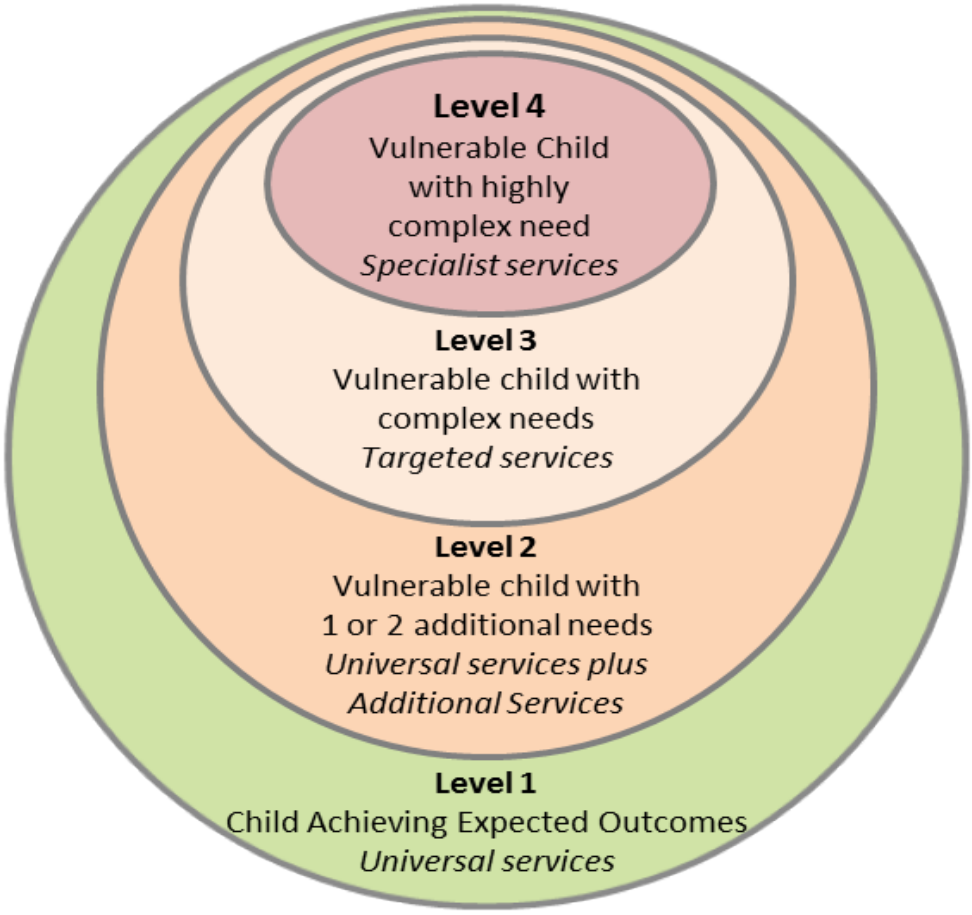
5.2 The following 'output' measure which constitutes a proxy indicator of an effective co-ordinated early help offer, will also be adopted:

- Increase in the number of 'open' Common Assessment Frameworks completed per agency.

6 Infrastructure

6.1 We already have many examples of early help good practice in Coventry. These include: Acting Early, Strengthening Families (formerly Troubled Families) and the Common Assessment Framework. Our delivery model includes a continuum of Early Help provided by a range of organisations including voluntary and community groups addressing different levels of need. We have integrated processes including Team around the Child and the Early Help Assessment and integrated teams including Children's Centre staff and Health Visitors to ensure earlier identification of emerging need and to provide a faster response.

6.2 The graphic below shows our graduated approach to service delivery with different types of services involved in different levels of vulnerability.



7 How effective is Early Help?

7.1 Early Learning and School Readiness

7.1.1 An Early Learning Programme ensures the delivery of the government participation targets for 2, 3 and 4 year olds are met. This includes optimising Coventry's private, voluntary and independent childcare sector. 63.1% of those eligible two years olds have taken up the offer. Participation rates 2/3/4/ years olds for Autumn 2015 increased by 11% on the previous year's data with the city now further exceeding national data published in January 15 by some 19% points. As of June 2016:

- The proportion of early year's settings judged good or better Ofsted judges 81% good, with 16% of settings judged as Requires Improvement and 3% of settings as Inadequate.
- The proportion of child-minders judged good or better by Ofsted in Coventry is 81%. With 18% of child-minders judged as Requires Improvement and 1% of child-minders judged as Inadequate.

7.2 Common Assessment Framework

7.2.1 The number of CAF's held is rising year on year, is currently just below the 2000 mark. CAF activity is focused on developing strengths within the family and support networks to allow families to benefit from universal services. In the year to date 68% of all CAF action plans have been completed successfully. In the year 2015/16, 171 staff across the education, health and third sector attended the Lead Professional training as part of the new initiative to support agencies outside social care, including the introduction of 'signs of safety' across the workforce. This resulted in an increase in CAF's at Level 2, demonstrating increasing confidence in the workforce. CAF Coordinators are attached to schools and offer case oversight and reflective practice sessions.

7.3 Strengthening Families

7.3.1 During Phase 1 'Strengthening Families' (formerly Troubled Families) successfully 'turned around' 905 complex families, indicating that thresholds and criteria for Intensive Family Support and CAF Level 3 was appropriately applied. Building on this success Coventry was invited by the Department for Communities and Local Government to become an 'early starter' for Phase 2. The first Phase 2 Payment by Results claim was made in January 2016, successfully claiming for 27 families. The adoption of the Strengthening Families 'whole family' methodology is now used across early help services, and all CAF's held by Children and Families First reflect this. Coventry YOS is often the lead agency on Strengthening Families cases and a representative from that team attends fortnightly case planning panels. These agree the intervention method and timescales, to ensure a holistic approach. This ensures that 'root cause' is addressed and the right services are put in place to support sustained change, thus improving children's attainment and aspirations for the future – 'breaking the cycle' of entrenched family behaviour.

8 How do we know if anyone is better off?

8.1 'Steps to Change' is a newly developed outcome impact tool that will be used by early help and prevention practitioners alongside the file audit process and case studies. The tool is as a measure of effectiveness of Early Help and Prevention and is helpful in engaging families so that they understand action required of them and the positive impact this has on their children. From April – July 2016 – Steps to Change will be tested out on 50 families to ensure its validity, before full implementation.

9 Future Plans and Challenges

9.1 The LSCB are leading on a piece of work to refresh local understanding of social care thresholds. It is evident from the number of contacts made to Social Care that some practitioners are not sufficiently skilled or confident to engage and support children who are just below the level of need which requires social care intervention and are not always managing 'risk'. The outcome is a high numbers of contacts and referrals which do not meet threshold, contributing to high caseloads in the Referral and Assessment Service (RAS). Where there are immediate concerns about a child's safety they are reviewed straight away within the Multi Agency Safeguarding Hub (MASH) and actioned without delay. However children who meet the criteria for assessments sometimes experience delays because the service is dealing with cases that do not meet threshold.

9.2 The Children and Families First service (CFF) employs five dedicated social work posts to ensure sufficient practical advice and consultation is available in the Early Help and Prevention arena. These social workers complement the CAF Co-ordinators, supporting front line practitioners in improving the quality of assessments so that the improved outcomes for children, young people and families are evident and measurable. The interface between Early Help and specialist services is constantly being developed ('step up' and 'step down') to ensure that children's needs are identified and met by the right service, at the right time.

10 Connecting Communities - Review and Redesign

10.1 Evidence tells us that children and family services are not working together as they could and all too often people still don't know where to go to get help. Family hubs are proposed as a 'game changer' for public services. Taking the best from current practice of working with the whole family and working across all ages, including all children and young people, as well as parents. Joined up and integrated working between different sectors, family hubs would become the bedrock everywhere, getting the right help to those who need it, when they need it. Working alongside social workers who would offer additional support in terms of advice and consultation.

10.2 Based on an analysis of need across the City – it is proposed that nine family hubs will be developed with the aim of integrating children's services into teams that delivers an Early Help offer in community settings, identifying when a problem first emerges and ensuring effective interventions. This new model of Early Help – from early intervention to social care will create a new local infrastructure, using money and resources more efficiently, doing more and doing it better, utilising the strengths of families in their communities to improve lives now and for the future.

11 Governance

11.1 A decision to merge the Early Help Board and Strengthening Families Board will improve the focus on key tasks around workforce development, using the feedback from parents about what interventions and type of support helped to turn their lives around. The Early Help action plan is shared and owned by key partners across all sectors that provide Early Help and Prevention services, reporting to the Children's Services Improvement Board and the Children and Young People's Board. (Appendix 2 – Early Help Action Plan)

Authors

Fran Doyle, Head of Early Help and Prevention
John Gregg, Director of Children's Services

Contact details: john.gregg@coventry.gov.uk
Tel: (024) 7683 3402

Fran.doyle@coventry.gov.uk
Tel: (024) 7683 1449

Appendix 1

Coventry Early Help Strategy

Our shared commitment

This Early Help strategy sets out our shared commitment to deliver effective early help to children, young people and their families.

Our vision for children and young people

Coventry's vision is of a city that promotes economic growth and jobs and protects the most vulnerable. Children and young people are at the heart of this. They are important to our city now and into the future. Our vision for children and young people is for:

Coventry children and young people to have supportive families, live safe from harm, fulfill their potential, are healthy, and have positive and fulfilling lives.

Children and young people need to to enjoy their childhood and adolescent years and grow up to be responsible citizens, contributing to our city.

What Early Help is

Early Help is an approach to maximise the chances of this vision becoming real for every Coventry child and young person aged 0-19 years old and up to 25 years old for young people with Special Educational Needs and Disabilities. Early Help is a way of working that supports children in the early years of their lives, or early on in the emergence of a problem at any stage in their lives. Our definition of Early Help is one that can practically be applied by any professional in any context. Our definition of early help is to:

- **Reach children, young people and families when the need first emerges; and**
- **Intervene when you can have the most impact.**

Why Early Help is important

Early Help is a high priority nationally and in Coventry for two key reasons.

Firstly, effective early help has a positive impact on the lives of children and young people. This has been evidenced through several reviews[1] - led by Graham Allen MP, Rt

[1] Reviews include: Early Intervention: The Next Steps. An Independent Report to her Majesty's Government (2011), Graham Allen MP; The Foundation Years: Preventing Poor Children from Becoming Poor Adults (2010), Frank Field; The Early Years: Foundations for Life, Health and Learning (2011), Dame Claire Tickell, The Monro Review of Child Protection (2011), Professor Eileen Monro; and The Marmot Review (2010)

Hon Frank Field, Dame Claire Tickell, Professor Eileen Munro, Sir Michael Marmot in addition to Working Together (2013) and work by the Centre for excellence in outcomes (C4E0).

Sir Michael Marmot underlined the significance of early help in the following way, *"Giving every child the best start in life is crucial for securing health and reducing health inequalities across the life course. The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood. What happens during these early years, starting in the womb, has life-long effects on many aspects of health and well-being".*

Secondly, effective Early Help has a positive impact on public finances in a context of significant financial pressures. Effective early help reduces the demand for higher cost services. Conversely late help has a high human cost and a high financial cost. Indeed the Early Intervention Foundation report estimated a £17bn national cost of late intervention. Our aim is for a redirection of our finite resources from high cost, high intervention services to prevention and early intervention support and services. In this context, there is a strong motivation to get Early Help right in Coventry.

Our Coventry context

Coventry is a city of around 329,800 residents with 83,800 of whom are aged 0-19 years old (2012). The population is younger than the average for England, the average age of a Coventry resident being 34 compared to 40 overall in England. The city is ethnically diverse, with 33% of Coventry's inhabitants coming from ethnic minority communities compared to 20% for England as a whole. Deprivation is higher than the England average; 25.9% (16,400) children live in poverty.

The majority of Coventry children and young people are safe at home and in the community, do well at school and are healthy. However, we have high numbers of children who are known to social care and have a Child in Need Plan, Child Protection Plans or are Looked After and high numbers of Troubled Families compared to our statistical neighbours. The 'toxic trio' of domestic violence, mental health issues and drug and alcohol abuse are significant issues for some Coventry parents, which impacts on their children. Some families have deeply entrenched multi-generational problems.

The high levels of demand for specialist services lead to significant financial costs against a backdrop of significant public sector financial pressures. This combination of

high service demand and financial challenges underline the importance of delivering effective Early Help. Our aim is for a redirection of resources from high cost, high intervention services to prevention and early intervention support and services. This benefits families and is a better use of finite resources.

Strategic Objectives

- To identify the needs of children, young people and their families across a continuum of need
- To understand and respond quickly to the needs of children, young people and families across the continuum of need
- To support the refocusing of resources from crisis intervention to prevention
- To support families to achieve their full potential and thereby mitigate the impact of issues such as child poverty and health inequalities
- To support an action learning approach that ensures the learning and evidence informs future service design and delivery. This includes listening to what children and families have to say about what best helps to prevent problems occurring or escalating
- To provide the context for multi-agency partnerships to work together to improve outcomes for children, young people and families for generations to come

The principles of how we will work together

The way that we work together is important. The following guiding principles set out the way we strive to work with families, together as practitioners:

- The experience, wellbeing and the voice of children and young people is central to everything we do so children are safe.
- Effective Early help is the responsibility of everyone in Coventry. This includes organisations working directly with children, young people and families such as schools, Children's Services Coventry City Council, Coventry and Rugby Clinical Commissioning Group, Coventry and Warwickshire Partnership Trust and community and voluntary organisations and groups
- Parents have the primary responsibility for the care and development of their children and for their growing up in a loving environment where there are strong attachments. The family is the primary resource. We believe that most parents want the best for

their children. We will build trusting relationships with parents in order to support them and to build on the strengths and skills they have to bring up their children.

- We will work with the whole family and recognise the uniqueness and diversity of each family and family member.
- We will work with families to enable the development of positive extended family, personal and community networks so that families access positive informal support.
- We will work with families to identify needs and root causes rather than with presenting issues at the earliest opportunity.
- We will deliver and target the right evidence-based support, at the right time and will flexibly endeavour to ensure the best outcomes for children, young people and their families. We will stick with families rather than just referring on.
- We will regularly evaluate the impact of our work with individual families and learn from this through measuring success outcomes of interventions delivered and seeking feedback from children and families on their perceptions of the effectiveness of work with them.
- We will involve families in shaping, designing and delivering support and services.
- We will use shared resources and assets more effectively and creatively together. This includes buildings, finances and most significantly people – the strengths of families and professionals.

How will we know Early Help is working?

The overall aim is to develop a cohesive Early Help offer embedded within the whole family approach that builds protective factors and family resilience, enabling families to help themselves, reducing expenditure on costly reactive services. Our ambition is that families, particularly those with multiple and complex needs will have access to co ordinated Early Help in accordance with need as soon as difficulties are identified.

The offer is personalised, multi agency and evidence based. Children and young people in those families will live safe, healthy and fulfilling lives and develop into responsible adult citizens, thereby breaking the intergenerational cycles of risk and vulnerability. Families will become more resilient and develop capabilities to prevent and resolve problems. Social capital and resilience within communities will be identified and enhanced.

Early Help Measures

There are a wide range of important measures that are indicators of the effectiveness of Early Help. We have identified the following measures that we will particularly focus on to measure the effectiveness of our combined efforts:

Effective Early Help will deliver against the following outcomes

- Maximise school readiness
- Maximise School attendance
- Minimise the numbers of referrals to social care
- Maximise the numbers of assessments completed to support the family when a need emerges
- Minimise the number of parents and children involved in crime and Anti-Social Behaviour
- Minimise the number of Looked After Children
- Minimise the number Child Protection Plans

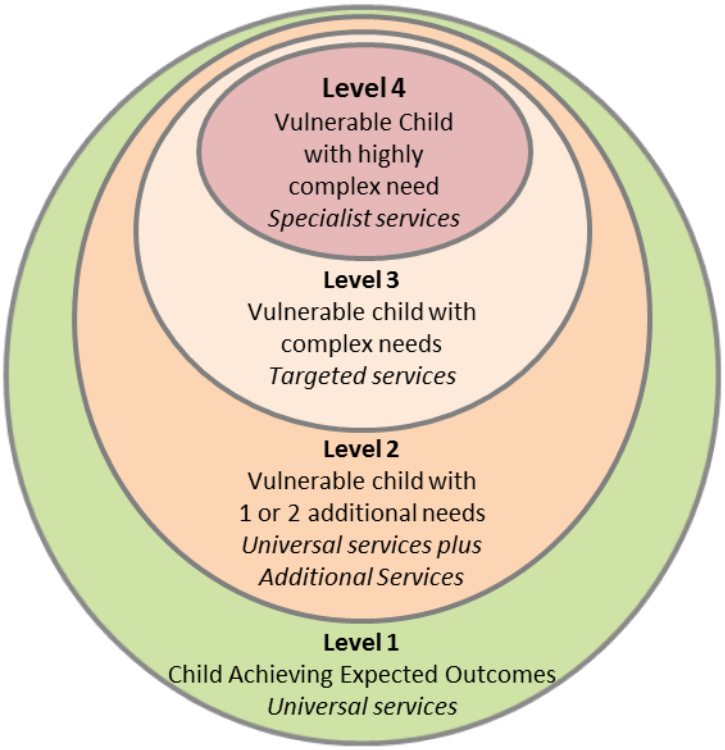
The following output measure which constitutes a proxy indicator of an effective co ordinated Early Help offer will also be adopted:

- Increase in the number of open CAF assessments (Common Assessment Framework) completed per agency.

Infrastructure

We already have many examples of early help good practice in Coventry. These include: Acting Early, Strengthening Families (formerly Troubled Families) programme and the Common Assessment Framework (see Appendix). Our delivery model includes a continuum of Early Help provided by a range of organisations including voluntary and community groups addressing different levels of need. We have integrated processes including Team Around the Family and the Early Help Assessment and integrated teams including Children's Centre staff and Health Visitors to ensure earlier identification of emerging need and to provide a faster response.

The graphic below shows our graduated approach to service delivery with different types of services involved in different levels of vulnerability.



Our delivery will include:

- Embed and roll out the **Acting Early** (0-5 year olds) initiative so that universal/universal plus professionals complete early targeted work with children and families, professionals hold risk and pull down specialist support rather than tending to refer on.

- Implement **Strengthening Families** phase 2 so that we meet the government targets of impacting 3,120 families over the next five years.

- **Integrate early years' services** including Children's Centres, Health visitors and the Family Nurse Partnership, building on the evidence and best practice identified in the Early Intervention Foundation publication 'Getting it Right for Families' (2014).

- Develop **"hubs"** that integrate children's services in community settings, for ease of access for children, young people and families.

- Deliver the **Early Learning programme** so that government participation targets for 2, 3 and 4 year olds are met. This includes developing and optimising the Coventry Private Voluntary and Independent childcare sector.

- Focus on the '**toxic trio' of domestic violence, alcohol and drug abuse.** This includes the development of the Family Drug and Alcohol Court work (targeting early intervention in repeat pregnancies and post care support after birth) and commissioning approaches.

- Building on the learning from 'Acting Early' develop our integrated **school-age early help** offer by developing strong partnership relationships between schools and early help services, parents and young people

- Strengthen our **parenting offer** so this builds on good practice and focus on **group as well as individual work,** bringing together parents and families to work effectively together.

- Develop a **new model for mental health and emotional wellbeing support.** Build capacity and expertise of universal professionals to spot signs and symptoms early, and put in place plans of early support after consultation from mental health professionals. Clear support and treatment pathways for young people who need stepping up to more specialist treatment.

- Deliver phase 2 of the **Special Educational Needs and Disabilities** reforms – "Lifting the Cloud of limitation" with a focus on person-centred approaches and an effective journey to adulthood.

- Deliver the **Ignite Programme** in partnership with Coventry Law Centre and Grapevine and funded by the Early Action Neighbourhood Fund. This programme has a specific focus on working with families at the earliest point to build capacity to manage day to day problems as well as developing personal and community networks. It is intended to change the relationship between families and services and to accelerate Coventry's investment in Early Help.

- Deliver effective **health promotion,** to empower families to have an influence over their own health through positive lifestyle choices.

- Develop our **collective workforce** in strengths-based working, working with parents as well as children, developing personal and community networks – to provide support and challenge and to work to the guiding principles.

- Implement consistent processes for **assessment** across all organisations.

- Use our children's services **buildings** more effectively by considering different ways of operating them and maintaining an appropriate balance between home-based services and building based services.

Governance

The multi-agency Children's Early Help Board will oversee the progress of the strategy, with accountability to the Children's Joint Partnership Board, and the Local Children's Safeguarding Board.

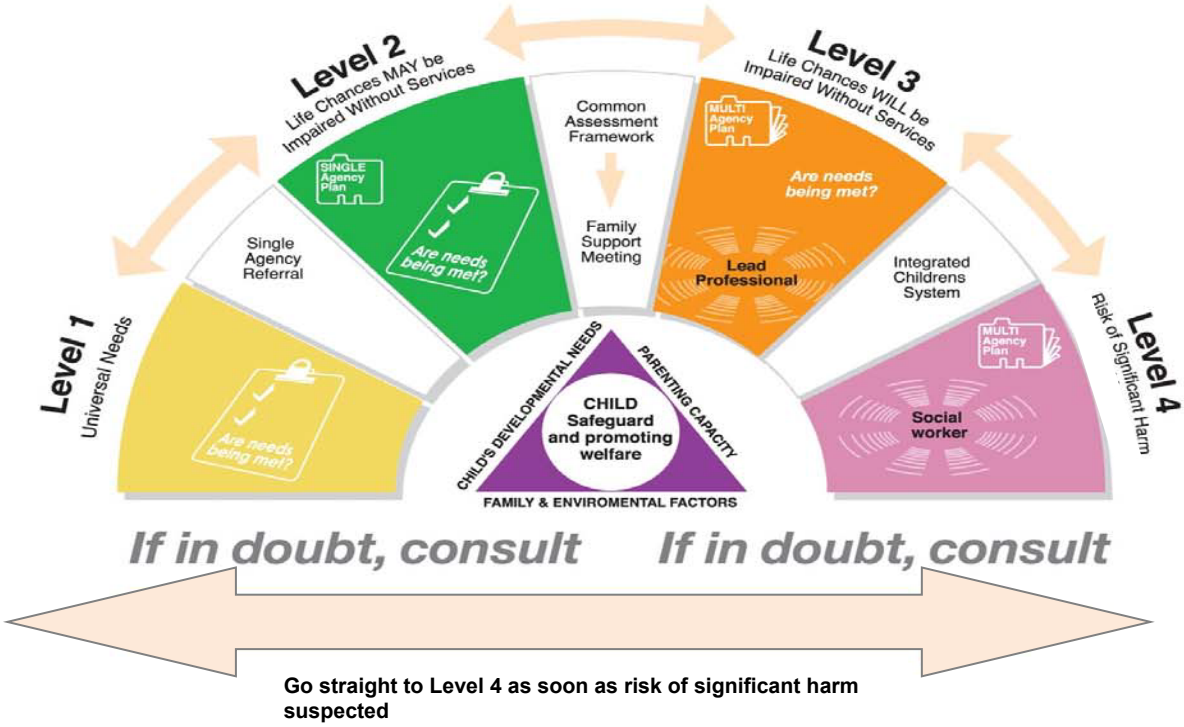
Appendices

Appendix A - Building on good practice

Much Early Help is already in place in Coventry. This includes: the Common Assessment Framework, Strengthening Families, Children's Centres delivering a range of programmes and support services, and 11 Children's Centres being designated as Acting Early Centres, which offer support from Health Visitors, GPs and midwives.

We will continue to improve support and services for children, young people and families. This strategy builds on and develops good practice.

The Common Assessment Framework (CAF). CAF is a key part of the strategy to shift the focus from dealing with the consequences of difficulties in children's lives to preventing things from going wrong in the first place. It is a nationally standardised approach to conducting an assessment of the needs of a child or young person and deciding how those needs should be met. The Common Assessment is Coventry's early help assessment and assists professionals in understanding the causes of difficulties and to identify and deliver the best and most appropriate support to the family. CAF is embedded in our safeguarding procedures.



Strengthening Families Programme (formerly Troubled Families). Phase 1 of the programme has supported 634 Coventry families to turn their lives around. These families need to meet criteria of anti-social behaviour/crime, education and workless-ness. Coventry is an early adopter of the Phase 2 national programme and are focusing on identifying a further 3,130 families who can benefit from the expanded programme over the next five years. Phase 2 of The Strengthening Families programme broadens the scope of the programme and in Coventry we have an integrated model which spans early help and more targeted services (e.g. intensive family support). A wider range of families will be worked with under phase 2, these include: parents and children involved in crime and anti-social behaviour, children who have not been attending school regularly, children who need help, adults out of work or a risk of financial exclusion and young people at risk of workless, domestic violence and abuse, health problems. The Payment by Results model facilitates the family support model.

Acting Early. The Acting Early model is based on integrated teams working together to deliver a robust universal 'core offer' and through that delivery, identifying those children and families requiring additional targeted early support. It is a key early intervention programme that aims to work in partnership with parents to prevent infant mortality, improve parental health and maximise early child development, nutrition and readiness for school.

We aim to;

- give disadvantaged and vulnerable children a better start in life;

- reduce the costs of dealing with later health and social problems; and
- provide effective, sustainable and scalable, preventable approaches in pregnancy and in very early life.

There are now 6 Acting Early sites across Coventry: Hillfields, Tile Hill, Foleshill, Longford, Henley and; Binley and Willenhall – with a further 5 to follow.

Multi Systemic Therapy (MST). MST is an evidence based programme working with 20 children and young people at any one time to prevent them from entering care. It offers intensive family support and therapeutic intervention. It is led by a team of highly qualified Social Care, provides 24 hour support to the families of children and young people aged 11 to 17 who are identified by the Intensive Case and Support Panel (ICaSP) as being on the edge of care or custody.

There is other good practice in Coventry including: the contribution of community and voluntary services (e.g. Volunteers in Child Protection, Citizens Advice Bureau, the Law Centre). Further, we have put in place the Multi-Agency Safeguarding Hub (MASH), the Child Sexual Exploitation team, the Family Nurse Partnership and the Children and Families First case-holding approach. The Coventry Early Help Directory of Services is aligned to this strategy.

Appendix B: Examples of changes to Early Help

1 – School readiness

School readiness is a key success measure for Early Help. Currently there is some partnership working between children's centres and schools to enable children to be school ready. This partnership working will increase through schools playing a more active role with 2, 3 and 4 year olds. This will enable better family working where a child may be in school and another in nursery. It will enable schools to better influence school readiness prior to arrival at school.

2 - School-age early help offer

Schools have on-going relationships with children and parents. Children and Family First and Social Care may also be involved with the family. The connection between these services and other services isn't as strong as it could be, meaning that information isn't capitalised on. Work to develop our integrated school-age early will bring schools, family support services and social workers closer together. Schools will be a focal point for

early help delivery and this will enable better collaborative working and information sharing leading to better outcomes for the child and family. It should also lead to appropriate referrals to the Referral and Assessment Service.

Early Help and Prevention Action Plan 2015 – 2018

Matrix area	Progress level	15 – 18 Action No.	Description	Achievement to date	Next steps - Action	Lead	Timescale	Progress
SERVICE DELIVERY	**3**	**1**	**Implement Strengthening Families Phase 2** Criteria for the expanded cohort now includes: Domestic Abuse Long Term Health conditions Physical and Mental Health Payment by results: Phase 2 started on 1st January 15, (4 months ahead) running phase 1 and phase 2 in parallel: Remaining 30% (274) families from phase 1 5% (156) families from phase 2 A further 535 families will need to be worked with in the rest of phase 2 Total of 3130 across the five years	The Intensive Family Support Team is a small team which is part of the Children and Families First Team. There are 14 keyworkers working with 203 children over 82 families (April 16). The casework performance data is covered within the eCAF performance data and Quality Assurance framework. Workforce development – analyse if the key workers can be used differently – need to develop a training programme across tier 2 – which uses multi systemic therapy as a methodology to find out root causes of problems with families, particularly primary schools . Team of 14 – now will have less intensive families in new phase. 1st claim completed – 27 families claimed – this may seem small – but it compares with like LA's who are all grappling with how to evidence successful outcomes against the broader criteria.	A proposal with recommendations is nearing completion – it will articulate about how mainstreaming can take place whilst maintaining case work needed re payments by results Completed – further work to identify evidence against outcomes will be completed by the End of May 16, so that auditors can approve evidence for payment by results 2nd claim – September 16, 535 families will need to be claimed by end of the financial year.	Louison Ricketts – Service Manager Louison Ricketts – Service Manager Stuart Hunter – Perf Manager	June 2016 End of May 16 September 16	
	3	**2**	**Sufficiency and Quality Assurance** Family Information Service 2/3/4 year old offer - linked to early learning and school readiness • 9 nurseries to be non local authority delivery 2.5 year check/assessment – will identify children who could benefit from the extra 15 hours for 3 year olds.	Autumn 15 - 76% 2 year olds have access to a place Spring 16 - 63% - 2 year olds (40% most disadvantaged) have a place – this dip is caused by 2 year olds turning 3. This should even out by Autumn 16, as those children projected to take place (figure above) take up the place. 3 and 4 year olds – 94% have access to a place 81% of all settings are good or above.	Needs to be fit for purpose when cuts kick in, so that self-help for parents linked to the customer journey – where else in the city can universal information be available Budget pressures £0.7K per year for the next three years. Service Manager is looking into role and function of CQRA – and statutory functions, which will support the work that needs to be undertaken with the expansion of the 2 and 3 year old offer Need an exit strategy linked to reductions in Dedicated Schools Grant – particularly affects the 2 year old offer, CQRA's and Children's Centre Team leader posts as a proportion of these posts are funded via this grant. DFE consultation on the extended 30 hours from 15 for 3 year olds – deadline for submission – end	Angela Harley – Service Manager	March 17	Level of funding cuts – will impact on statutory ability to deliver the 2 year olf offer.

					of June 16 Link up Health Visiting and early years to ensure an integrated health check process – joined up integrated way – avoid duplication and ensure			
	3	**3**	**Acting Early 0 – 5** – Universal engagement points to track children's progress Key stakeholders: Health visiting, midwifery and Children's Centre staff ***Core integrated team activities*** Each site developed an action plan outlining how they would implement Acting Early and their local priorities. In summary, the key activities undertaken in the demonstrator sites to improve integration have involved: — **Weekly integrated team meetings**, to identify concerns at an earlier stage, and ensure that preventative measures are in place to safeguard children. — **Workforce development** and encouraging new ways of working, including raising awareness of the S-BAR (situation background assessment recommendation), a tool for practitioner use to aid communication in child case meetings. — **Mapping out services** to highlight duplication, gaps, and take action to address issues identified, for example, introducing breastfeeding support groups. — Efforts to secure **GP engagement** and referrals into the weekly case meetings. — **Co-location of clinics** within children's centres. — **Promotion of support** available from the integrated team. — Development and implementation of an **information sharing agreement** to share birth notifications with the children centre. — Ensuring the **most appropriate lead professional undertakes the CAF**, working in partnership with others as appropriate. — **Linking with voluntary and**	11 sites already up and running 12 parents already involved in the Develop parent leadership programme	Roll out and embed a further 5 sites 1. Develop and implement integrated pathways: Breastfeeding Healthy Weight Employment Drugs and alcohol Social, emotional, behavioural Speech and Language Special Needs Immunisations Develop audit tool – reflective practice and improvement in quality of practice 2. Implement family and friends survey – parental satisfaction with service 3. Increase engagement upto 20 parents Ensure the programme can be sustained as public health staff withdraw; this is a real challenge given that Children's Centre staff may be fewer. An action plan needs to be produced that describes how the acting early sites will become sustainable – once project management is withdrawn. Ensure performance data is shared at Early Help Board to ensure all partners understand what success looks like – which areas need to be monitored to ensure performance is managed: Number of LP's Number of CAF's – tiers 2 and 3 Performance against PI's Link up evaluation with finances to report back to board	Sue Frossell – consultant Public Health Harbir Harbir	March 2016 April 2016 February 2016 EH Board	

			community sector agencies.					
	1	**4**	**Acting Early – school age** (primaries and secondary's) 5 - 19	4 secondary schools identified and interested in engaging with the perfect week exercise: Lyng Hall, Cardinal Wiseman, Foxford, Grace Academy Primary Schools – Stoke Heath – Jeanette Hyatt, Aldermoor Farm – Ann Stacey – linked to 0 – 5 acting early sites – explore benefits of 0 – 5 team helping transition in to school + identifying children that could benefit from 2/3/4 year old offer. Explore an integrated model of delivery. How do build in transition from primary into secondary. John Forde to attend primary heads forum – to update on progress and explain future plans - Jan 16 = completed Sidney Stringer – model of educational excellence – opportunity for through put of 2 year olds upto 18. Secondary school, outstanding, maintained nursery provision outstanding. Further exploration of the model is required Fran Doyle to update Exec Heads Group re CAF Co Offer – attached to school, support with Case supervision and reflective practice February 16 = completed	Call to Action Conference – 30th November engage key stakeholders in design Ensure information sharing agreement is fit for purpose 4 more schools – May + Sept + Jan – co production events facilitated by us + workforce development needs sense checking against connecting communities Christina Some concerns on this – review of where we are decision - mkaing Plans have since changed the maintained nursery provision is not becoming part of the academy, will be included as part of the Hillside Early Help Hub – costs for additional staff will be deducted. Fran Doyle meeting with governing body 28th June to explain.	Christina Walding – programme manager, public health Fran Doyle	July 2016 March 2017 June 16	
	1	**5**	**Connecting Communities phase 1** – close 2 play centres Agreement Proposal to offer 2/3/4 year old provision from these two sites	Proposals went to cabinet and where approved Nov 15. Consultation started 7th December and ends 1st February 16, for both staff and the public. Procedure for Interested Parties Weekly analysis sessions scheduled to understand themes/views etc Final cabinet decision March 16 Implementation from April 2016. • All interested parties must complete an initial expression of interest form and return by 5pm on Monday 4th January 2016 - completed • The Local Authority panel will review applications - completed • Interested Parties will be contacted to complete a full business proposal and return by 5pm Monday 25th January	• The potential provider will be supported to apply for any possible capital and revenue grants if appropriate and may need to apply for any planning permissions required • The appointed service provider will be offered support from the local Childcare Quality Regulation Advisor to prepare and register the childcare provision with	Amanda Reynolds – Service Manager Angela Harley – Service Manager	September 17 September 17	

				2016 – completed • The Local Authority Panel will undertake a selection process against set criteria and inform the potential childcare provider for each site of next steps • All interested parties will be informed of the outcome within two weeks of the panel taking place. - completed • The potential childcare provider will be informed on the 4th March 2016 of the cabinet decision relating to phase 1 of the connecting communities programme - completed • Heads of Terms will be agreed and signed by 1st April 2016 – completed	Ofsted. • Staff reduction – stop delivering unregulated play centre activity – supported by HR, with engagement of unions. Consultation and 1.1 meetings with staff concerned.	Amanda Reynolds – Service Manager Richard Pearson - HR	Savings felt by March 17	
	2	**6**	**Children's Centres** Buildings Getting to Good – Ofsted Commissioned services	Full review has been undertaken by Indigo Recommendations from the report being implemented CC improvement Board in place from November 15 – meets monthly – Cllr Ruane, Sue Johnson (head of perf), Heather Blevins (head of adult and family education) Fran Doyle – Chairs. Monthly feedback template completed by CC Managers focusses on vulnerable families, areas of highest deprivation Supports Acting Early – quality universal provision picking up problems really early on Training for Partnership Adv Boards x 2 days – focussed on analysing data – the story behind it, target setting, measuring impact etc – completed March 16 Evidence scrutiny meetings to be diarised for all centres/clusters – completed March 16	Need to set clear targets – delivery plans to be updated	Amanda Reynolds – Service Manager	June 16 Starting February 16 – every two months there after	
	2	**7**	**Integrated working between social care and internal Early Help and prevention service:** Edge of Care Effectiveness – targeted Early Help which supports families to remain outside of social care	Spot purchasing – use of integrated youth support service to support existing young people at risk of being accommodated Research undertaken to understand the flow of work through the system that needs to be picked up Early Help and Prevention	Analysis of need – what constitutes Edge of Care – already assessed in social care? Research existing best practice - Calderdale/North Yorkshire/Staffordshire Scope of project – who needs to be involved, definition, numbers to resource, where it needs to sit, evaluation and review Staffing – review the role family support workers in Neighbourhoods and determine duplication of work between CSC and CFF	Sally Giles – commissioning Fran Doyle & Nancy Meehan	End of September 16 Completed Feb 16	

			Step up and down – effectiveness and prompt interventions.		Staffing – Review structure of CFF and integrated team structure		Now forms part of the review and redesign of Children's Services	
					QA and re referral audit – Review process for step up and down and clarity roles and responsibilities – not following current procedures		March 16 – completed	
					Threshold criteria – This is under review and will impact on any decisions	Terri Cartwright & Cat Parker	March 16 – threshold document reviewed and updated	
					Performance data – understand and scrutinise to performance data to determine how many cases would step up/down between services	Include Shoayb Khalid	Beg April 16	
					Implement clear processes and systems for step up/down – brief staff at PIF and team meetings so that practitioners understand	Nancy Meehan and Fran Doyle	End April 16 - completed	
					Review audit – meet with team managers to get feedback and continue improvements		June 16	
					MST – loop in the Trust – as have the staff member in MST – clinical psychologist, therapist			
INTEGRATED SERVICE DELIVERY	**1**	**9**	**Connecting Communities phase 2 – integrate children's services**. Develop Early Help hubs – multi agency, multi-disciplinary teams	Update Early Help Strategy for approval from CYP Strategic Partnership Board – include draft action plan established against maturity matrix – completed February 16	Map, understand and evaluate the resources currently available for Early Help including budget and staff. b. Evaluate the impact of current services. c. Understand the value that services deliver and how we can get more value from them. d. Have a way of predicting where efficiencies can be delivered showing where and how cost saving can be achieved. Evidence and needs • Improve our knowledge and understanding of the data and information so that we can: - a. Target resources at those most in need of extra help. b. Locate families who need help who do not necessarily identify themselves. c. Build on the opportunity to understand the	Fran Doyle – supported by the Early Help Board		Full programme implementation March 2018

			Ignite – Willenhall 1st live hub pilot – explore new ways of working to provide a better and more effective Early Help offer – with a goal of making Willenhall a place where children can thrive, which in turn will head off demand into more costly acute services. Will support families by working with their strengths and get to root cause of the problems first whilst stabilising the symptoms eg debt, housing issues, legal issues, etc. Listen to the families voice – how do families think they can help themselves, and what helped them to get to this point of confidence and resilience. What might be a 'hub' - a team that is working collaboratively with other locally focused organisations and people in the community to create capacity to achieve the above goal.	First team meeting undertaken with Children's Centre staff	breadth of support families who need Early Help may require in order to move forward successfully: e.g. public health and emotional wellbeing data. Presentation back to the next board A slice through Children's Services X 2 Children and Families First X 2 Integrated Youth Support Service Manager Social Care – Karen Ogle Finance – Sarah Kinsell/Rachael Sugars Performance – Ross Hughes Set up two further meetings before the beginning of July 16. Include planning/learning cycles every 2/3 months Trust services need to be further engaged with IGNITE – data gathered on services – health visting, 5000 open cases, FNP 25 cases and intensive, speech and language 300, primary mental health, CAMHS – 50 open cases	Sue Bent/Emma Bates/Clare Wightman – Ignite – with Children's Service senior managers	June 17 – 12 months	
WORKFORCE DEVELOPMENT	**2**	**10**	Workforce development strategy: 1. progression routes – grade 3 & 4's Children's Centre staff, Grade 5 & 6's Children and Families First 2. Step up to social work: Coventry and Warwickshire Universities 3. Open university 4. Professional development – 5. Recruitment and vacancy management 6. Supervision and appraisal	Current activity and attendance mapped Recruited 5 qualified social workers – extend advice and consultation re thresholds to support partners	1. Develop future training plan Explore opportunities to utilise Working with parents level 3 and level 4 – giving staff the right skills and knowledge to progress Include compulsory and essential training requirements – signs of safety, family group conferencing, Multi Systemic Therapy – programme Develop opportunities for elearning Cost up and gain approval Coventry City Council plan to ensure staff have the right support to gain this qualification Extend Children's Centre contracts – expiry 31st March 16 Embed new appraisal across the service	Andrew Brunt/Grace Haynes - LODS		
INTEGRATED PERFORMANCE MONITORING	**2**		**E**nsure Early Help are identified and defined in the Children and Young People's Plan based on outcomes	Measures identified Children's Service Improvement Board targets: NOVEMBER 15				

Data and intelligence				70% of all CAF's closed with outcomes met – no further action – current 67.4% 15% contacts to Social Care – current 18.8% 40% of all CAFS are non LA – current 26.6% JUNE 16 70% of all CAF's closed with outcomes met – no further action – current 72 % 15% contacts to Social Care – current 24% 40% of all CAFS are non LA – current 33%	Plan in place – see CAF CO's* Sue Frossell to link with Fran			
			Performance managements Systems and processes Rationalising systems – linked to the Strengthening Families criteria and workspace		Develop one performance management system to measure the effectiveness of Early Help and Prevention. Meeting arranged	Jed Francique - CWPT		June 17
			Impact Reporting Capacity and Demand	Radar charts – Steps to Changes – an outcome impact tool	Test with 50 families Roll out to internal council Children and Families First and Children's Centre staff Roll out to external Early Help providers.			July 16 September 16 September 17
QUALITY ASSURANCE	**1**		Re Referrals – what is causing this? CAF Co's updating their role and function – setting targets to work towards, to improve quality of CAF's to improve outcomes for children and families Increase the numbers of CAF's at level 2 – 400 new cafs CFA both service and CAF's Focus: Effectiveness: Quality assessment, clear plan with smart targets, reviews that keeps the plan on track or update the plan given change, visit, purpose, Child's voice strong, management oversight.	Mash – CAF co analyse Visit to Lincoln – research CAF co function Explore ways of supporting schools eg focussed supervision format with school staff eg	SENCO's/learning mentors/pastoral – to go through cases (4 weekly). This type of case supervision could see issues escalating to support earlier - and helps to enhance the team around the family, encourage schools to think about issues effecting families, absence from school. Draw down more intensive support or lower level support into localities, to avoid hand off's and transitions/referrals into the same service. This is particularly supportive during school holidays, as the team around the family carries on. Supervision model will include: family and children and young people issues eg why children are being absent from school, parenting capacity, behaviour management, housing, domestic violence, drugs alcohol and mental health, root causes of family issues. Prioritise schools – worst 30% areas 1st, move onto 40/50% areas of deprivation Launch 'new'case supervision Schools Forum – briefing/consultation session	Starting new way of working September 16 Review June 16		

			Case studies Parent satisfaction and feedback – on line Practice Improvement sessions: • Curious questioning • Think the unthinkable • Families that are hard to engage • Disguised compliance • Neglect CAF training internal CAF training external: Schools, PVI, Voluntary sector		Safeguarding Leads briefing/consultation session Half termly meetings – to ensure learning and quality of practice, practice improvement practical Understand the step down (has had a C&F assessment RAS) diversion issues from social care RAS into level 2 Set up CAF surgeries – to establish peer support and learning opportunities for schools. Unblock challenges re schools inputting into ECAF – reconfigure support services ie Steve Turner to set up school user group, realign current admin staff (to support inputting to keep the system upto date in the short term, medium term is that schools have the knowledge and are trained to input in the system. Introduce CFA template – review findings and feed into practice improvement plan Health Visitors to undertake ECAF training as planned from April 16 Bi monthly practice improvement for EH and Prevention internal staff diarised After first planning session – 27th January 16 – need to complete action plan for the rest of the year.	Sarah Newton – Service manager	April 2016 – completed August 2016 review	
COMMUNICATION AND ENGAGEMENT	**2**		6 monthly Early Help and Prevention Newsletter 6 monthly team visits Monthly Children's Service Newsletter Blogs	Christmas News letter circulated internally Visited Children and Families teams – Jan/Feb 16 Monthly Children's Newsletter circulated John Gregg – Blog now set up and distributed to all Children's Service staff	Next newsletter due June 16	Fran Doyle John Gregg for Children's	June 16	
GOVERNANCE	**2**		Ensure appropriate governance is in place for the leadership of Early Help. Establish a board to support and embed the implementation of the Early Help Strategy.	Early Help Strategy agreed at CYP commissioning Board December 2015 Children's Service Improvement Plan in place – which includes Early Help and Prevention Decision to merge Early Help and Troubled Families Board Report to: Joint Partnership Board	Consult with membership – re benefits Create new terms of reference and circulate Speak to members of current Troubled Families Board members to ensure they know what to expect. First merged board – 26th January 2016. Ensure performance management report highlight continuous improvement, along with challenges that need unblocking	Sue Frossell	June 2016 – review 6 months	

				Improvement Board Cabinet – Children's Education and Children's Scrutiny	*Reinstate TF operational group to feed into board and report back* *Review whether the board is right to incorporate TF*			

4 levels of progress against the matrix are:

Basic level	1
Early Progress	2
Substantial progress	3
Maturity	4

Progress	**1**	**2**	**3**	**4**
Service delivery		2		
Integrated Service Delivery	1			
Workforce development		2		
Integrated Performance Management		2		
Quality Assurance		2		
Communication and Engagement		2		
Governance		2		

This page is intentionally left blank

Coventry City Council

Briefing note

To: **Education and Children's Services Scrutiny Board (2)** **21 July 2016**

Subject: **Progress on Children's Services Improvement Plan in response to Ofsted Single Inspection and the Review of the Local Safeguarding Children's Board**

1 Purpose of the Note

1.1 To inform the Education and Children's Services Scrutiny Board (2) of the progress with the Children's Services Improvement Plan reported to the Children's Services Improvement Board on 22 June 2016. The report is based on data from May 2016, unless stated otherwise. The next Improvement Board will be held on 14th September 2016.

2 Recommendations

2.1 It is recommended that Scrutiny Board 2:

1) Note the progress made to date.

2) Receive regular updates from the Children's Services Improvement Board that will include further progress relating to the children's services improvement plan

3 Information/Background

3.1 The Ofsted Inspection of Coventry's Children's Services and the review of the Local Safeguarding Children Board (LSCB), published in March 2014, judged services and the LSCB to be inadequate. The Ofsted report identified a number of priority actions and areas for improvement. In response to the Ofsted report, a Children's Services Improvement Board was established and an Improvement Plan published on 27th June 2014. A revised and updated Improvement Plan was published on 10th March 2015. The plan has been further updated, and will be reviewed again with the Independent Chair in July 2016.

3.2 The Children's Services Improvement Board on 22 June 2016 was chaired by Steve Hart, the new incoming chair. Mark Rogers, Chief Executive at Birmingham City Council, stepped down from the role as Independent Chair on 11th May 2016. The Board includes elected Members, Council representatives and representatives from partner agencies in the City as well as a representative from the Department for Education. Progress is reported to the Improvement Board every six weeks.

3.3 The Department for Education issued an Improvement Notice on 30th June 2014. The Improvement notice is reviewed every six months by the Department for Education. Reviews were completed on 20 January 2015, 30 June 2016 and 2 February 2016.

3.4 The Independent Chairs of both the Improvement Board and the Local Safeguarding Children Board also submit a written report to the Minister on a regular basis.

3.5 An Executive Board was established in January 2015 in order to focus on maintaining momentum and evaluating progress against the Improvement Plan. This Board meets every six weeks prior to the Improvement Board.

3.6 The Council, alongside partner organisations will retain a relentless focus on securing improvements in services for children, young people and families to ensure they are safeguarded and achieve positive outcomes.

4 Improvement Plan Themes

4.1 The Children's Services Improvement Plan, includes six key themes, which have been aligned to the DfE improvement notice. The plan provides a stronger focus on quality of practice and workforce development, and the continuation of improvements to the LSCB. A summary of the plan is shown in **Appendix 1**. The six themes are as follows and will be subject to change pending a review of the plan.

- Early Help & Partnership Working
- Local Safeguarding Children Board
- Quality and Effectiveness of Practice
- Quality of Assurance and Audit
- Leadership and Governance
- Services for LAC, Care Leavers and Permanency

5 Children's Services Improvement Plan Progress to date

5.1 The new leadership is continuing to provide the renewed focus and direction. Middle management teams are stable and committed. The new improvement partners are working at pace to help deliver the improvements and changes required.

5.2 The new Independent Chair has proposed a number of actions to maintain and accelerate the development of good and better services for children and young people in Coventry. The following will be addressed as a result of the Independent Chair's initial analysis of improvement activity and its impact at the front line:

1. The pace of change will be accelerated.
2. The work and objectives of the Board will be more aligned with operational front line managers, practitioners and partners who are charged with delivering the changes.
3. The Improvement Plan will be re-focused for change in the short term to mitigate the risks.

5.3 The Improvement Board members endorsed the specific actions to be delivered in the short term and agreed to moving forward on the proposals.

5.4 A revised proposal for rationalising and focusing the objectives and priorities of the Improvement Plan will be discussed at the next Improvement Board on 14 September 2016.

5.5 The following progress was reported at the Children's Services Improvement Board on 22 June 2016.

6 Theme 1 – Early Help and Partnership

6.1 Coventry City Council Early Help and Prevention Services hold 67.3% of all CAFs, with external agencies making up the other 32.7%. The number of CAF's held by external agencies is improving each month as further work is completed to redress the balance, the target is 40%.

6.2 CAF Co co-ordinators have refocused to concentrate on delivering additional support to the largest external partners e.g. schools, in particular primary schools, ensuring that when an issue or problem first emerges with a family that schools have the ability and skills to deliver interventions that have the greatest impact.

6.3 The issue to address step up/step down between children's social care and early help is being progressed. An audit has been completed by the Head of Safeguarding, 30 early help cases have been audited where step up is a feature. The report highlights areas of work that need further development and improvement, all recommendations will be implemented and monitored in the Early Help action plan.

6.4 The re- referral rate still remains high, and has increased significantly in May to 32.7%. The conversion of contacts to referrals from agencies identifies that 54% of the police contacts are converted to referrals. However education conversion for May is only 32% conversion and health is 21%. Further work is being undertaken in determining the impact on the re-referral rate or whether these contacts have been MASHED. There has been ongoing activity with partners to analyse the low conversion and contacts that do not meet threshold to support a shared understanding of threshold.

6.5 Contacts remain stable at 1671 which is not dissimilar amount when compared with the same time in 2015. Education are still the highest single referring agency accounting for 30.7% of the contacts within the month of May 2016.

6.6 Timeliness is still an issue due to the amount of work that is received in to the service that is then not converted to referrals.

6.7 Children and Family assessments remain on track with 94.8% completed under 45 days. The quality of Children and Family assessments is still variable and continues to be scrutinised by first line managers and service managers.

6.8 There has been a significant increase in children and young people being reported missing. The increase is due to better recording and a more robust approach to those young people who would have initially been deemed as "absent" rather than missing.

7 Theme 2 - Local Safeguarding Children Board

7.1 The Local Safeguarding Children's Board provides a regular progress update to the Improvement Board to highlight progress against the three requirements set out in the improvement Notice. These are:

- the LSCB to be strengthened so it can ensure that partners work together effectively
- multi-agency practice and individual partner audits are robust
- all partners are committed to a shared set of priorities for safeguarding, child protection and early intervention.

7.2 The following progress was reported to the Improvement Board on 22 June 2016: The chair highlighted the excellent safeguarding work being undertaken at Aldermoor Primary School.

7.3 Work continues on improving the dissemination of learning from serious case reviews (SCRs), peer review panels, surveys and audits and the voice of the child. As part of the annual review of training programmes, training on working with hard to engage families is being revised in response to what is known about current practice in Coventry.

7.4 The findings of recent Board multi-agency audits have now been analysed and reported. Following audit work by social care on the rise in re-referrals, a Board multi-agency audit looked at referrals and the application of thresholds. Some good practice was found, but in too many cases, recording needed improvement.

7.5 A further audit looked at care planning. Information and decision making recording often lacked detail and focus on outcomes. Some plans lacked clarity and focus on the rationale for action. Where the voice of the child was evident in plans, there was a clearer focus on

achieving better outcomes for the child, but too many plans failed to adequately reflect the voice of the child

7.6 A third audit examined responses to missing young people. Improvements were noted including work with young people to complete return home interviews in most cases. However, information gained from the interviews is not yet being used to inform planning for the young people in question.

7.7 The audits were discussed by the Board and some recommendations were made for action in response to the audit findings. The Effectiveness and Quality subgroup of the Board is now action planning for improvement and will report back to Board after six months.

8 Theme 3 - Quality and Effectiveness of Practice

8.1 Children's Services recognises that the workforce is its most valuable resource. A key element in delivering high quality services is improving the effectiveness of the recruitment of permanent social work staff across all teams and strengthening the service's ability to retain a high quality experienced workforce.

8.2 The Strategy embraces the priority of Children's Services to put children and young people at the centre of all its work. Human Resources and Children's Services has developed a range of recruitment and retention strategies to increase the number of good quality staff within the organization.

8.3 The service has successfully appointed a Principal Social Worker, and will be joining in the autumn.

8.4 An in-house social media recruitment campaign launched on 22 April 2016. The campaign has targeted experienced Social Workers through a range of digital and social media platforms to specifically target active and passive job seekers based on their connections, their internet usage and the organisations they support and champion. Over 100 Web Adverts and created an email marketing Campaign to reach over 1000 Experienced Social workers based in Ireland to inform of the vacancies and the relocation package.

8.5 The table below summaries activity up to 3 June 2016. A total of 48 offers have been made:

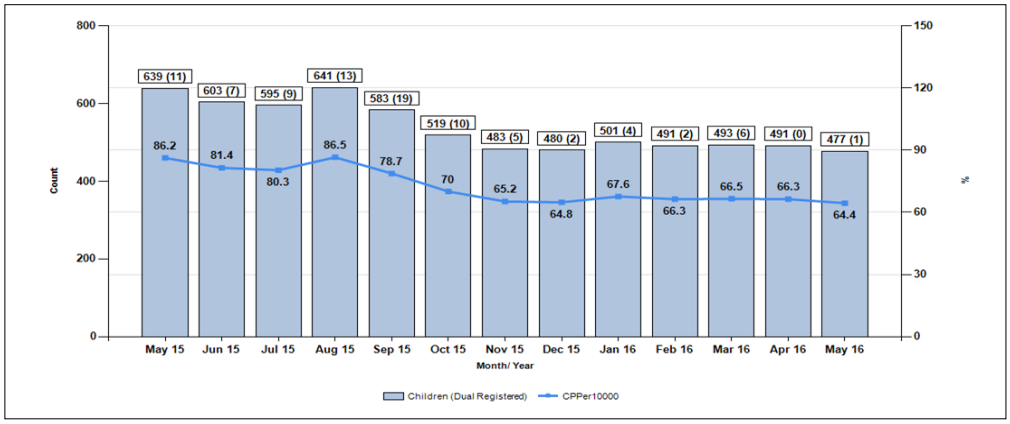
Table 1: Recruitment Activity for the period 11 February – 3 June 2016

Source of recruitment	No. of CV's received	No. of interviews held	No. of offers during this period
TMP Recruitment campaign	27	18	1 Service Manager 5 experienced Social Workers
Sanctuary	23	17	2 experienced Social Workers
Other agencies	4	4	3 experienced Social Workers
Internal candidates	6	2	1 Team Manager 1 Newly Qualified Social Workers
Compass Jobs Fair – March 2016	140	61	23 Newly Qualified Social Workers
NQSW's applying for posts	23	20	5 Newly Qualified Social Worker
Converting agency staff to permanent	12	7	7 agency staff converted to Experienced Social Worker
In house social media	22		Applications are currently being reviewed
Total	**257**	**129**	**A total of 48 offers:** 1 Service Manager 17 experienced Social Workers 1 Team Managers 29 Newly Qualified Social Workers In addition to this 11 candidates have withdrawn from the process

8.6 The number of children subject to a Child Protection Plan has decreased to 477 in May 2016 and continues to be lower than it has been since 2013. The indicator appears to have stabilised with no great increases since October 2015. The more stable number is a positive sign. This indicates that children are receiving support earlier and in a less reactive way. Signs of Safety is gradually beginning to focus not just on child protection plans but also on the use of safety plans. The number of children subject to a plan for 2 years plus continues to be higher than that of statistical neighbours but is relative to an overall higher number.

8.7 Table 2 below highlights numbers over the last 12 months:

Table 2: Child Protection Plans



9 Theme 4 - Quality Assurance and Audit

9.1 Coventry City Council Children's Services have since November 2015 developed a stronger more robust programme of audits to inform continuous practice improvement. Audits have been undertaken by a number of different sources, including, Practice Improvement Partners and the LSCB. The outcomes of each audit have led to the construction of action plans, focused on using the findings of audits to drive up the quality of practice.

9.2 The results of audits have reinforced findings across a range of different services along the child's journey. This has allowed for some triangulation and definitive conclusions in relation to both the strengths and weaknesses in practice across the whole of the Children's Service.

9.3 In April 2016, a Threshold/Missing and Care Planning audit have been completed jointly with the LSCB. Action Plans have been developed and are being implemented.

9.4 Work has begun with Early Help staff around the need for intervention which is focused and has clear outcomes and timescales. This has been facilitated through the audit work. The Care planning audit will lead to work being done with Child Protection Chairs around child centred outcomes and plans which are achievable for families. A session has been held with early help to look at the purpose and quality of their intervention and further sessions working with staff are planned. A session has also taken place with the child protection chairs to specifically gain a common understanding of what a good child protection plan should look like.

10 Theme 5 - Leadership and Governance

10.1 The Supervision Policy has been reviewed. A presentation was delivered to Board members on the new policy and supervision activity across the service.

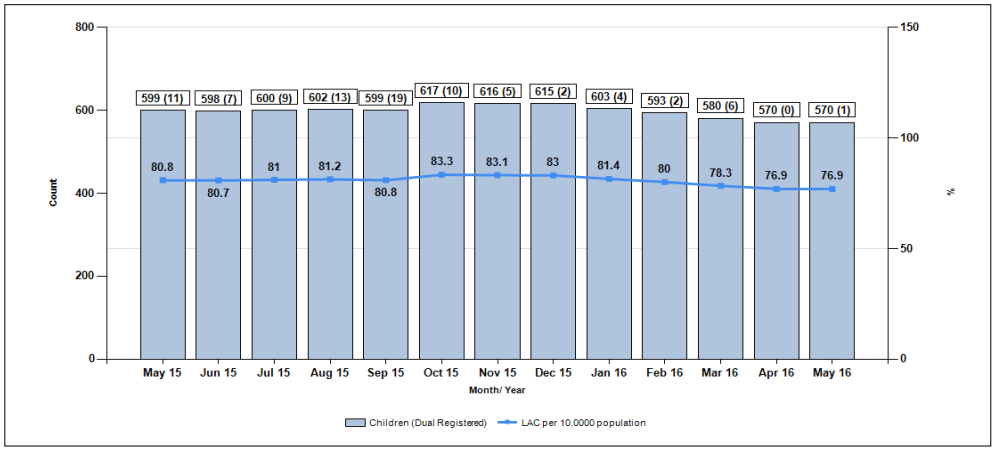
10.2 The revised policy provides more direction and guidance and tools for staff. The service are continuing to push the quality of practice and have a clear understanding of what good supervision looks like and how it is recorded. Supervision sessions are taking place and are critical to make sense of decisions around the child.

11 Theme 6 - Services for LAC, Care Leavers and Permanency

11.1 The total number of children looked after by the local authority has reduced since the new DCS was appointed. This is a result of better management oversight and grip

11.2 The table below highlights the direction of travel over the last twelve months for the numbers of Looked After Children.

Table 3: Number of Looked After Children



11.3 There are currently 71 children (12.6%) of children in residential care which is higher than the national average. A review of children in residential provision has recently been carried out and as a result 7 will be moving into supported accommodation, and a further 4 are having their plans reviewed.

11.4 The percentage of children in internal foster care remains at 29.6 %. A streamlined fostering recruitment and assessment pathway has led to an increase in the number of fostering assessments. A specialist fostering scheme has been developed. These initiatives, plus robust tracking of children, will help to reduce the number of children in residential care and increase children in fostering placements.

11.5 54 children were adopted in 2015/16. At the end of May 2016, 39 children have been placed for adoption a further 15 applications are lodged with the courts.

11.6 Coventry is now working formally with the regional adoption agency partners to ensure the larger pool of adopters recruited and approved are assessed and that where possible all children are provisionally linked to approved adopters before a Placement Order is granted.

11.7 A Corporate Parenting Strategy has been developed to set out the rationale and associated activity which will enable better local understanding of the looked after children system and lead to improved life chances for children in and leaving the care of Coventry City Council.

12 Communication

12.1 The e-newsletter continues to be produced focusing on Children's Services ahead of Ofsted re-inspection. This is issued to all staff in Children's Services, all partners, senior managers and Members to ensure everyone is aware of the progress made so far, what has still to be achieved and the role all employees can play in supporting the service in

achieving a better Ofsted result. In addition to this, the Director of Children's Services completes a regular blog.

Authors:

Sonia Watson, Children's Improvement Plan Project Manager,
John Gregg, Director of Children's Services
Contact details: john.gregg@coventry.gov.uk Tel: (024) 7683 3402
sonia.watson@coventry.gov.uk Tel: (024) 7683 1890

Appendix 1

A One Page Summary of the Children's Services Improvement Plan March 2015

Note: Themes 1-5 theme are aligned to the DfE notice, the additional theme highlights services for LAC, Care Leavers and Permanency

1. Early Help & Partnership Working

- An enhanced and transformed Early Help Service
- MASH is embedded & information shared effectively
- Full Multi Agency Engagement in CAF
- Children and young people who go missing and are vulnerable to CSE are protected

2. Local Safeguarding Childrens Board

- Ensure that partners work together effectively and are held to account for their responsibilities
- Effective practices are in place to safeguard and promote the welfare of children
- Robust performance management assurance function
- Development activity has a positive impact

3. Quality and Effectiveness of Practice

- Improve timeliness and recording of Assessments
- Ensure children are safeguarded
- Recruit and retain an effective workforce
- Learning and Development impacting positively on practice

Key Challenges

Sustainability - managing future work volumes, resourcing and sustainability of improvements

Evidencing Impact - evidencing improvements and the impact on achieving good outcomes for children, young people and families

4. Quality Assurance and Audit

- Learning from regular audits and demonstrating improved practice
- Learning from User Feedback
- Regular accurate Performance Information
- Strengthen care planning function of Independent Reviewing Service

5. Leadership and Governance

- Accountability and oversight by Chief Executive and Council leadership
- Effective Management Oversight of cases
- Effective Supervision and reflective practice
- Manageable Caseloads

Services for LAC, Care Leavers and Permanency

- Improved service outcomes for LAC and care leavers
- Health of LAC
- Increase number of children adopted
- Increase recruitment of foster workers

Coventry City Council

Briefing note

To: Education and Children's Services Scrutiny Board
Date: 21st July 2016

Subject: Outstanding Issues Report

1 Purpose of the Note

1.1 To inform Members of the approach to be taken on progress, outcomes and responses to recommendations and substantial actions made by the Scrutiny Board.

2 Recommendations

2.1 Members are recommended to:

1) Note the attached template and examples from 2015-16

3 Information/Background

3.1 When recommendations and actions are made following a scrutiny meeting, they are circulated to the relevant Cabinet Member and officer, and recorded on a recommendations tracker.

3.2 The purpose of this report is to bring to the Boards attention the responses received from Cabinet Members and Officers in regards to recommendations and actions.

3.3 Once a response has been received or an action dealt with, it will be removed from this report and kept in the full recommendations tracker. The complete tracker can be viewed by contacting the Scrutiny Team on the details below.

Gennie Holmes
Scrutiny Co-ordinator
gennie.holmes@coventry.gov.uk
024 7683 1172

Outstanding Issues

Meeting Date	Agenda Item	Cabinet Member/ Responsible Officer	Rec', Action or Information	Recommendations/ Actions	Officer contact	Response/ Status
10/09/2015	Adoption Annual Report		I	Information regarding numbers of older children in long term foster care to be sent to members	Liz Gosling	Members updated at matters arising 14/10/15 COMPLETE
18 June 2015	Serious Case Review – Child T	LSCB	R	Recommendations to LSCB re: Housing Providers and functioning boilers.	Cat Parker	Briefing note sent to the LSCB COMPLETE
10 December 2015	Progress of Recommendations of the Task and Finish Group on Fostering		A	The SB noted progress of the recommendations of the Task and Finish Group and requested a further update in 6 months on 'Staying Put'	Gennie Holmes	Added to the work programme for next Municipal Year COMPLETE

Last updated 23/6/16

Education and Children's Services (2)

Scrutiny Work Programme 2016/17

16th June 16
Recruitment and Retention of Social Work Staff (task and finish group) Improvement Board - 11 May 2016
21st July 16
SCR Early Help Strategy Improvement Board - 22 June 16
15th September 16
'Stepping Up' and 'Stepping Down' Process for Social Care cases. Quality Assurance Auditing SCR – Child F
13th October 16
Supervision of Social Care Staff recommendations Teen pregnancy and PSHE in schools Health Visiting Contract Improvement Board Report – 14 September 16
10th November 16 **8th December 16**
Improvement Board Report – 2 November 16
12th January 17
Education Performance Report Improvement Board Report – 14 December 16
9th February 17
Improvement Board Report – 25 January 17
9th March 17
Monitoring of SCR recommendations from 15/16
6th April 16 **Progress Reports**
Changes to adoption agency – progress report Unaccompanied Asylum Seeking Children - briefing note LSCB Annual report Youth Offending Service – progress report Family Drugs and Alcohol Court – progress report MASH update - progress report 12 Jan 17 Children's Social Care Workforce Strategy – progress report 9 Feb17
Proposed Agenda Items
Voices of Care Consultation on proposed changes to the school transport service. Staying Put Policy and Preparation for Leaving Care Young Carers Serious Case reviews Commissioned Services including Residential Care

CAMHS Academisation Programme Short Breaks Review School based police panels Prevent in schools

Date	Title	Detail	Cabinet Member/ Lead Officer
16th June 16	Recruitment and Retention of Social Work Staff (task and finish group)	Members wanted to look in depth at the recruitment of social workers including consideration of reasons for lack of interest in previous recruitment campaigns and remuneration and responsibility levels of social workers. To include reputational factors as well.	John Gregg Cllr Ruane
	Improvement Board - 11 May 2016	A standing item as agreed by Council reporting progress against the areas identified in the improvement notice.	John Gregg Cllr Ruane
21st July 16	SCR	The Board will consider recommendations from a serious case review.	Janet Mokades Cllr Ruane
	Early Help Strategy	To receive a progress report on the Early Help Strategy including the Strengthening Families. Also to include hard to engage families (see SCR recommendations)	John Gregg Fran Doyle Cllr Ruane
	Improvement Board - 22 June 16	A standing item as agreed by Council reporting progress against the areas identified in the improvement notice.	John Gregg Cllr Ruane
15th September 16	'Stepping Up' and 'Stepping Down' Process for Social Care cases.	Following the Boards consideration of the SCR on Baby C Members requested more information on the new processes implemented as a result of the recommendations	John Gregg
	Quality Assurance Auditing	Following the Boards consideration of the SCR on Baby C Members requested more information on the auditing of case work to ensure consistency and quality of practice	John Gregg
	SCR – Child F	The Board will consider recommendations from a serious case review.	
13th October 16	Supervision of Social Care Staff recommendations	A progress report on the recommendations accepted by the Cabinet Member on 14/4/16	John Gregg Cllr Ruane
	Teen pregnancy and PSHE in schools	To consider what schools are doing to support the Teenage Pregnancy Strategy and how the Council is supporting them	Kirston Nelson, Nadia Ingliss Judith Simmonds Cllr Maton
	Health Visiting Contract	Members wanted to know more about the current health visiting contract particularly Health Visitors involvement in	Cllr Ruane

Date	Title	Detail	Cabinet Member/ Lead Officer
		CAF's.	
	Improvement Board Report – 14 September 16	A standing item as agreed by Council reporting progress against the areas identified in the improvement notice.	
10th November 16			
8th December 16	Improvement Board Report – 2 November 16	A standing item as agreed by Council reporting progress against the areas identified in the improvement notice.	
12th January 17	Education Performance Report	An annual report with the headline performance data from schools, including vulnerable groups including children educated out of school and excluded pupils.	
	Improvement Board Report – 14 December 16	A standing item as agreed by Council reporting progress against the areas identified in the improvement notice.	
9th February 17	Improvement Board Report – 25 January 17	A standing item as agreed by Council reporting progress against the areas identified in the improvement notice.	
9th March 17	Monitoring of SCR recommendations from 15/16	The Board wanted to know how the outcomes of recommendations from SCR's are monitored and whether implemented recommendations have been effective in protecting children	Cat Parker
6th April 16			
Progress Reports		These items will only be reported to the Board by exception. Where progress is on track reports will be circulated to the Board for information only	
	Changes to adoption agency – progress report	A regional adoption agency has been established. Members wanted a progress report and information on performance	John Gregg Cllr Ruane
	Unaccompanied Asylum Seeking Children - briefing note	Members requested to be kept up to date on numbers of UASC in the city and services to support them	John Gregg
	LSCB Annual report	The annual report of the local safeguarding children's board	
	Youth Offending Service –	An update on progress of the Youth Offending Service	Angie Parks

Date	Title	Detail	Cabinet Member/ Lead Officer
	progress report		Cllr Ruane
	Family Drugs and Alcohol Court – progress report	Progress on the work of the FDAC	John Gregg
	MASH update - progress report 12 Jan 17	Following the meeting in January 2016, Members requested a further progress update, particularly in relation to the recommendations made.	
	Children's Social Care Workforce Strategy – progress report 9 Feb17	Following the introduction of the Workforce Strategy at their meeting on 25 February, Members requested a further progress report	John Gregg Cllr Ruane
Proposed Agenda Items	Voices of Care	Members requested regular updates on the work and benefits of the Voices of Care Council, including the results of surveys with LAC	Sheila Bates
	Consultation on proposed changes to the school transport service.	Following the change in timescales to implementation of changes Members requested that the Board considers the new proposals as part of the new consultation process.	Jeanette Essex Cllr Maton
	Staying Put Policy and Preparation for Leaving Care	To look in more detail at the Staying Put Policy, involving representation from the Foster Carers Association. The report should cover promotion of the policy with young people, children social work support at 18, financial support to Foster Carers. The Voice of the Child Task and Finish Group raised the issue of independence training and the Chair suggested that it be looked at separately. To include input from foster carers and care leavers as well as Route 21.	John Gregg Jivan Sembi Cllr Ruane
	Young Carers	Referred from the Corporate Parenting Board, to look at support offered to children and young people who are carers, especially those that are children in need, child protection or who come into care because of the health of their parents.	
	Serious Case reviews	The Board will consider recommendations from serious case	Cat Parker/Hardeep Walker

Date	Title	Detail	Cabinet Member/ Lead Officer
		reviews when they are published. To also include Wisteria Lodge investigation.	Cllr Ruane/Janet Mokades
	Commissioned Services including Residential Care	Members requested further information about commissioned services and how contracts are awarded and monitored, including Barnardo's. Members requested information on residential care provided by both the local authority and commissioned services	John Gregg/Sally Giles Cllr Ruane
	CAMHS	A follow up and progress report on work done with SB5 last year, especially in terms of prescription drug use. Also a task and finish group to investigate why there significantly high number of referrals through CAMHS on the ASD pathway.	Jacqueline Barnes
	Academisation Programme	The Board wanted to consider the implications of the Government white paper and the proposals for all schools to become academies by 2020.	Kirston Nelson Cllr Maton
	Short Breaks Review	To look in more detail at the provision of short breaks for disabled children	John Gregg Cllr Ruane
	School based police panels	A report on how the police are supporting improving behaviour in schools and tackling anti-social behaviour in partnership	Kirston Nelson Cllr Maton
	Prevent in schools	To look in more detail how the Prevent agenda is being delivered in schools	Kirston Nelson Cllr Maton