Learning from SSCB Assurance Activities (2015 – 16)

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1. Introduction

1.1. A common area for development for LSCBs is that lessons from case file audits, local/ national serious case reviews, management reviews and child death reviews need to be built into a multi-agency programme for practice improvement.

1.2. The following report - drawn from an analysis undertaken by Sandwell Safeguarding Children Board (SSCB) Business Unit - encapsulates the key learning points emanating from the performance management and assurance activities undertaken by SSCB during 2015-16. Through this analysis a number of key themes have been identified. These have been organised under the following main categories:

1.3. Using these categories a number of proposed actions have been derived to inform the 2016-17 SSCB Business Plan which will be structured around the following key strategic priorities:

a.) **Strategic Priority 1:** SSCB **communicates effectively** to ensure that the work of the Board is well publicised, that learning is disseminated and that the voice of children, young people, practitioners and the wider community (including minority groups and faith groups) are able to influence the Board's work.

b.) **Strategic Priority 2:** SSCB is assured that **effective arrangements are in place** for responding to key safeguarding risks including early help, child sexual exploitation (abuse), neglect, domestic abuse, mental health of children and young people and that there is consistently good practice across safeguarding services.

c.) **Strategic Priority 3:** SSCB has a **clear understanding of the effectiveness of the safeguarding system** in Sandwell and can evidence how this is used to influence the Boards priorities

2. Assessment of Changing Need and Risk:

2.1. Concerns about the effective assessment of need and managing risk are repeatedly referred to throughout the assurance activities. The Ofsted inspection of services for children in need of help and protection, children looked after and care leavers (published in June 2015) commented that *"The application of thresholds is inconsistently, and at times, inappropriately, applied. This results in cases not being allocated for a social work assessment when appropriate and in cases remaining in early help when a social work intervention is required due to known and potential risk to children"*.

2.2. The Understanding and Application of Thresholds (commissioned by SSCB and SMBC in June 2015) confirmed the challenge that Early Help services faced in engaging with families on a voluntary level, particularly when cases stepped down from a statutory social intervention. It identified that cases sometimes drifted, and in some instances required re-escalation with little or no effective work having been undertaken in the interim period.

2.3. This was echoed in the Safeguarding Board's *'Walk the Floor'* initiative during which staff, whilst having a good understanding of thresholds, expressed frustration as to what the next steps should be if intervention was not effective. A primary school also school also highlighted an issue of a child being moved between a child in need plan, early help and child protection with no progress or improvement.

2.4. Managers of integrated targeted family support services (COGs, Family Solutions Team, Youth Service and Early Help Desk) had already identified engagement as a significant challenge. In response to this issue, Salford University School of Social Work were commissioned to develop an Integrated Services Training Programme for all staff, covering solution focused approaches, working with hard to engage families, risk analysis and a range of other practical approaches. Mixed feedback was received on the usefulness of this training.

2.5. The subsequent Early Help Review (September 2015) highlighted that Early Help staff across the partnership continued to report that it was more difficult to step cases up than step them down and that traffic appeared to be more one way than the other (performance information at that time showed of 301 cases closed, 11% were step-ups and 23% step-downs). However, the introduction of Challenge Panels reviewed all open Targeted Early Help cases. This empowered workers in the COGs to challenge partner agencies over effective multi-agency working to

prevent escalation and also social care colleagues over step ups which have been declined.

2.6. The reviewers undertaking the CSE Assurance Review (September 2015) found that of the 15 CSE cases audited 5 were considered to have risks higher than stated. However, they concluded that 14 cases were being managed in the right part of the system (Early Help or Children's Social Care). This was considered as positive and a significant change in findings since the publication of the Ofsted report.

2.7. During September 2015 SSCB commissioned the GS Serious Case Review (SCR). The SCR identified similar findings about the effective assessment of need and managing risk with a key conclusion being that *"…a multi- agency core assessment of needs and risks was never completed despite extensive agency involvement over many years…This meant that all information was not used to 'identify difficulties and risk factors as well as developing a picture of strengths and protective factors'".* The SCR went on to say that *"…the completion of a Core assessment should have included a suicide risk assessment with updates in response to changing circumstances, consistent with Sandwell's Safeguarding consistent with Sandwell's Safeguarding Board procedures 'Suicide Prevention Care Pathway for children and young people' (2014). Such an assessment would have identified the risk to GS and possibly served to mitigate future attempts by GS by exploring her personal history, personal functioning, verbal warning signs and trigger points".*

2.8. Responses to a workforce survey undertaken by the Safeguarding Board's Quality of Practice & Performance Subgroup during the year also elicited responses from front-line practitioners in respect of inconsistencies in the application of thresholds and improvements in Sandwell's Early Help offer.

Proposed Key Actions for 2016-17 SSCB Action Plan
1. **Strategic Priority 3:** Repeat the external audit of the understanding and application of thresholds during the autumn of 2016 in order to ascertain the progress made since the June 2015 external audit.
2. **Strategic Priority 3:** Recommendation to Children's Social Care to undertake periodic Challenge Panels of all open Targeted Early Help cases and report back to SSCB accordingly.
3. **Strategic Priority 3:** SSCB 2016-17 audit schedule to incorporate audits that have a focus on assessment of changing risk and need.
4. **Strategic Priority 3:** SSCB Threshold Training to be refreshed in light of key

	learning from OFSTED review and external assurance activities
5.	**Strategic Priority 3:** SSCB Threshold Document to be refreshed to reflect current practice in Sandwell.
6.	**Strategic Priority 2:** Coordinate a Board development day during which members will work closely with frontline practitioners and undertake an audit.

3. Communication (including information sharing and recording):

3.1. Effective communication was a recurring theme in the assurance activities.

3.2. Despite the positive affirmation of improved **communication** and **information sharing**, the Domestic Abuse multiagency audit (undertaken in April 2015) highlighted the fact that GP details were not routinely shared at Barnardo's Screening meetings as well as the fact that domestic abuse notifications themselves were not routinely shared with school health nurses. In addition, the audit led to a specific recommendation to develop guidance for Children's Centres regarding the appropriate action to take following receipt of domestic abuse notifications - this has subsequently been developed and circulated to all Sandwell's children's centre.

3.3. Additionally, the FS Management Review explicitly recommended the review of the Local Authority's Children Missing Education protocol in conjunction with health services to ensure a robust sharing of information particularly around first entry to school to prevent children being at risk of missing education.

3.4. The FS Management Review also spoke more broadly about communication and recommended that the Board should consider **raising awareness** to increase third party reporting of children at risk of neglect.

3.5. The issue of *'raising awareness'* was also echoed in the CSE Assurance Review with the reviewers recommending the wider use across the workforce of the information sharing form that is to be used to submit intelligence to the West Midlands Force Intelligence Bureau (FIB). The form is now available on the Safeguarding Children Board's website and featured in the Board's Autumn 2015 Newsletter.

3.6. There was commonality across the assurance activities in respect of **information recording** with a key recommendation from the ES SCR (published in January 2016) being that a multi-agency case audit be undertaken to ensure that prior interventions, accurate family histories and chronologies are part of the records and inform risk assessments. Whilst a formal audit has not been undertaken, the Quality of Practice & Performance Subgroup has incorporated specific questions into its audit tool to ensure the capture of these crucial pieces of information with a view to then analysing the collated information.

3.7. Both the Review of the Understanding and Application of Thresholds and the Domestic Abuse multiagency audit also made similar recommendations about case

responsible staff ensuring case files had fit for purpose updated chronologies, and accurate details of workers, involvement with the child and family and child names/DOB/GP & School.

3.8. The *'Compliance with West Midlands Cross Border Protocol'* audit (November 2015) similarly highlighted gaps in information recording, record keeping and a lack of robust chronologies/ recording. However the audit did also identify cases which benefited from having holistic chronologies and good analysis with the wishes/ feelings of the child/ parent/ carer included in the assessment.

3.9. The workforce survey undertaken during Q4 of 2015-16 also provided useful feedback to SSCB that a number of respondents were of the view that they had not received feedback from MARFs and that processes needed to be clear and consistent.

3.10. A similar point was also echoed in the findings from the Board's *'Walk the Floor'* initiative during which front-line practitioners within Children's Centres identified a lack of communication when cases are de-escalated.

3.11. The Serious Case Reviews and Management Reviews undertaken during 2015-16 resulted in a number of recommendations being made in respect of Policy & Procedures. These ranged from:

- ensuring that there is a clear policy and pathway for the handover from Health Visiting to School Nursing;
- ensuring that health providers in Sandwell review their DNA policy and making sure that it is being appropriately applied;
- developing multi-agency procedures and practice guidance for missed appointments;
- receiving assurance that Sandwell Local Authority Education have undertaken a review of the Children Missing Education protocol in conjunction with health services to ensure a robust sharing of information particularly around first entry to school to prevent children being at risk of missing;
- ensuring that single agency procedures include practice guidance for children who are subject to supervision orders;

3.12. A key area of focus during 2016-17 will therefore be to drive forward the development of local policies against a backdrop of potentially phasing down the work of the Policy & Procedures Subgroup in light of regional developmental work.

This will need to be supplemented with a robust 'Communications Strategy' which clearly identifies what messages will be shared with which groups and how this will be done..

3.13. Whilst the Board has been routinely disseminating learning across the partnership from SCRs and audit activity through its quarterly newsletters, coupled with a rolling programme of multiagency 'learning from SCRs' training, which is supplemented with single agency briefings, there remains much work to be done in order to embed learning in a timely manner across the wider workforce.

3.14. This was a theme from SSCBs Section 11 audit activity (comprising the submission of an online audit supplemented by a series of *scrutiny panels* with each partner in respect of their submission) undertaken during the year. A key theme identified that whilst agencies provided assurance that learning was disseminated, there was little evidence of impact.

3.15. The Safeguarding Children Board's *Walking the Floor* initiative undertaken between January 2016 - March 2016 highlighted the need to do more to increase practitioner knowledge and understanding of the role of SSCB as well as the need for clearer communications from the Board and wider circulation of the Board's newsletter/ CDOP briefings. In addition, further clarity on the SSCB Serious Safeguarding Incident Notification Form (SSINF) was also identified as an area for improvement as well as broadening the range of information accessible on the SSCBs website. During the Section 11 audit activity the majority of organisations provided assurance that key staff were aware of the SSINF process. However, given that the majority of SSINFs to date have been submitted by Children's Social Care and Police it would seem logical that further work in this area is required.

3.16. The review of child deaths during 2015-16 identified several modifiable factors which led to the launch/ continuation of several campaigns. These included the:

a.) development of 'Dog, Duck and Cat' books around poisonous household substances, dog safety and water safety

b.) revision, production and distribution of Safer Sleeping bags and thermometers with the inclusion of messages around bed sharing and the use of more imagery to support with EAL (English as Additional Language)

3.17. Data was also provided to Public Health to support with campaigns around maternal smoking

3.18. Looking forward to 2016/17, CDOP will continue to respond in real time to the emerging issues raised through the collection and review of child death information through campaigns, briefings and dissemination of learning. In addition, a project funded through Sandwell & West Birmingham Clinical Commissioning Group regarding the use of 'Baby Boxes' with the most vulnerable mothers will be carefully evaluated and scrutinised for further distribution and profile raising both locally and nationally.

Proposed Key Actions for 2016-17 SSCB Action Plan
1. **Strategic Priority 1:** SSCB to actively promote the third party reporting of children at risk of neglect
2. **Strategic Priority 2:**SSCB Module 3 / Core *'Working Together'* Training to make explicit reference to the importance of cumulative chronologies and recording of accurate and timely information
3. **Strategic Priority 1:**SSCB to publicise the need to adhere to the West Midlands Cross Border Protocol
4. **Strategic Priority 2:** SSCB to request an assurance report in respect of feedback provided to agencies submitting MARFs
5. **Strategic Priority 1:** Develop a Communications process to better disseminate learning and policy development across the partnership
6. **Strategic Priority 2:** Drive forward the development of local policies in light of regional developments in respect of policies and procedures.
7. **Strategic Priority 1:** Develop and implement a communications strategy which clearly identifies what messages will be shared with which group and how this will be done.
8. **Strategic Priority 3:**CDOP to continue to respond in real time to the emerging issues raised through the collection and review of child death information through campaigns, briefings and dissemination of learning

4. Workforce Development:

4.1. Workforce development is the mechanism to equip staff (and volunteers) with skills and knowledge so that they can effectively deliver and improve services to children, young people and families.

4.2. Whilst there is sufficient regular, appropriate and purposeful multiagency training across and within disciplines it is important that learning from the Boards assurance activities are reflected in its training programme.

4.3. To this end, the Review of the Understanding and Application of Thresholds made some basic observations about case plans including the need for plans - LAC, CP or CiN - to be SMART with clear alternative plans if objectives are not met. Furthermore, the reviewers highlighted the importance for case assessments and plans to be child focused. This was echoed in a key finding from the Domestic Abuse audit which called for an increase in staff awareness about understanding and assessing a child's demeanour, ensuring that it is recorded in domestic abuse incidents.

4.4. The ES SCR was also clear in its conclusions about basic procedure stating that *"…there are few if any new findings from this SCR. The main finding is that agencies failed to get the basics right*. *The history of the case was 'lost' not just by one but by all the agencies when the family moved from one area to another, information was not recorded accurately, the outcomes of meetings were not recorded, professionals did not share information both within and between organisations, child protection procedures were not followed…"*

4.5. Similar recommendations about basic practice were made following the Review of Early Help Services which suggested that staff need to be reminded of Working Together guidance and that a failure of parents to allow consent to sharing information needed to be considered for *'step-up'* where there is a perceived risk to the safety of a child. It also recommended that Senior Family Support Workers should be provided with training in supervision as soon as possible.

4.6. The CSE Assurance Review highlighted the need to not only improve the consistency and quality of CSE casework but to also embed the use of the CSE Screening Tool across the partnership supported by a programme of training. In order to be effective, the reviewers further recommended that data collection regarding the nature and scale of CSE in Sandwell should be used to inform a CSE

training programme. This is a key activity that will need to be taken forward by the Safeguarding Board's Learning & Development Subgroup.

4.7. A finding from the FS Management Review focused on adopting a more targeted approach with Housing and Neighbourhood Officers in respect of Module 1 training. This was to equip those officers who complete home visits with the skill-set to identify and report child neglect. To this end the MASH Education Officer delivered a number of sessions across the housing sector about thresholds and was supported by colleagues who provided additional information about Early Help, Troubled Families agenda and CSE.

4.8. One of the key issues of substance arising from an analysis of SSCBs s175 audit with schools during the 2014-15 academic year (which spanned the 2015-16 financial year) related to the development of the Personal, Social, Health and Economic (PSHE) curriculum in respect of CSE and Extremism. Although the audit activity found that schools were increasing their awareness in CSE (demonstrated through the number of referrals being received), it was clear that a more targeted approach needed to be taken with specific schools in order to raise awareness further. This finding was reflected in the SSCB's CSE Strategy. Primary Schools in particular expressed concerns with regard to CSE being within the key stage 1 (ages 5 - 7) & key stage 2 (ages 7-11) curriculum. A consistent approach of how to manage disclosures made by children was also highlighted as a particular area of concern by schools during the s175 audit. This was addressed by making a West Midlands Police presentation that supports practitioners in managing disclosures available to schools.

4.9. The Section 175 audit also identified that a number of schools have either had specific training, or bespoke workshops for pupils, thereby increasing their awareness and engagement in respect of extremism/ radicalisation, this is not routinely being done across the sector. It is clear that a more targeted approach needs to be taken in order to raise awareness further. In light of the withdrawal by West Midlands Counter Terrorism Unit (CTU) of their Securities and Partnership Officers from the delivery of WRAP (Workshop to Raise Awareness of Prevent) training, SSCBs Learning & Development Subgroup coordinated the delivery of a *'Train the Trainer'* program in November 2015 equipping twelve multiagency colleagues with the skills to now deliver WRAP training on behalf of SSCB. The Local Authorities Strategic Prevent Coordinator, who commenced employment in

October 2015, has also supported a delivery plan where training and awareness has been prioritised accordance with the expectations set out in the Prevent Duty.

4.10. Both the external review of thresholds and the CSE assurance review made explicit reference to the need to strengthen staffing levels within the MASH/ MAET, CSE Service/ Team as well as COGs, not only in terms of capacity but also in terms of skill-mix. The external review of thresholds for example highlighted that *"…although the speed and professionalism of the decision-making by team managers in MASH was impressive, we concluded they were working at the edge of capacity"*. The reviewers also commented that *"…MAET is also under considerable pressure and one of the 2 Team Managers indicated that there had not been enough time to carry out routine supervision".*

4.11. In response to this, staffing levels within both MASH (1.5 x FTE) and MAET (1 x FTE) were strengthened during the summer of 2015. A review of the roles and responsibilities within COG teams has also resulted in each COG Manager now being supported by two Senior Targeted Family Support Workers who manage five Targeted Family Support Workers per COG. The role of the Early Help Social Worker (EHSW) has also been reviewed and refocused to complement the weekly COG Case Discussion Forums, providing consultancy type advice to schools, supporting risk assessment and operation of thresholds. Following the establishment of a new Single Assessment Team within Children's Social Care it is no longer necessary or appropriate for EHSWs to undertake Single Assessments.

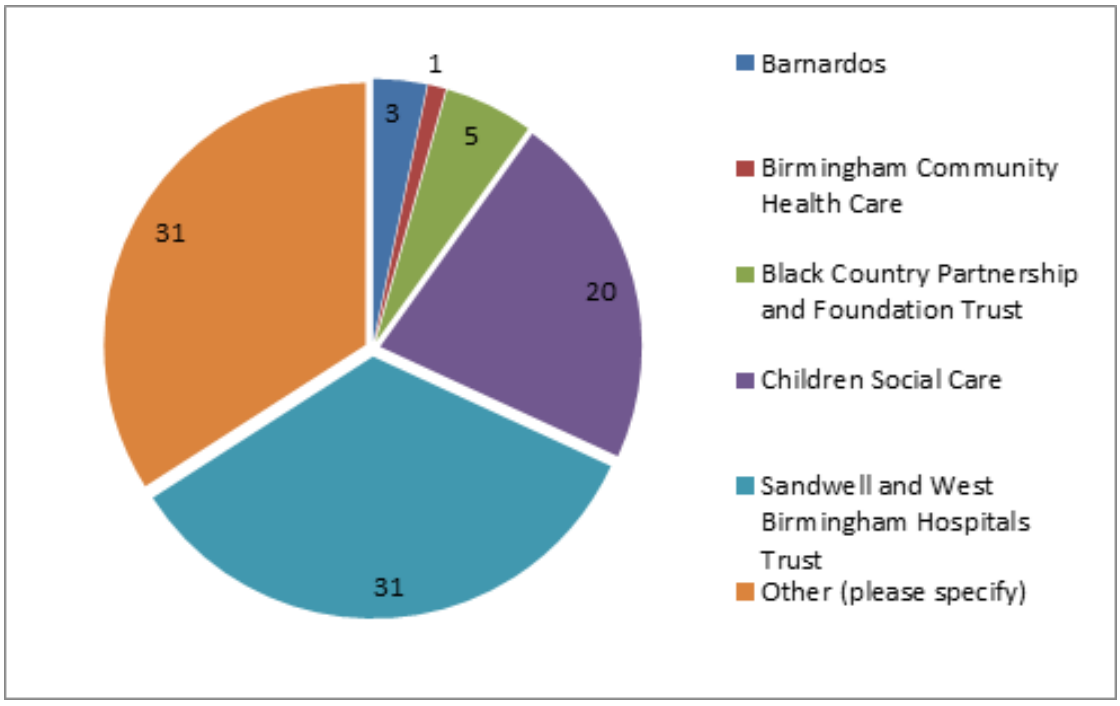
4.12. Additionally, the appointment of a single Group Head for Targeted Services from September 2015 responsible for all 6 COG services is providing greater coherence to the development of the service in the future.

4.13. The Section 11 audit activity also highlighted *workforce development* as a theme with recommendations that relevant staff within organisations attend CSE and multi-agency threshold training as appropriate; undertake DASH risk assessment training and MARAC training; complete on-line training on Domestic Violence and Abuse, Forced Marriage, Honour Based Violence and Female Genital Mutilation.

4.14. The CSE assurance review also recommended that the Board be sighted on progress of plans by West Midlands Police to develop dedicated capacity and capability to tackle CSE and confirm witness care arrangements for CSE victims.

4.15. It should be noted that during the year there have been a number of initiatives to strengthen practice with the appointment of a Principal Social worker team and the introduction of Signs and Safety and Outcome Star. Outcome Star (a suite of tools designed for supporting and measuring change in work with individuals and families) has been rolled out and over 600 professionals from across the multi-agency Early Help workforce have been trained in its use. 'Signs of Safety' has also recently been rolled out across the workforce in Children's Social Care. SSCB will be working with partners during 2016-17 to ensure that frontline practitioners within their respective agencies have an understanding of the Signs of Safety model.

4.16. A key component of the Board's Quality Assurance Framework is *'Workforce Engagement and Development'* and the survey undertaken during the year was specifically designed to proactively engage with the Partnership's workforce who work directly with children in Sandwell. The survey was live between 12th January 2016 - 12th February 2016 and a total of 91 responses were received from organisations as illustrated below.



4.17. Based on the limited number of responses the key issues highlighted by the survey results were as follows:

a.) Approximately 50% of respondents either agreed or strongly agreed that children were being effectively safeguarded in Sandwell. Conversely this means almost

50% do not have this view and communicated that high caseloads, being over-worked and thresholds being high as possible reasons for this.

b.) A similar split and similar reasons were also echoed in responses to the questions asking whether staff were able to spend enough time working with children and young people and whether current caseloads were manageable.

c.) 85% of respondents felt that they did receive regular supervision with the vast majority commenting that they also found the process effective.

d.) Three-quarters of respondents felt that their interventions had improved the safety and welfare of children. However, resource constraints and a reducing workforce were cited as potential reasons that weaken the effectiveness of interventions. This latter point was also identified in the 'Walk the Floor' initiative during which more capacity within services to attend the COG meetings, and within services to support families were highlighted as challenges facing practitioners.

Proposed Key Actions for 2016-17 SSCB Action Plan
1. **Strategic Priority 2:** EAG, in conjunction with the CSE Team, to identify and work with those schools that would benefit from a more targeted approach in order to raise awareness in respect of CSE.
2. **Strategic Priority 1:** L&D Subgroup to reflect the learning from assurance activities in both the 2016-17 training catalogue and the tutor briefings
3. **Strategic Priority 3:** SSCB to be sighted on progress of plans by West Midlands Police to develop dedicated capacity and capability to tackle CSE and confirm witness care arrangements for CSE victims
4. **Strategic Priority 1:** L&D Subgroup to incorporate Signs of Safety into the refreshed threshold training and supplement this with 'bite-sized' training

5. Performance Information & Quality:

5.1. A further recurring theme identified during 2015-16 related to performance information and quality.

5.2. The CSE Assurance Review questioned the reliability of data given that of the 20 cases that the reviewers explored, 5 (25%) were not in fact CSE cases. Discussions with staff about these cases indicated that the reason they were considered as CSE was due to the high emphasis placed on CSE. Reviewers considered that additional training may be needed in the recognition of CSE, distinguishing it from other types of need/ risk. Further issues were also raised about the reliability of available data.

5.3. In order to address this agreed information is now routinely provided to Strategic CMOG and SSCB. A monthly scorecard is produced by the Local Authority and quarterly information is supplied to SSCB which provides information on victims, perpetrators, locations and overarching themes.

5.4. It should be noted that 5 of the 15 cases audited were escalated to senior managers in terms of the quality of assessment, planning and effectiveness of safeguarding activity. Of note in terms of timeliness and effectiveness of support to victims is that three of these five cases had previously been audited by SMBC following the Ofsted inspection so in effect the cases were raised again for further enquiries.

5.5. In response to the CSE Assurance review, both SMBC and SSCB have implemented a cycle of audit of CSE cases to ensure risk has been identified and is being managed effectively. The Safeguarding Board are scheduled to undertake a multiagency audit focusing on multiagency intervention during 2016-17 and the Board's current Section 11 audit incorporates specific questions in respect of CSE. This will be further supplemented when SSCB develop arrangements during 2016-17 to scrutinise and challenge the partner agency CSE self-assessment process and any associated action plans that were produced as part of the CSE Assurance Review.

5.6. Both the external review of thresholds and the CSE assurance review made explicit reference to the need to undertake further audit work. With respect to the former, a review of Early Help was recommended and duly undertaken in August 2015. The latter highlighted the need for SSCB to commission regular audits of CSE risk ratings, case plans and MASE meetings to ensure consistency and quality in the work. This will be taken forward by SSCB during 2016-17.

5.7. The Early Help Assurance Review made several recommendations about performance information and at the time of writing, a range of draft outcome-based performance indicators have been developed, drawing from the Troubled Family Indicators (TFI) criteria, by Children's Social Care. The indicators, which have yet to be signed off, will inform Locality Score Cards and local partnership working and will include data in respect of school attendance, school exclusions, educational attainment, anti-social behaviour and juvenile crime.

5.8. The Early Help Assurance review further recommended that Children's Services and the SSCB needed to have a clearer perspective on all agencies and schools' performance in terms of providing early support to children and families with non–compliant schools being an early priority for COG managers in ensuring a consistent Early Help offer from schools. With this in mind, consideration is being given to the governance arrangements and remit of the Early Help/MASH/MAET Board and whether it should become a formal subgroup of SSCB. This would better ensure that the monitoring of lead agencies is overseen at the Early Help/MASH/MAET Board with issues being directly escalated to SSCB.

5.9. The Section 11 audit activity also resulted in several recommendations in respect of performance information and quality. These included:

a.) Strengthening the Board's current data set further in order to enable SSCB to effectively scrutinise outcomes for children within the court system

b.) Seeking full engagement from partners in respect of their single agency audit programmes and outcomes.

c.) Seeking further assurance in respect of how agencies are taking forward the Prevent agenda by increasing staff awareness and engagement in respect of extremism/ radicalisation including identifying a Prevent Lead to coordinate this work

d.) Seeking further assurance in respect of how agencies are embedding CSE as a priority throughout their organisations

5.10. On a broader note, in September 2015 SSCB agreed a new Constitution which included a Board member role description and referenced an ongoing Board development programme. The development programme is part of the way in which SSCB can assure itself that it functions well and can demonstrate its effectiveness.

One element of the development programme is the completion of a Board member Annual review, the purposes of which are to:

a.) strengthen individual and collective responsibility
b.) clarify expectations of Board members
c.) learn from members' experiences to measure the Board's effectiveness
d.) improve communication and engagement
e.) provide an opportunity for open discussion between members and th
f.) Independent Chair on how to improve the Board's functioning
g.) maximise members' contributions
h.) identify areas for development
i.) model good practice and reflective learning

A recurring theme from the Board member review exercise focused on strengthening SSCB challenge. Whilst it was acknowledged that this was an improving area members commented on the need for more challenge to be made to the education agenda in terms of quality safeguarding practice and training. In addition there were comments that whilst the majority of challenge rightly comes to Social Care there is a need to replicate this with the same intensity for other partners.

Proposed Key Actions for 2016-17 SSCB Action Plan
1. **Strategic Priority 3:** SSCB to commission audits of CSE risk ratings, case plans and MASE meetings to ensure consistency and quality in the work.
2. **Strategic Priority 3:** SSCB develop arrangements during 2016-17 to scrutinise and challenge the partner agency CSE self-assessment process and any associated action plans that were produced as part of the CSE Assurance Review
3. **Strategic Priority 2:** Early Help/MASH/MAET Board to be reframed into a formal subgroup of SSCB
4. **Strategic Priority 1:** The SSCB CSE training offer to specifically distinguish CSE from other types of need/ risk.
5. **Strategic Priority 2:** SSCB to give consideration to resurrecting the use of a 'Challenge Log'