Annual Report

of the

Slough Local Safeguarding Children Board

2013/14

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1. Foreword from Independent Chair

I am pleased to present my third Annual Report of the Slough Local Safeguarding Children Board (SLSCB) for 2013/14.

Publication of an annual report has been a requirement of LSCBs since 2009 and this is the fifth such report to be published in Slough. Working Together 2013 sets out a revised framework for Annual Reports and this has been followed in formulating this report.

The key purpose of the Annual Report is to assess the impact of our work to safeguard and promote the well-being of children and young people in Slough. Specifically it is intended to report on our performance in delivering the objectives set out in the SLSCB Business Plan for the year. It highlights the successes and identifies continuing challenges and development needs that now form the focus of our Business Plan for 2014-15, the priorities for which are covered in the final section of this annual report.

Our Business Plan priorities for 2013/14 drew on the:

- Safeguarding Improvement Plan put in place after the Ofsted inspection of April 2011 and overseen by the Safeguarding Improvement Board;
- outcomes of the Peer Review undertaken in November 2012;
- areas identified as key risks to the safeguarding and welfare of children and young people that arose from our needs analysis undertaken before agreeing our priorities for action in 2013/14.

Our priorities for 2013/14 were:

STRATEGIC OBJECTIVE 1:

To be assured of the effectiveness and co-ordination of safeguarding practice in Slough through

1A Effective early help that reduces the proportion of children requiring formal child protection interventions

1B Quality support to children that require formal child protection or local authority care

1C Responding to the new Working Together Framework 2013

STRATEGIC OBJECTIVE 2

To target areas of particular safeguarding risk in Slough which have been identified as:

- CSE and Child Trafficking
- Domestic Violence
- Homelessness (16-19 year olds)
- Neglect
- Mental Health – both children and parents
- E-Safety
- Drug and Alcohol Abuse

STRATEGIC OBJECTIVE 3

To improve the effectiveness of the Slough Local Safeguarding Children Board

STRATEGIC OBJECTIVE 4

To improve communication and engagement between the SLSCB and children and young people, wider communities, front-line practitioners and partner agencies

STRATEGIC OBJECTIVE 5

To develop our workforce to enable it to deliver the improvements and outcomes sought.

Our performance against each of these priorities is set out in detail in this report.

In November 2013 Slough was the subject of an Ofsted inspection under the new framework entitled 'Inspection of services for children in need of help and protection, children looked after and Care Leavers'. This new framework includes a formal 'Review of the effectiveness of the Local Safeguarding Children Board'. The inspection took place between19 November – 11 December 2013 and was published in February 2014. Whilst the inspectors recognised improvements had been secured since the previous inspection these were not deemed sufficient to secure an improved grade judgement and the SLSCB therefore remains 'inadequate' in Ofsted terms. Clearly this was a significant disappointment to the Board particularly given the positive findings of the Peer Review process undertaken in the previous year and reported in last year's annual report. The areas for immediate action and for development that were identified in the Ofsted review of the LSCB were incorporated into our Business Plan for 2013/14 with immediate effect and feature prominently in our Business Plan for 2014/15.

Our work to transform the SLSCB and its effectiveness has taken place at a time of significant change for many constituent partner agencies. All those engaged in the

work of the Board have faced significant financial challenge during the period covered by this annual report. Others, in particular the health sector, have moved through a major change process with the transition from PCTs to CCGs.

I would like to thank all members of the SLSCB and its sub-groups for their continued commitment to the Board and their sustained motivation and enthusiasm in driving forward improvement, particularly given the major challenges each has faced across the past year. Together we have put in place the foundations of what I believe has become a more effective and efficient Board that is beginning to secure effective safeguarding of the children and young people of Slough and contributes to effective co-ordination between the agencies that form part of the SLSCB. These are our key purposes and we are determined to ensure that we positively impact on both.

In addition I would also wish to thank staff across the partnership for the work that they have done to improve the effectiveness of safeguarding in Slough and to secure improved outcomes for the children and young people of the Borough.

I trust that this report will enable you to recognise the success that we have achieved during 2013/14 and to understand the continuing significant challenges that will form the core of our Business Plan for 2013-16.

Paul Burnett

Independent Chair, Slough Local Safeguarding Children Board

2. BOARD MEMBERSHIP 2012/13

Name	Title	Organisation
Paul Burnett*	Independent Chair	
Louise Asby	Community Safety Manager	Slough Borough Council
Neil Aves/Hamid Khan	Assistant Director, Housing/Head of Place Shaping, Housing and Environment	Slough Borough Council
Damodara Baliga	Lay Member	Community Representative
Nancy Barber* (Left the Board September 2013)	Director of Nursing	Berkshire Healthcare Foundation Trust
Jill Barker/Susannah Yeoman*	Director of Slough Locality	Berkshire Healthcare Foundation Trust
Virginia Barrett	Deputy Principal	East Berkshire College
Sarah Bellars	Director of Nursing	Slough CCG
Simon Broad	Head of Adult Safeguarding and Learning Difficulties	Slough Borough Council
Jesal Dhokia	Children and Young People's Development Worker	Slough CVS
Caroline Dulon*	Headteacher	Ryvers Primary School
Janine Edwards	Scheme Manager	Home Start, Slough (CVS)
Kitty Ferris*	Assistant Director, Children, Young People and Families	Slough Borough Council
Helen Huntley*	Headteacher	Haybrook College
Julie Kerry	Assistant Director of Nursing	NHS England (Thames Valley Area Team)
Shelley LaRose	Head of Service, Slough YOT	Slough Borough Council
Councillor Pavitar Mann* (Observer status)	Cabinet Commissioner Education and Children	Slough Borough Council
Mansfield, Margaret/Ann Owen	Named Nurse for Safeguarding Children/Interim Director of Nursing	Heatherwood and Wexham Park Hospitals Trust
Colin Pill	HealthWatch Officer	HealthWatch
Julie Penney/Nicola Carty*	Service Manager	CAFCASS
Jim Reeves*	Detective Chief Inspector	Thames Valley Police
Harish Rutti	Lay Member	Community Representative

Jenny Selim/Debbie Hartrick	Designated Nurse	Slough CCG
Louise Watson	Designated Doctor	Slough CCG
Debra White/Caroline MacGowan	Senior Probation Officer	Thames Valley Probation Service
Jane Wood*	Corporate Director for Well-Being (DCS)	Slough Borough Council

*denotes Members that are also a member of the SLSCB Executive

Where dual memberships are listed in this table it reflects an in-year change in personnel during the year covered by this report. It is important to note the significant number of changes of membership the Board has experienced during this period. In some cases this has also affected attendance levels recorded by the agency concerned particularly where posts were not filled immediately and the agency did not provide substitute membership.

3. ASSURANCE OF THE EFFECTIVENESS AND CO-ORDINATION OF SAFEGUARDING PRACTICE IN SLOUGH

This part of the Annual Report focuses on Objective 1 in our Business Plan 2013-14. This was to secure assurance of the effectiveness in safeguarding practice across Slough in three key areas:

1A Effective early help that reduces the proportion of children requiring formal child protection interventions

1B Quality support to children that require formal child protection or local authority care

1C Responding to the new Working Together Framework 2013

The scope of this objective was intended to cover 'the child's journey', a concept drawn from the Munro Review of child protection published in May 2011. It also responded to the identified need to improve service performance across the continuum of safeguarding provision as identified in both the Ofsted inspection of 2011, the Safeguarding Improvement Plan and the review of the SLSCB undertaken by C4EO. The outcome of the Ofsted inspection of 2013 further underlined the importance of these areas of work.

Priority 1a: To be assured of the effectiveness of Early Help in reducing the number of children and young people requiring formal child protection interventions

What was planned?

In April 2013 Slough was in the process of reviewing and revising its Early Help Strategy and supporting Early Help Action Plan. The purpose of the review was to address improvements that the SLSCB and Children and Young People's Partnership Board (CYPPB) had deemed essential to secure greater effectiveness in early intervention work most importantly to secure greater synergy between early help and children's social care interventions for children in need, children in need of child protection and children that needed to be looked after. A key part of this new strategy was the introduction of a single 'front door' for access to services.

The specific objectives set by the SLSCB were to secure assurance that there was a clear and effective early help framework that:

- was shared and signed up to by all partner agencies
- incorporated appropriate safeguarding arrangements
- was appropriately resourced across the partnership;
- was understood by all partner agencies, front-line staff and service users – including shared understanding of relevant thresholds for access to service interventions in the Early Help offer;
- was monitored and evaluated to test the effectiveness of cross-agency working and enables impact on outcomes for children and young people to be effectively gauged including impacts on referrals into formal child protection arrangements and the effectiveness of CAF in securing improved outcomes for children, young people and families;
- coherent with the 'Troubled Families' programme.

To achieve this the SLSCB requested quarterly reports from the CYPPB that included:

- Quantitative data reporting on the agreed Early Help scorecard;
- Qualitative performance reporting based on multi-agency auditing of early help co-ordination and effectiveness;
- The views of children, young people and families about the quality, effectiveness and impact of early help;
- The views of staff in relation to their understanding of early help arrangements, their capacity and ability to operate within the early help arrangements, the effectiveness of co-ordination between agencies and the impact of the early help arrangements on both service users and on achievement of individual agency and shared service objectives and priorities.

This reporting arrangement reflected the 'four quadrant' quality assurance and performance framework that had been agreed by the SLSCB and that was similarly to be adopted by the CYPPB during 2013/14.

What action did the Board take?

The Board actively engaged in the development of the new Early Help Strategy and Action Plan and the establishment of the one 'front door' arrangement. The SLSCB adopted a scrutiny and challenge role given the lead role of the CYPPB in formulating the strategy and action plan and then commissioning its implementation. The key focus for the SLSCB was to assure itself that safeguarding arrangements were core to the new arrangements and that the strategy would secure the intended outcomes in terms of addressing need before risk reached levels that required formal child protection interventions. It was recognised, however, that in the initial stages the implementation of the Early Help Strategy and the new contact and referral arrangements could increase the number of child protection and care proceedings and this indeed turned out to be the case.

Key actions taken by the Board during 2013/14 included:

- engaging in the formulation of the Early Help Strategy and supporting action plan;
- agreeing the Early Help Strategy and action plan;
- funding programmes of multi-agency training relating to the implementation of the Early Help Strategy through the Munro training monies;
- agreeing with the CYPPB an Early Help scorecard based on the 'four quadrant' approach adopted by the SLSCB and the core indicators that would be reported on a quarterly basis to the SLSCB;
- receiving regular reports on Early Help performance as part of the Business Plan and Quality Assurance and Performance Management arrangements;
- monitoring agency engagement with the Early Help strategy and action plan.

Reports on the Early Help Strategy and Action Plan to the SLSCB have been highlight reports focusing on the 9 key strands in the Early Help Action Plan as set out in last years' Annual Report namely:

1. The implementation of the new multi-agency Early Help Strategic Plan for Slough;
2. The creation of a Head of Service (Early Help) post;
3. The further development of an Integrated Early Help modal – Early Help Collective (0-19);
4. The creation of 'One Front Door' to social work and Targeted Family Support Services;
5. The development of a Family Support Service (0-18);
6. The re-launch of CAF as the Slough Early Help Assessment and Plan;
7. Improving links through the Head of Service to commissioning;
8. Addressing both resource and workforce investment required to enable this approach to be successfully implemented;
9. Ensuring appropriate consultation and communication across the partnership and with children, young people and families themselves.

The lead body in this work will be the Children and Young People's Partnership Board (through the Early Help Strategic Board). The CYPPB established an Early Help Sub-Group to lead this work and the chair of that group is a member of the SLSCB and its Executive which has assisted cohesion. The role of the SLSCB has focused on securing assurance of the intended impact on both service quality and effectiveness together with improved outcomes for children, young people and families.

What has been the impact?

- The new Early Help Strategy and Action Plan was agreed and in place with a partnership launch on November 29th 2014;

- Workforce development and training was provided through LSCB and Munro training monies on a multi-agency basis to support the implementation of the strategy and action plan including co-hosting of the Early Help partnership launch held in November 2014;
- The SLSCB challenged and secured some resolutions to concerns expressed by partner agencies in terms of thresholds and the new Early Help Assessment process;
- The LSCB ensured that in formulating its new Threshold Protocol, as required by Working Together 2013, that concerns expressed by partners about the clarity of early help thresholds were addressed;
- The SLSCB scorecard monitored the number of CAFs/Early Help Assessments being undertaken though the rate of initiation remained inconsistent as commented on below;
- There has been little evidence of the impact of CAF/Early Help interventions on the number of referrals received by Children's Social Care. Indeed the overall number of referrals has risen and the increased identification of children assessed as requiring early help may have led to more children being referred into formal child protection processes. This is being further tested in the roll out of the Early Help Action Plan.

As set out above a key concern of the SLSCB during 2013/14 has been the fluctuation in the rate of Early Help referrals and assessments across the year. In the Annual Report 2012/13 we had reported positively on the on-going increase in the number of referrals and assessments carried out. This trend did not continue and during the summer and autumn of 2013 reductions in the rates of Early Help referral and assessment were reported. Clearly this was partly due to the review of Early Help being undertaken and some under-reporting within the information systems. Nonetheless it caused significant concern. The downturn in the number of Early Help referrals coincided with the period immediately preceding and covering the Ofsted inspection with the result that this was a key cause for concern.

Concerns about the effectiveness of Early Help resulted in two priority and immediate actions for the LSCB in the Ofsted inspection that took place in November 2013. Whilst it was recognised in the Ofsted review of the LSCB that partnership working was becoming more effective in some areas the inspectors stated that 'increasing the impact of its challenge to partner agencies, so that they co-operate fully in the improvement of early help, is the single most important area for the board to develop'. This judgement resulted in two priority and immediate actions for the LSCB notably:

- Ensure all partner agencies are engaged in the delivery of the early help strategy so that children and families have equal access to the services they need as early as possible;

- Ensure that agencies take full responsibility for their roles as set out in Working Together to Safeguard Children (Department of Education 2013) and that they commit to multi-agency strategies and working groups, including sharing responsibility and resources where necessary.

Clearly, the SLSCB Business Plan was immediately updated to address these priorities for action.

What developments and improvements are required in the future?

The new Business Plan sets out the actions required toaddress both the SLSCB assessment of performance complemented by the findings and actions required of the Board as a result of the Ofsted review of the SLSCB.

Key priorities for 2014/14 are as follows:

Assurance that there is effective and co-ordinated early help in place that secures:

- equality of access to support services and an increase in the number of CAFs/TACs;
- early intervention in response to need;
- avoids children's social care involvement.

Specifically we want to be assured by the CYPPB/Early Help Board that:

- thresholds for access to early help and referral processes are understood and effectively implemented by all;
- all partners are engaged in the delivery of early help, co-operating in the delivery of the early help interventions and actively supporting integrated service provision at the point of delivery.
- early help provision incorporates appropriate safeguarding arrangements
- quality assurance and performance management arrangements are in place to test the effectiveness of cross-agency working and impact on outcomes for children and young people, including impact on referrals into formal child protection arrangements and the effectiveness of CAF in securing improved outcomes for children, young people and families;
- Assures coherence between Early Help and the 'Troubled Families' programme.

During 2014/15 the SLSCB will look to be assured specifically on the impact of early help on 'Children in Need' so that we are confident that those most at risk of child protection referral benefit from early help and avoid referral into formal child protection arrangements

Priority 1b: Quality support to children that require formal child protection or local authority care

What was planned?

For the majority of the year 2013/14 the SLSCB aligned its activity under this priority with the work of the Safeguarding Improvement Board. Indeed the intention of the SLSCB had been to ready itself to assume the role of the Safeguarding Improvement Board when Ofsted assessed safeguarding provision in Slough to have improved to a level that no longer required intervention.

The key objectives set out in the Business Plan 2013-14 were:

To be assured that arrangements for child protection and looked after children in Children's Social Care (CSC), in other individual services across the partnership and in multi-agency working are effective.

To be assured that the improvement priorities for CSC in the safeguarding improvement plan are secured and specifically that:

- Children and young people are safe and feel safe and feel safe as a result of improved social care practice;
- Outcomes for children are improved through management oversight and good planning;
- The children's socal care workforce are able to carry out high quality work with children, young people and families, leading to improved outcomes;
- Recruitment, induction, training and management of social work staff results in a workforce capable of carrying out the required standards of work and retention of skilled staff.

Specifically to be assured that there is:

- efficient and effective safeguarding practice when children are in the child protection and care services both in terms of adherence to working together requirements, timeliness of action and quality of provision
- quality partner contributions to services/support to children who have a child protection plan or are in the care of the local authority.
- effective partner contributions in securing improved outcomes

What action did the Board take?

The SLSCB has 'shadowed' the Safeguarding Improvement Board in scrutinising and challenging the performance of Children's Social Care against the five key improvement strands set out in the Safeguarding Improvement Plan:

- Identification, contact and referral
- The child's journey in the children's social care system

- A confident and competent workforce
- Quality and Performance
- Partner engagement and working together

In addition the SLSCB has extended this work to include wider partnership arrangements to support effective child protection and children in care services, their co-ordination and their impact on safeguarding outcomes.

A variety of means has been adopted to address these pieces of work as follows:

- Implementing a new Quality Assurance and Performance Management framework that has combined quantitative and qualitative information to test the effectiveness and impact of child protection and children in care services;
- Delegating detailed quality assurance and performance management monitoring to the Quality and Performance Sub-Group and raising issues of concern through a RAG rated performance system to both Executive Group and Board level as appropriate;
- In relation to quantitative information, adopting the children's social care scorecard adopted by the Safeguarding Improvement Board to ensure consistency of data reporting and coherent focus on key improvement areas;
- Developing a wider multi-agency audit arrangement planned to test key stages in the child's journey through the safeguarding pathway.
- Consideration of the outcomes of our Section 11 audit
- Receiving the annual report of the IRO service (on child protection and looked after children) and on private fostering;
- Receiving presentations from officers on issues causing concern. This included presentations on: the quality of referrals from key agencies most notably Thames Valley police referrals; the timeliness of initial assessments; the effectiveness of core and strategy group arrangements.
- Keeping under review policies and procedures through the Pan-Berkshire Policy and Procedures Sub-Group (see report in Chapter 5).

Clearly, the outcomes of the Ofsted inspection provided an important external judgement of performance within the year covered by this Annual Report and the findings of this were considered and acted upon immediately by the LSCB even prior to formal publication of the final report in February 2014.

The SLSCB has played a role in the introduction and implementation of the 'Strengthening Families' approach – often referred to as 'Signs of Safety'. The LSCB will want to scrutinise the implementation of these changes, consider feedback from children, families and professionals and evaluate whether the changed approach is contributing to keeping children safe. However, as of March 2014 the SLSCB has not received sufficient information to judge whether this new approach has secured improved outcomes in service delivery and outcomes for children and young people.

What has been the impact?

As the outcome of the Ofsted inspection would suggest performance overall has been disappointing and the Ofsted team judged performance in relation to child protection to be 'inadequate'.

A full report of the performance of Children's Social Care is presented at Appendix 4. As can be seen from that report there are areas of performance in relation to Child Protection that have improved including increases in the number of contacts and referrals which was a development sought by both the Board and the Safeguarding Improvement Board. However, a greater number of indicators are judged to be 'red' on the RAG rating system that were so rated last year.

Quantitative data monitoring for the year 2012/14 has illustrated a number of performance improvements against key indicators:

- Increases in the number of contacts and referrals that brought the authority closer to the average for our statistical neighbour group;
- De-registration of children from child protection plans is occurring at a faster rate than benchmark comparator areas;

With regard to Looked After Children;

- All looked after children have an allocated social worker
- Performance on statutory visits has improved
- The % of children placed for adoption has continued to increase;

As stated above a copy of the full Performance Scorecard for children's social care is attached at appendix 4.

It is important to note some of the positive comments made in the Ofsted inspection in relation to children in need of help and protection. These included:

- The out-of-hours service has offered a good level of support for children and families;
- When child protection concerns are identified decisions are made in a timely manner and case records are accompanied by a clear rationale and initial action plan;
- Decisions for children who no longer need a child protection plan are timely;
- There is clear commitment by social workers and managers to work in partnership with parents;
- Multi-agency meetings are mostly well attended;

- Core groups take place regularly;
- Information sharing at MARAC and MAPPA reflect a clear understanding of the dangers posed to children living in circumstances where domestic abuse is a factor;
- There are clear systems for establishing the whereabouts of children missing from education;
- Good progress has been made in developing co-ordinated multi-agency approaches to the identification and protection of young people at risk of CSE.

Overall the judgement of the Ofsted inspection was that performance was 'inadequate'. Of particular relevance to the SLSCB were concerns expressed by inspectors in relation to the contribution of partner agencies to child protection arrangements notably:

- The quality of referral information which is often insufficient and leads to delay in decisions and actions taken by social workers – there is particular criticism of the Police in this respect in relation to domestic violence incidents;
- Thresholds not being universally understood and embedded across partner agencies

What developments and improvements are required in the future?

The new Business Plan has set out a range of priorities for 2014/15 as follows:

To be assured that arrangements for child protection and looked after children in Children's Social Care, in other individual services across the partnership and in multi-agency working are effective.

To be assured that the improvement priorities for CSC in the safeguarding improvement plan are secured and specifically that:

- Children and young people are safe and feel safe and feel safe as a result of improved social care practice;
- Outcomes for children are improved through management oversight and good planning;
- The children's socal care workforce are able to carry out high quality work with children, young people and families, leading to improved outcomes;
- Recruitment, induction, training and management of social work staff results in a workforce capable of carrying out the required standards of work and retention of skilled staff.

Specifically to be assured that there is:

- efficient and effective safeguarding practice when children are in the child protection and care services both in terms of adherence to working together requirements, timeliness of action and quality of provision
- quality assure partner contributions to services/support to children who have a child protection plan or are in the care of the local authority.
- effective partner contributions in securing improved outcomes

To be assured that contact, referral and initial assessment arrangements through the 'One Front Door' are understood and are effective.

To be assured that the engagement of Police personnel on the 'Front Door' improve both the quality of referrals and secure effective triage of cases.

Annual Report from the IRO Service

An important part of the SLSCBs work in relation to both child protection and children looked after is to consider reports from the Reviewing Service (Independent Reviewing Officers for children in care, and Child Protections Conferencing Chairs). Following a review by C4EO after the Ofsted inspection of April 2011 the relationship between the Reviewing Service and the SLSCB was reviewed and formalised.

The SLSCB now receives formal reports from the Reviewing Service and some of the headlines from 2013/14 are set out below.

What has happened?

Additional resources have been invested in the service and a number of changes were made to the management and structure of the Slough Child Protection Conferencing Service during 2013/14.

An Independent Reviewing Manager has been in post since 1 October 2013. This is a new post with responsibility for managing the team of Independent Reviewing Officers. A permanent Head of Service for the Unit took up post in April 2014. The 2 posts of the Quality Assurance Manager and the Local Authority Designated Officer (LADO)/Safeguarding in Education Manager remain vacant but covered by agency staff within the team.

A significant change to the Independent Reviewing and Conference team since last year's report has been the separation of the roles of Independent Reviewing Officers and Child Protection Chairs. This was a key recommendation of an independent, sector led review of the service undertaken in 2012. This has now been implemented with the aim to further develop practice and performance in these respective areas and to strengthen the scrutiny and challenge function of the team to take on the full scope of their responsibilities.

There is an establishment of three FTE Child Protection Chairs, currently covered by 2.6 FTE staff (1 of whom is an agency worker). One of the Conference Chairs (alongside the Head of Service) covers the LADO role for part of their hours. Difficulty in recruiting to all posts on a permanent basis has led to the need to provide cover through agency staff, which in turn has left the service unable to fully cover all vacant posts because of the additional cost of agency staff. Set alongside the rise in numbers of children subject to a child protection plan (covered later in this report), this has created a capacity issue within the unit and restricts the role of the conference chairs, specifically around mid-way monitoring and on occasions in consultation with social workers and managers before conferences.

The new work flow arrangements in the social work teams which now follow the child's journey, giving a focus to assessment and the alignment of child protection work with care proceedings and the 'raising of the bar' in terms of the quality of social workers employed in Slough is beginning to show improving practice, particularly in the last 3 months of 2013/14. However, recurring issues include the lateness of social work reports for conference, problems with the Integrated Children's System (ICS) which have created blockages in the process and a delay in progressing recommendations.

Conference Chairs have increased their use of the 'Issue Resolution Process' whereby concerns are raised with managers when procedures are not followed or where practice falls short of expected standards.

Most 'Issues Resolution' notices are resolved by first line managers or Heads of Service. Very few have needed to be escalated to the Assistant Director. Positive outcomes from the issue resolution process include care proceedings initiated, permanency plans being progressed and inadequate social workers identified.

Caseloads have reduced as is shown in the following table

	April 2011	March 2012	March 2013	March 2014
LAC children	186	184	182	192
CP children	144	209	146	254
Total	330	393	328	446
Average caseload	82.5	72.8	65.6	

The caseloads for IROs have remained relatively stable and are well within the recommendations outlined in the IRO handbook. The average caseload for an IRO is between 60 and 65 in Slough. The caseload for each IRO takes into consideration that the number of children placed outside of the area as of 31 March 2014 was 134 (71 %) with the average distance from St Martins place of 24.4 miles, 34 children are placed 50 to under 100 miles and 7 are placed 100 miles or more.

Team members have begun to specialise in either the chairing of child protection conferences or Looked After Children reviews.

Child Protection and Conference work

The number of children subject to a child protection plan at the end of March 2014 was 254. This was an increase of 108 over the previous year.

Numbers of Initial Conferences

There were 403 ICPCs (Initial Child Protection Case Conferences) held between April 2013 and March 2014 an increase of 60% from the previous reporting year, when concerns were flagged in the 2012/13 Annual Report about the low numbers of children made subject to CP Plans. The increase in activity resulted from work within children's social care to ensure that thresholds into children's social care and throughout the children's social care system were applied appropriately and consistently. This work has led to increased rates of referral to children's social care and rates of children subject to CP plans. In November Ofsted commented that thresholds were now applied appropriately. Rates of children subject to CP Plans are now above the average for statistical neighbours and whilst we would expect a 'lag' effect from the work described above, a close watch will be kept on this part of the system

Children subject to a plan for 2 years or more:

The percentage of children subject to a plan for 2 years or more has fallen compared to a year ago (5.4%) and now stand at 0.8%.

The reduction of children subject to plans for 2 years or more is likely to be due to the robust Slough protocol put in place where at the 9 months stage (2nd review conference) the plans for children who are deemed to continue to be at risk of significant harm and remain subject to a child protection plan are subjected to increased scrutiny. A Practice Manager will attend this conference so that decisions can be made about whether the Public Law Outline (PLO) process is required to reduce harm to children. The aim is to ensure decisions for children are timely and all measures to prevent them from remaining at risk of significant harm are in place. The conference process is instrumental in ensuring that where risk is not reducing under a child protection plan, alternative action (usually through the PLO process) is taken to ensure that risk is reduced.

Only 11% of children were subject to a plan for more than a year, a decrease from the previous year when 22% had been subject to a plan for more than a year.

Both measures above suggest an improvement in timely decision making which reduces drift and reduces risk.

Children subject to repeat plans

369 children were made subject to a child protection plan in Slough during this reporting year and 69 of those had previously been subject to plans. This means that 18.7% were repeat plans (compared to 15% for statistical neighbours and England average)

A themed audit is planned to understand why children are returning to conferences and are being made subject to repeat child protection plans. The themed audit should pay particular attention as a priority to the repeat plans that were made within a year.

The timeliness of child protection conferences was as follows:

	March 2011 to April 2012 and	March 2012 to April 2013.	March 2013 to April 2014
The percentage of initial child protection conferences that were held within 15 working days of the strategy discussion	83.5%	74.3%	74.2%
The percentage of child protection plans that were reviewed within expected timescales	94.1%	100%	100%

The percentage of ICPCs held within the statutory timescales has remained static at just over 74%, which is slightly above statistical neighbour and national average. Given the rise in the number of initial conferences it is positive that performance has been maintained. The IRO admin service works with vigour to ensure conferences are held within the required timescales. When they are not it is almost always due to late notification from the operational teams. Next reporting year should see an improvement in these figures.

Review child protection conferences were all held within the expected timescales, meaning within 3 months of the ICPC and within 6 months after that.

Categories of abuse

In the last 12 months 362 children have become subject to a child protection plan. Of these, 163 (44.8%) have become subject under the category of Neglect. The national average is 41%

Abuse Category	Total
Neglect	162 (44.8%)
Emotional abuse	131(36.2%)
Multiple	23 (6.4%)
Physical abuse	38 (10.5%)
Sexual Abuse	8 (2.2%)
Grand Total	362

The level of sexual abuse cases discussed at conferences in Slough continues to be very low. Nationally during 2013/14 the percentage of child protection plans due to sexual abuse was at 4.8%.

Children subject to a child protection plan by age, ethnicity and disability

As at 31 March 2014 by age:

	March 13	March 14
Under 5s	36%	39%
5 - 11	41%	38%
12 - 16	23%	22%
17 and above	0%	1%

As at 31 March 2014 by Ethnicity:

	March 13	March 14
White	60%	50%
Mixed Ethnic Origin	21%	14%

Asian or Asian British	18%	29%
Black or Black British	1%	5%
Other Ethnic Groups	0	2

As at 31 March 2014 four children subject to a CP Plan were allocated to the Learning and Disability Team. This is an increase from last year when there were no children from this team subject to a CP plan

Since last year there has been an increase of children from an Asian background subject to CP plans and an increase of children defined as Black or Black British. Children from Black and minority ethnic backgrounds now make up nearly half of child protection plans in Slough.

Children attending their Case Conference:

Children aged over 10 are invited to their conference. 35 children between the ages of 10 and 17 attended their conference for this reporting period.

Child Protection Chairs are instrumental in ensuring that children are prepared to attend this meeting and should be meeting with them prior to the conference. Good practice and Working Together Guidance (March 2013) is clear that the Conference Chair 'should meet the child and parents in advance to ensure they understand the purpose and process'.

The CP Chairs do meet with the child and parents in advance of a CP conference but often the meeting of a child is done on the day and just before the meeting. The standard that we are working towards is each child that has stated that they would like to attend their conference is met by the Chair of that conference prior to the date of the actual meeting. Each child, where appropriate, is supported by an advocate and plans for their emotional wellbeing after the conference is also included as part of the child protection plan.

The figures below are based on the Quality Assurance Audit forms filled in by CP Chairs following each conference.

The parental risk factors noted in conferences continue to show a high number where domestic abuse is a significant factor, with drug and alcohol abuse also high. Mental Health and Neglect are significant factors, too. Multiple factors (in half of all conferences) explain the percentages.

	No. conferences	Mental Health	Alcohol Misuse	Drug Misuse	Domestic Violence	Neglect	Multiple Factors
Jan to Mar 2013	72	22%	18%	26%	48%	19%	35%

	No. conferences	Mental Health	Alcohol Misuse	Drug Misuse	Domestic Violence	Neglect	Multiple Factors
Jan to Mar 2014	**117**	**25%**	**26%**	**30%**	**73%**	**43%**	**43%**

Reports received prior to conference:

There continues to be a problem according to the current Slough standard of Chairs receiving the social work report three days before the ICPC in this reporting period. However there is a slight improvement from figures reported for the same period last year.

However, since April 2014 we have begun using the Pan-Berkshire standard set out in the Pan-Berkshire procedures which state that Chairs should be in receipt of the ICPC social work report 24 hours before the conference. These figures will be reported in next year's data. The change has been agreed because the timescale for holding a conference is 15 days from the strategy meeting which means that producing a report 3 days before a conference restricts the amount of time available to social workers to investigate, assess and produce a report. We have agreed 1 day before is more realistic.

In the first 3 months of 2013, just 33% of reports were received 3 days in advance by conference chairs, this increased to 41% in the first 3 months of 2014.

Just as important is the number of Social Work reports received on time by the main carer(s) who attended conferences. The figures below also show an improvement on last year's reporting figures for the same period.

In 2013, 40% of mothers and 51% of fathers received reports on time whilst in 2014 this improved to 62% and 55%.

Police attendance at initial conferences has improved since last year based on figures for the same reporting period. In the first 3 months of 2013 they attended 62% of conferences to which they were invited and 0% of review conferences, this had improved to 88% and 3% in 2014.

The record of Health Practitioners attending conferences continues to be good. There has however been a slight dip in the figures of reports being provided to the meeting.

In January to March 2013 health practitioners attended 83% of conferences and provided reports for 99% of conferences. In 2014, they attended 88.8% of conferences but only provided reports in 95%.

The record of GP's attending Conferences together with the low number of reports provided when requested continues to be disappointing and has decreased in numbers since last reporting quarter.

In the first 3 months of 2013, GPs attended only 5% of conferences and provided reports to 25% whilst in 2014, they attended only 2% of conferences and provided reports to only 15%.

Positive steps are underway to address this. As a result of joint partnership working between health and social care the figures for next reporting year should be greatly improved.

The record of children's School or Nursery attending conferences is again good as for the same period for last reporting year.

In the first 3 months of 2013, schools attended 94% of conferences and provided reports for 84%, In 2014, they attended 96% of conferences and provided reports to 85%..

Looked After Children Reviews

At the end of March 2014 there were 192 children in full time care - this equates to a rate of around 50.1 children in care for every 10,000 children aged under 18 in Slough. This rate is below both the latest published national average (60) and below our statistical neighbours' average (66) Latest published benchmarking data is for March 2013. The figure of 192 is a 5.5% rise when compared with 1 year ago.

7 of the 192 (4%) full time LAC are Unaccompanied Asylum Seeking Children.

Of the local Slough children in care, 62% are from a white ethnic background, 21% are from a mixed ethnic background, 8% are from an Asian / Asian-British ethnic background and 7% are from a Black / Black-British ethnic background. These are very similar to the proportions one year ago, with small percentage increases to the mixed and white groups, and a slight reduction in Asian and Black heritage children.

25% of the children in care at 31st March 2014 are less than 5 years of age

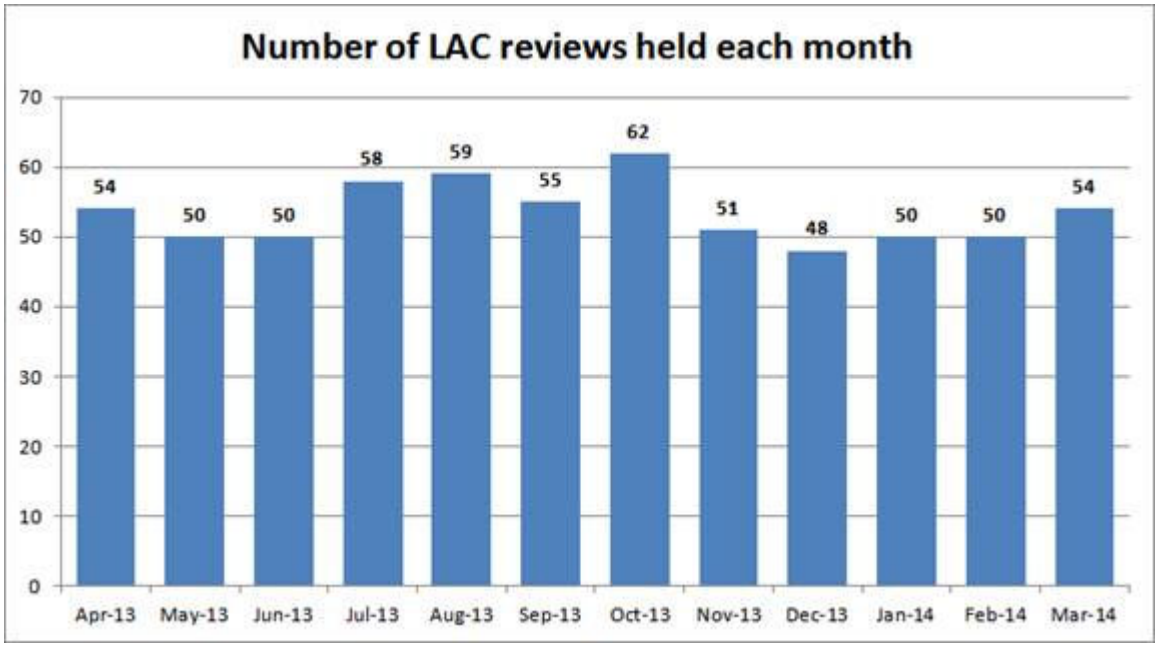
49% are aged 5 -15 and 26% are aged 16 or over.

A year ago there were 55 children aged 10-15 years old, now there are 57;

48 children aged 16 and over were in care at the end March 2014, an increase of just 3 since the previous year.

At the end of March 2014 most (140 or 74%) were placed in foster care; 72 (51% of those in foster placements) are placed with in-house foster carers, 3 with a relative / friend and 65 (46% of those in foster placements) are placed with independent foster agency or other local authority foster carers. Other placements include 5 children placed in adoptive placements, 20 placed in children's homes (of which 6 are placed in Slough in our council run children's home), 14 are placed in supported residential settings such as lodgings, 7 are placed in a residential care homes and 2 placed with own parents.

The Numbers of LAC Reviews undertaken between April 2013 and March 2014



Over the course of 2012 – 2013, 579 LAC reviews were carried out.

Over the course of 2012 – 2014, 641 LAC reviews were carried out which is an increase of 11%.

Performance

The IRO Service is responsible for two key performance indicators:

Timeliness of Reviews

Children's Participation

Timeliness of Reviews

To be added

Children's Participation

There are 3 booklets for children that are used by the IRO service:

- 'All about me' for 4 and 5 year olds
- 'My Views' for 6 to 11 year olds
- 'My Views' for 12 to 17 year olds
-

From January to December 2013 the participation officer received a total of 149 completed booklets from children to input for data analysis,

(Breakdown of 149 = ***16*** *4-5 years /* ***51*** *6-11 years /* ***82*** *12–17 years)* **Children's reviews and placement**

Children told us:

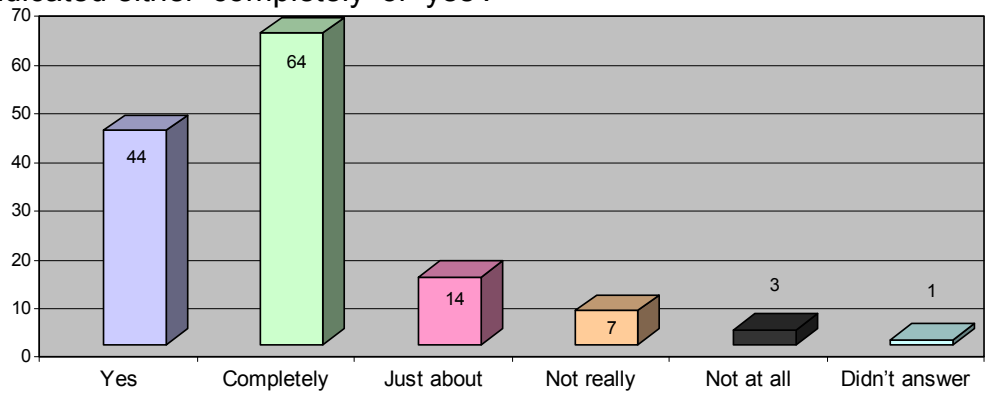
Where do children want their review to take place?

A common theme again this year is that the majority of children aged 6 – 17 would like their review to take place where they are living. For some children aged 6 – 11 the next option would be for their review to take place at their school and for those aged 12 + their next option would be 'in the office'.

Do children feel someone has talked to them about the decisions made at the review?

Do children feel happy and settled where they live?

Overall, children feel 'completely' happy and settled. For each quarter the majority of children indicated either 'completely' or 'yes'.

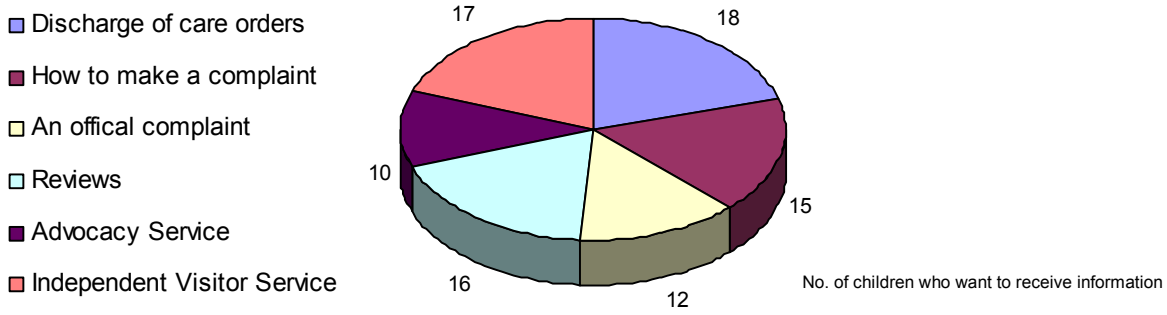


Age 6 - 17

Do children want to have an independent visitor or advocate?

Eleven children indicated that they would like to talk to someone else, like an independent visitor or advocate.

Children within this age range can also indicate if they wish to receive further information on the following:



The IROs are reporting positively about the use of consultation booklets for children and young people and actively use them as part of the LAC review process. It is also worth while noting that not all young people particularly those in long term placement like completing them and would prefer to give verbal feedback. All forms of children's views whether it is via booklet or verbal feedback are given equal consideration as part of the LAC review process.

What developments and improvements are planned for the future?

In strategic terms organisational change that is driving the new Early Help model, Slough Borough Council's Targeted Family Support Service, the Integrated 'One Front Door' and Early Help 'Collective' approach – endorsed by the Improvement Board, LSCB and the Children's Partnership will be key mechanisms through which further improvement can be secured. The new Quality Assurance and Performance

Framework that has been developed across the SLSCB and the CYPPB is designed evaluate the impact of these changes.

Similarly the wider improvement plan in relation to Children's Social Care described above is designed to secure improvement. This will similarly be monitored by the SLSCB.

In specific relation to the IRO service whilst there has been some improvement in the performance of the service in 2013/14 there are areas where further action is required.

In response to the Ofsted inspection the service has identified the need to:

- Ensure that the voice of the child is recorded and used in children in need, child protection and looked after reviews
- Secure progress in the development of multi-agency child protection work between the police and children's social care
- Better engage partner agencies in getting involved with children and families early enough to resolve problems before they get worse
- Ensuring social workers have sufficient time to spend with children to learn about their lives, leading to poor quality assessments, plans and outcomes.
- Greater priority being given to children in need causing their situations to escalate into the child [protection system. Many children experience delays in getting the services they need.. They have too many changes of social workers

In addition the role of IROs needs to shift from being observers and roles with a primary function of ensuring due process and timescales are followed to a role where the CP chairs see themselves as the champions for children with a role to scrutinise forensically and challenge persistently (with purpose) is the step change for the team to make – a process which has begun but is work in progress.

Areas for development (for 2014/15) identified include:

- Practice Managers to routinely provide a written response to issue resolution notices.
- CP Chairs to employ issue resolution notices consistently (there was variable use during 2013/14)
- CP chairs to identify issues requiring challenge where the responsibility lies with partners and to pursue the challenge

The Reviewing Manager has ensured that all CP Chairs now understand their instrumental role in 'raising and keeping the standards'. There was a definite sense in the latter part of 2013 going onto early 2014 that CP Chairs were overwhelmed by the volume of issues presenting as a result of some poor quality agency staff and inexperienced managers. There has been a definite turn around in this attitude (supported by improving standards of social work) and a clearer sense of purpose

and function has now been injected into the team. They are supported in their independence and quality assurance function by the Assistant Director of Children, Young People and Family Services.

As part of their quality assurance functions, CP chairs are now consulting with social workers and their managers prior to ICPCs. They are also required to mid way monitor cases in between each CP review period but are hindered in doing so on a regular and consistent basis due to the amount of conferences they are currently chairing.

Specific improvements identified in the IRO annual report were:

- Three Houses consultation tool to be used at every ICPC for each child.
- Improvements in the receipt of reports (to chairs and parents) prior to conferences
- Improvement in the percentage of initial conferences held within the 15 day timescale
- Advocacy to be offered to children over the age of 10 to support attendance at conference or to ensure their views are heard and taken account of
- CP Chairs to meet with each child prior to their attendance at a child protection conference.
- Analysis to be undertaken to understand the rate of repeat plans
- A reduction in the use of multiple categories for children becoming subject to a child protection plan so that the incidence of specific parental factors can be better understood
- The service to produce a development plan to ensure that CP Chairs are exercising their role to its full extent
- Health professionals to provide a report for each conference they are invited to.

The SLSCB has endorsed the annual report, agreed the areas for improvement and will continue to monitor and evaluate performance against these objectives.

Private Fostering

The Private Fostering Annual Report 2012/13, reviewed the position in Slough against the national minimum standards that were published in 2005. As a result of this review an Action Plan was produced to ensure that Slough meets these standards.

The Action Plan was structured under the following headings:

- Statement of Purpose
- Promoting Awareness
- Monitoring Compliance

As a consequence, a significant amount of work has been undertaken to take forwards the actions under these headings.

What has been done in 2103/14

The Private Fostering Statement of Purpose has been revised to bring it into line with the national minimum standards. A Private Fostering Awareness Plan has been developed by the Council which includes a media plan to run throughout 2014/15 and the production of printed information to build awareness within the local community. In February 2014, a full page article was included in 'The Citizen' which is the Council's regular communication to the residents of Slough. In addition, the plan sets out a programme of professional awareness which includes online training for multi-agency staff who are not social workers and for social workers and a range of promotional materials for display and information, both printed and on line.

The online training for multi-agency staff who are not social workers can be accessed through the Children and Young People's Partnership Board web site and the training for social workers is part of the Councils Learning and Development programme for social workers.

Slough was inspected by Ofsted in November/December 2013 in respect of services for children in need of help and protection, children looked after and care leavers. Slough was judged as inadequate overall by Ofsted. However, inspectors acknowledged that improvements were beginning to be made against a legacy of previously poor practice. Whilst there were no immediate and priority actions or areas for development stated in the report (published in February 2014) in respect of private fostering, the report states that:

'Arrangements to raise awareness about private fostering have not been effective. The number of known private fostering arrangements has been consistently low'.

The Awareness Plan referred to above was in development at the time of the inspection and its focus is on ensuring that agencies who work directly with children and families understand what is meant by 'private fostering' and understand their responsibility to notify children's social care.

Private Fostering Activity in Slough 2013 to 2014.

The table below sets out the activity in 2013/14 and shows comparison with the 2012/13 activity

	2013 - 2014	2012 - 2013
Number of notifications of new private fostering arrangements received during the year in accordance with Regulation 3(1) and Regulation 5(1) of the Children (Private Arrangements for Fostering) Regulations 2005 :	2	3

Number of cases where action was taken in accordance with the requirements of Regulation 4(1) and Regulation 7(1) of the Children (Private Arrangements for Fostering) Regulations 2005 for carrying out visits :	2	3
Of these, the number of cases where this action was taken within 7 working days of receipt of notification of the private fostering arrangement :	2	3
Number of new arrangements that began during the year :	2	0
The number of private fostering arrangements that began ON or AFTER 1 April 2014 where visits were made at intervals of not more than six weeks :	2	N/A
The number of private fostering arrangements that began BEFORE 1 April 2014 that were continuing on 1 April 2014:	1	2
The number of private fostering arrangements that began BEFORE 1 April 2014 that were continuing on 1 April 2014 where scheduled visits in the survey year were completed in the required timescale 1 :	1	2
Number of private fostering arrangements that ended during the year :	1	1
Number of children under private fostering arrangements	2	1

The 2 children whose private fostering arrangements began between April 2013 and the end of March 2014 were both aged between 10 and 15 and were born in the UK.

The National Context

In January 2014, Ofsted published an analysis of inspections of Private Fostering undertaken in 2011 to 2013 (12 local authorities). The key findings from this analysis are as follows:

- Only one third of local authorities inspected were judged good.

- Low reporting of private fostering arrangements suggests there must be extensive ‘unknown’ private fostering in many areas.
- The annual DfE data collection produces little useful information and does not help manage risk
- Performance measures over-emphasis timely completion of set tasks rather than focusing on trends in the overall impact of local authority private fostering arrangements
- There is little evidence that awareness raising campaigns have any impact on self-referrals by the public, although strategies can help to raise awareness among professionals
- Annual Reports, whilst a requirement, are rarely of any significant value and do not address major strategic issues, such as how well they are performing against others or form an effective means of self-evaluation.
- A better system of classifying types of private fostering arrangements is well within the capabilities of local authorities.
- Risk assessment is hampered by the weakness of national data and the poor quality of local authority self-evaluation.

The report sets out a number of recommendations. The following are the relevant recommendations that could be carried out at a local level:

Data Collection:

The report makes recommendations for the DfE but consideration could be given at a local level to how we record and categorise private fostering arrangements:

- Recording how notifications were first made
- Categorise children by reason for placement (to enable the separation of high and low risk groups)
- How long children were living in the arrangement before notification
- The proportion of voluntary self-referral (by the adult private foster carer) being seen as the key indicator of effectiveness
- Schools being required to clarify numbers of children not living with their parents as part of the admissions process

Awareness Raising

- Re-branding Annual Reports as ‘self-evaluation’ and publishing them in full on the LA and LSCB web sites
- Place the emphasis on ‘key contact’ points such as school enrolment and GPs, verifying that children are living with their parents
- Make regular contacts with all language colleges in the LA area to check whether they have relevant young people on roll and where they are living and review such arrangements at regular intervals with the service provider

What is planned for the future

Objectives for 2014/15 are as follows:

To reduce unknown private fostering arrangements in Slough by:

- Raising awareness within the community and in all services working with children and families to ensure that private fostering arrangements are identified and appropriate referrals made to children's social care. In particular, to identify 'key contact' points and for those working with children and families to undertake the relevant on line training
- Publishing the Private Fostering Annual Report on the LSCB and CYPP websites and seek agreement from partners to ensure the Annual Report is discussed at relevant management meetings within organisations.

Target 'key' contact points:

- Identify language colleges within a 10 mile radius of Slough and initiate contact with these colleges in respect of any arrangements in place for students that might constitute private fostering within Slough. To consider with other LSCBs the benefits of undertaking this on a Berkshire wide basis
- Seek agreement from schools and GPs to identify situations where children are not living with their parents by seeking verification from the adults caring for children.

A scorecard that will help measure progress

- Consideration of a Slough scorecard for Private Fostering, taking account of the recommendations in the Ofsted report referenced above

The proposed actions for 2014/15 are set out in the Action Plan which is Appendix 6 of this Annual Report.

Priority 1C: Responding to the new Working Together Framework 2013

In March 2013 the Department for Education issued a revised Working Together. The new version required the Board to review its constitution, modus operandi and a range of documentation to secure compliance with the new framework.

What was planned?

The Business Plan 2013/16 set out a range of actions it planned to undertake to secure compliance with Working Together 2013 including:

A programme of measures to secure compliance with the expectations of LSCBs in the new Working Together framework in relation to Assessing Need and Providing Help.

A programme of work to agree with the local authority and partners a single assessment framework.

The development and publication of a threshold document that included:

- The process for early help assessment and the type and level of early help services to be provided;
- Criteria for when a case should be referred to the local authority's CSC for assessment under Section 17, 47, 31 and 20.

The publication of a Learning and Improvement Framework including revised arrangements for undertaking Serious Case Reviews and others forms of review.

Assurance that appropriate information sharing arrangements are in place across the partnership.

What action did the Board take?

A full scale review was undertaken of the constitution, governance and day-to-day operation of the Board to ensure compliance with Working Together 2013. The work relating to the operation of the Board itself and its relationship with other key partnership bodies is covered in detail in Chapter 5: Improving the Effectiveness of the Board. In addition, the Pan-Berkshire Policies and Procedures Sub-Group in collaboration with Tri-x worked to update all policies and procedures to secure alignment with the expectations of Working Together 2013 – work which is covered in more detail in the annual report of the Sub-Group later in this report.

In addition three specific strands of work took place to develop:

- The single assessment framework
- The Threshold Protocol
- The Learning and Improvement Framework

These three programmes of work were led by the Head of Safeguarding but supported by a multi-agency reference group to ensure both ownership and understanding across the partnership.

What has been the impact?

Board arrangements were reviewed in a timely manner and Ofsted confirmed in their inspection in November 2013 that the LSCB met its statutory requirements as set out in Working Together 2013. It specifically confirmed that:

> 'The LSCB ensures policies, procedures and the threshold for access to services are fit for purpose, kept under review and regularly updated to reflect statutory responsibilities and changes'

The three key documents referred to above were approved by the Board by the deadline of March 2013 and are all available on the new SLSCB website at **www.slough.gov.uk**

What developments and improvements are required in the future?

The three documents referred to above were all published in April 2014. Clearly, monitoring the effectiveness and impact of these new arrangements will be a key priority in 2014/15. In particular the Board has identified specific actions that relate to areas for improvement identified in the Ofsted inspection of November 2013.

Specific actions set out in the Business Plan 2014/17 are:

To secure the implementation of:

- The Threshold Protocol;
- The Learning and Improvement Framework

To formulate plans of action to implement these frameworks

To review the QA and PM framework to test the impact of these frameworks particularly in relation to:

- Understanding and application of thresholds for early help;
- Criteria for when a case should be referred to the local authority's CSC for assessment under Section 17, 47, 31 and 20.

Secure assurance that appropriate information sharing arrangements are in place across the partnership.

STRATEGIC OBJECTIVE 2:

To target areas of particular safeguarding risk in Slough which have been identified as:

- **CSE and Child Trafficking**
- **Domestic Violence**
- **Homelessness (16-19 year olds)**
- **Neglect**
- **Mental Health – both children and parents**
- **E-Safety**
- **Drug and Alcohol Abuse**

What was planned?

CSE and Child Trafficking

The priorities in this area were to:

- Carry out risk audit to determine levels of potential CSE prevalence in Slough.
- Hold CSE Conference
- Formulate and implement the CSE pathway set within the context of the wider service provision pathway;
- Implement a specific QA and PM framework for CSE that will incorporate quantitative and qualitative data (including multi-agency audit) and engagement/feedback from service users and front-line staff;
- Secure appropriate links and coherence between work on CSE and that on: children missing; children receiving services from the YOT; gang and youth violence; PREVENT and Channel (vulnerability to extremism and radicalisation)

Domestic Abuse

The priorities in this area were to:

Agree with the Safer Slough Partnership the interface between their role in leading the Domestic Violence and the SLSCB and SVAB roles in scrutinising and challenging performance on DV – and then to put in place arrangements that enable the SLSCB to be assured that:

- there is a reduction in the number of children facing safeguarding risk as a result of Domestic Abuse.
- there is improved capability to identify risk and secure multi-agency responses to the risks presented as a result of report Domestic Abuse

- responses to domestic abuse are effectively managed by partner agencies individually and in partnership

Homelessness

The priorities in this area were to:

Receive an assessment of the impact of new housing policies and practice in response to the Southwark Judgement on levels of homelessness amongst 16-19 Year Olds specifically in relation to safeguarding risk.

Negotiate, agree and secure the implementation of risk mitigation to reduce and manage safeguarding risk

Neglect

The priorities in this area were to:

Receive a report on the reasons why neglect remains the most significant CP category and what steps can be taken across the whole pathway of provision (the child's journey) to secure earlier intervention that reduces the number/proportion of cases that reach the threshold for 'significant harm'.

Mental Health of both children and adults

The priorities in this area were :

In collaboration with the Safeguarding Vulnerable Adults Boad to devise a plan for better integrated approach to assessing impact of mental health assessments across children and adult services

The two Boards to agree QA and PM framework to scrutinise and evaluate impact.

E-Safety

The priorities in this area were to:

Gain assurance that there is a 'Safeguarding in Education' lead.

Be assured that prevalence audit of e-bullying incidents is undertaken and that strategy and action plan to reduce levels of prevalence is agreed and in place

Appropriate interventions in place to address needs of both victims and perpetrators

Drug and Alcohol Abuse

The priorities in this area were :

In collaboration with the Safeguarding Vulnerable Adults Boad to devise a plan for better integrated approach to assessing impact of mental health assessments across children and adult services

The two Boards to agree QA and PM framework to scrutinise and evaluate impact.

What action did the Board take?

CSE and Child Trafficking

A full report of the work of the CSE and Child Trafficking Sub-Group is set out in Part 6 of this Annual Report

Domestic Violence

Strategically, the first actions taken were targeted at clarifying the governance interface between, on the one hand, the Safer Slough Partnership in its role as strategic commissioning lead for Domestic Violence and, on the other, the Slough LSCB and the Safeguarding Vulnerable Adults Board (SVAB) in relation to their scrutiny and challenge role in this important area of service provision.

The SLSCB and Slough Adult Safeguarding Partnership Board (SASPB) held a joint development session in July 2013 to consider routes to improving governance and performance relating to domestic violence. At this meeting a number of actions were agreed:

- to secure clarity about the relative roles of the SLSCB, SASPB, Safer Slough Partnership (SSP) and Children and Young People's Partnership Board (CYPPB);
- at both strategic and operational levels agree a process through which commissioning partnership boards consult with the safeguarding boards on domestic violence strategies and action plans;
- Partnerships collectively agree key priorities for action e.g.
    - Effectiveness of DV co-ordination
    - Staff 'thinking family'
    - Better quality reporting of DV incidents
- To develop arrangements for quality assurance and performance management that will assure the safeguarding boards of the effectiveness and impact of strategies and action plans. To secure this the safeguarding boards will need to be clear about what they are looking to be assured of.

The relative roles of the partnerships were clarified and agreed very early in the year. It was also agreed that there was a need for a strategic lead for domestic violence – both in terms of an individual post-holder and in terms of a forum through which the domestic violence strategy and action plan could become more robust. Both have been established and it is worth noting that the Ofsted team recognised that:

‘The LSCB has been instrumental in ensuring the appointment of a strategic lead for domestic. This post is now operational and leads on co-ordinating both the strategy and the delivery of services’.

In addition work has been undertaken to strengthen referral and assessment processes relating to domestic violence in collaboration with the Thames Valley Policy. Thames Valley Police have allocated two risk analysts to assist in improving a ‘child centred’ approach to risk assessment of domestic abuse referrals, one of which has been co-located with the ‘front door’ duty team in children’s services during 2013/14. Front line police officers have received training that focuses upon the need to be alert to the child’s perspective and risk when attending domestic abuse incidents.

Homelessness (16-19 year olds)

Since the appointment of the current representative of the Housing Team to the Board the SLSCB has been better engaged in and informed about the development and implementation of Housing strategy, its implementation and its potential impact on safeguarding for children. This has included discussion of the implications of the Southwark Judgement and steps taken to avoid increased homelessness amongst 16-19 year olds and young adults. Slough has formulated a new Housing strategy during 2013/14 that has included arrangements better to support care leavers and other vulnerable young people and young adults. The Board has been kept well informed of these developments and has been provided with opportunities to scrutinise and challenge developments from a safeguarding perspective.

Neglect

To be added

Mental Health – both children and parents

The key focus of work under this priority was to identify ways in which we could secure safeguarding arrangements that cross-cut the children and adult services arenas. This was a key focus of the development session between the SLSCB and the SASPB in July 2013. From this session a number of priorities for action were agreed:

- to secure clarity about the relative roles of the SLSCB, SASPB, Safer Slough Partnership (SSP), Children and Young People’s Partnership Board (CYPPB) and Health PDG;
- at both strategic and operational levels agree a process through which commissioning partnership boards consult with the safeguarding boards on mental health strategies and action plans;
- partnerships collectively agree key priorities for action e.g.

        - Understanding the impact of individuals' mental health on those around them
        - Staff 'thinking family'
        - Improved co-ordination of service delivery across agencies
- To develop arrangements for quality assurance and performance management that will assure the safeguarding boards of the effectiveness and impact of strategies and action plans. To secure this the safeguarding boards will need to be clear about what they are looking to be assured of.

E-Safety

The importance of securing action in this area was reinforced by consultations with young people who, across all forums consulted, identified e-safety as their key safeguarding concern (the outcomes of consultations with young people are set out in more detail in Part 5 of this report.

Agreement was secured to the proposal that this work should be led by the Safeguarding in Education Officer role that formed part of the new Safeguarding and Quality Assurance team arrangements in Children's Social Care. However, little further progress was made during 2013/14 since the post remained vacant despite exercises to recruit.

Drug and Alcohol Abuse

The key focus of this priority was to secure clarity in the strategic interface between the SLSCB and SSAPB on the one hand, and on the other the key strategic commissioning partnerships such as the Safer Slough Partnership and CYP Partnership Board. Again, this was a matter for discussion at the joint development day held between the SLSCB and the SSAPB. At this meeting the following actions were agreed:

- to secure clarity about the relative roles of the SLSCB, SASPB, Safer Slough Partnership (SSP), Children and Young People's Partnership Board (CYPPB) and the Health PDG;
- at both strategic and operational levels to agree a process through which commissioning partnership boards consult with the safeguarding boards on drug and alcohol strategies and action plans;
- partnerships collectively to agree key priorities for action e.g.
    - Chaotic lifestyles – are there effective responses from services in terms of safeguarding e.g. alerts, preventative action;
    - Effective safeguarding through effective commissioning – the Boards need to be assured that commissioners are achieving this both individually and collectively;
    - Workforce development re 'ThInk Family' for those delivering drug and alcohol services

- Agree arrangements for quality assurance and performance management that will assure the safeguarding boards of the effectiveness and impact of strategies and action plans. To secure this the safeguarding boards will need to be clear about what they are looking to be assured of.

What has been the impact?

The impact of actions taken in relation to CSE and Trafficking are set out in the CSE and Trafficking Sub-Group Report in Part 7 of this report.

During the financial year 2013/14 there were ? Contacts received that could be attributed to domestic abuse. The table below is compiled from the monthly breakdown of contacts received.

Contacts received from TVP

Chart to be added

What developments and improvements are required in the future?

The SLSCB Business Plan for 2013-16 identifies 6 risk areas on which it wishes to secure assurance of improved service performance and outcomes for children, young people and families. These together with the key intended actions are:

CSE and Child Trafficking

- Repeat risk audit to determine levels of potential CSE prevalence in Slough.
- Formulate and implement the CSE pathway which clearly outlines multi-agency responses and interventions, setting out how risk will be continually reviewed on individual cases and set within the context of the wider service provision pathway;
- Further develop specific QA and PM framework for CSE that will incorporate quantitative and qualitative data (including multi-agency audit) and engagement/feedback from service users and front-line staff;
- Secure appropriate links and coherence between work on CSE and that on: children missing; children receiving services from the YOT; gang and youth violence; PREVENT and Channel (vulnerability to extremism and radicalisation)

Domestic Abuse

Agree with the new Domestic Abuse Strategic Group the interface between their role in leading the Domestic Violence and the SLSCB and SVAB roles in scrutinising and challenging performance on DV – and then to put in place arrangements that enable the SLSCB to be assured that:

- there is a reduction in the number of children facing safeguarding risk as a result of Domestic Abuse.

- there is improved capability to identify risk and secure multi-agency responses to the risks presented as a result of report Domestic Abuse
- responses to domestic abuse are effectively managed by partner agencies individually and in partnership

Homelessness (16-19 Year Olds)

The SLSCB to receive an assessment of the impact of new housing policies and practice in response to the Southwark Judgement on levels of homelessness amongst 16-19 Year Olds specifically in relation to safeguarding risk.

SLSCB to receive report on the new Borough Housing Strategy to assess its impact on safeguarding and to determine any changes/mitigation it may wish to see in place to protect children and young people. This to include reference to; the impact of benefit reform; out of borough housing placement policy

Negotiate, agree and secure the implementation of risk mitigation to reduce and manage safeguarding risk

Mental Health (Children and Adults)

SLSCB and SSAPB to devise plan for better integrated approach to assessing impact of mental health assessments across children and adult services

Boards to agree QA and PM framework to scrutinise and evaluate impact.

SLSCB to be assured of performance of CAMHS in contributing to effective safeguarding arrangements at both universal and specialist levels

E-Safety

Gain assurance that there is a 'Safeguarding in Education' lead.

Be assured that prevalence audit of e-bullying incidents is undertaken and that strategy and action plan to reduce levels of prevalence is agreed and in place

Appropriate interventions in place to address needs of both victims and perpetrators

Be assured that there is a e-resilience strategy and action plan in place to support reduction in impact of e-bullying

Female Genital Mutilation

Deliver annual conference focused on FGM.

Establish a task and finish group to formulate Slough FGM strategy and action plan

PREVENT

Secure more effective links between the SLSCB and PREVENT/Channel activity across the Borough

4. IMPROVING THE EFFECTIVENESS OF THE BOARD

The SLSCB has met four times during 2013/14. These meetings were held on 23rd May 2013, 19th September 2013, 12th December 2013 and 13th March 2014. In addition there was a Development Day held on 23rd January 2014 and a joint meeting of the SLSCB with the Safeguarding Adults Partnership Board on 10th July 2013.

Attendance rates at full Board meetings were as follows:

Organisation	Attendance Rate	Comments
Independent Chair	75%	One meeting missed due to illness
Director of Well-Being	100%	
Slough Borough Council, AD Children, Young People and Families	75%	
Slough Borough Council, Safeguarding lead	75%	
Slough Borough Council, AD Housing	50%	The current Housing representative has achieved 100% attendance since his appointment.
Slough Borough Council, Adult Services	100%	
CCG	50%	
Berkshire Healthcare Foundation Trust	100%	
Heatherwood and Wexham Park Hospital	25%	
Thames Valley Police	25%	
Headteachers (Primary)	75%	
Headteachers (Secondary)	75%	
FE Colleges	75%	
YOT	75%	
CVS	75%	One meeting missed due to illness
Probation	50%	There was a change in personnel during the year which created a gap in attendance.
CAFCAS	25%	A period of illness and then change in personnel contributed to this low attendance rate.
Lay Members	100%	Lay members have been present at all meetings but one lay member has not recorded

		100% attendance.
Healthwatch	50%	Healthwatch representation began in the autumn of 2013 – since that time the representative has recorded 100% attendance.
Lead Member for Children and Young People (Observer)	75%	

Priority 3: To improve the effectiveness of the SLSCB

What was planned?

The priorities set out in the Business Plan for 2013/14 were as follows:

Secure a level of Board effectiveness that enables the SLSCB to assume the role of the Safeguarding Improvement Board.

The implementation of changes to Board arrangements to reflect and secure compliance with the new Working Together framework – including revised assessment, threshold and SCR/Learning and Development frameworks.

Robust and rigorous partnership arrangements at a time of organisational and structural changes in some partner agencies.

Implement the new QA and PM framework in collaboration with CSC, individual partner agencies and the CYPPB and, as a result, enhance its ability to scrutinise and challenge safeguarding effectiveness and co-ordination of safeguarding services across the partnership.

Secure clarity and coherence in the SLSCBs relationships with other partnership bodies including: the Slough Well-Being Board, the Safer Slough Partnership, Safer Communities Partnership, DAAT, and the Safeguarding Adults Board.

Secure a 'Think Family' approach to safeguarding effectiveness through effective co-ordination and coherence with the SSAPB.

Secure assurance that children's services commissioning arrangements build in effective safeguarding arrangements

Be assured that there is compliance with safeguarding policy and procedures across the partnership whilst promoting a learning culture.

Be assured that appropriate arrangements are in place to plan and prepare for an Ofsted Inspection of Child Protection and the multi-agency inspection of safeguarding should this be introduced

What action did the Board take?

Following the publication of Working Together the SLSCB conducted an audit of its constitution, membership and working arrangements to ensure continuing compliance with statutory expectations. In terms of constitution and membership existing arrangements required little change beyond the changes that had recently taken place in terms of organisational change specifically within the health sector.

Particular emphasis was placed on ensuring effective interface with other partnerships such as the Slough Well-Being Board, the Safer Slough Partnership, the Children and Young People's Partnership Board (CYPPB) and the Slough Safeguarding Adults Partnership Board. Protocols between the SLSCB and the Slough Well-Being Board and CYPPB were already in place. Whilst the relationship with the CYPPB was no longer a requirement of Working Together 2013, locally it was agreed that the CYPPB would continue to be the lead strategic commissioning partnership body for multi-agency service delivery and so the relationship between the two partnerships was both sustained and indeed developed. Existing protocols were revised to ensure compliance with Working Together 2013.

Significant work was undertaken in collaboration with the Slough Safeguarding Adults Partnership Board to secure clarity in the inter-relationship between their work on safeguarding and the work of the Safer Slough Partnership specifically in relation to domestic violence, mental health services and drug and alcohol abuse services. The detail of this work was addressed in a joint development sessions between the two safeguarding boards in July 2013 subsequent to which the two Independent Chairs engaged in work with the Safer Slough Partnership to secure clarity of roles and relationships on these key areas of work. In essence the conclusion was to identify the Safer Slough Partnership and its domestic violence strategic group as strategic commissioners of these services with the safeguarding boards adopting a scrutiny and challenge role. Underpinning this was work to agree a shared quality assurance and performance management framework through which performance and impact could be assessed. This work was not concluded within 2013/14 and continues into the current year.

Changes were made to the performance management arrangements for the Independent Chair in light of the requirement of Working Together 2013 that the Chief Executive assume the 'line- management' role previously undertaken by the Director of Children's Services (Director of Well-Being in Slough). The quarterly one-to-one meetings between the Chief Executive and the Independent Chair began in July 2013. These were supplemented by meetings of the Chief Executive, Independent Chair, Director of Well-Being and the Councillor lead for children and young people primarily to improve working across partnership bodies.

In addition work was undertaken to develop a threshold protocol and learning and improvement framework and to scrutinise the development of the new assessment framework developed by the local authority with its partners. These pieces of work have been outlined in earlier parts of this report.

A number of member agencies experienced significant structural and organisational change during 2013/14 and the Board had set itself the goal of ensuring that these changes take place with minimal detriment to the effectiveness of the Board. There were significant changes in the health sector at the beginning of the year with the creation of the CCG and the Area Team. In addition the Probation Service was preparing for significant change that finally took place in June 2014. Our performance in securing seamless transition has been mixed. Whilst attendance by some agencies has remained high as can be seen in the table above for others we have experienced a fall in attendance levels. This has been exacerbated by a not insignificant number of personnel changes in organisations, in some cases preceded by periods of ill health, that have created gaps in membership and a reduction in the attendance rates. This matter has been raised with chief officers of those agencies where attendance levels have caused concern and, in the main, we have experienced improvements as a result.

A particular concern has arisen in relation to attendance rates at sub-groups and this was a matter highlighted by Ofsted when they reviewed the Board in November 2013. This led to a review of sub-group membership and of the chairing of these groups to secure wider agency engagement levels.

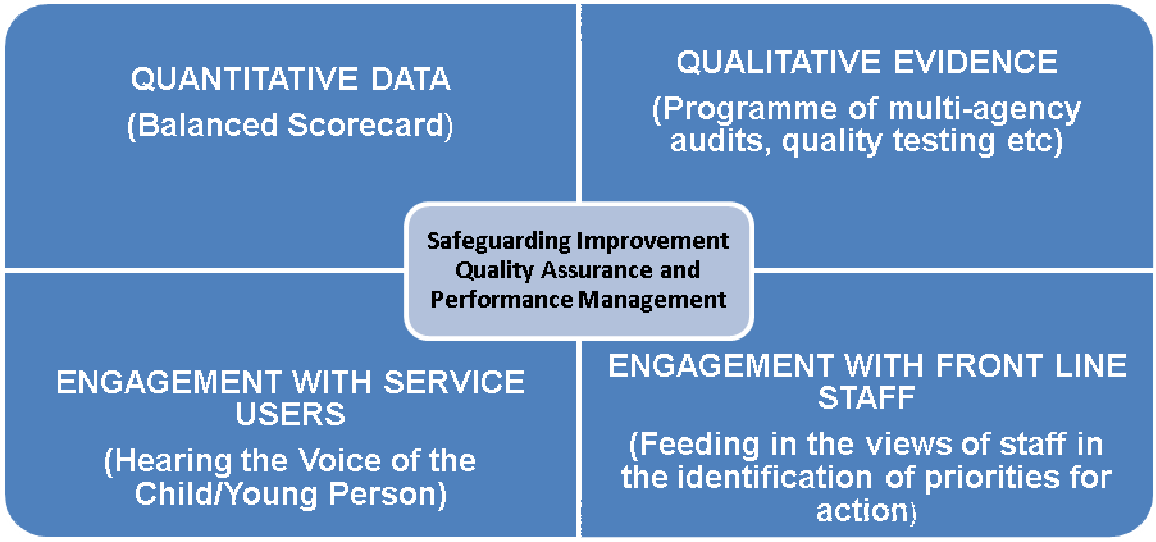
A key piece of work undertaken was the review and re-design of the SLSCBs Quality Assurance and Performance Management Framework. This was undertaken in close collaboration with the CYPPB. The new arrangements were developed in response to decisions to formulate a cross-cutting framework that will secure both robust scrutiny and monitoring of performance and coherent and co-ordinated arrangements across the three key elements of the safeguarding improvement governance structures – i.e. children's social care services (CSC), the Children and Young People's Partnership Board (CYPPB) and the Slough Local Safeguarding Children Board (SLSCB). In addition there was an intention to extend the scope of the QA and PM framework to include other parts of Slough Borough Council beyond Children's Social Care and other statutory partner agencies.

The new framework was based on a number of principles that we wished to underpin the new arrangements. These were that:

- Quality assurance and performance management data and information should be collected only once – by the agency or body identified as lead for this area of QA and PM in this framework document;
- The agency or body that collects the information will be responsible for analysis of the data;
- Analysis must enable other forums to recognise and understand the reasons for success and enable them to focus their attention on remedial action required to address performance concerns;

- Analysis of QA and PM information may then be shared with other agencies/bodies where this analysis informs their business and contributes to their ability to test outcomes and impact relevant to their strategic priorities;
- There is an expectation that Partnership Bodies will selectively draw on QA and PM information that is already collected by agencies – only in very exceptional cases will Partnership bodies create additional indicators;
- The QA and PM framework will be continually reviewed to reflect agencies changing national quality assurance and performance management arrangements (e.g. the current changes to health sector arrangements in light of the transition to CCGs and Area Teams).
- The QA and PM framework must reflect the expectations of the new multi-inspectorate regulatory arrangements due to be introduced in June 2013 to assist in speedy presentation of relevant outcome and impact evaluation and support inspection preparation and performance.

Following the Peer Review undertaken in November 2012, the CYPPB and SLSCB agreed a conceptual framework within which the safeguarding improvement QA and PM arrangements would sit. This comprised four 'quadrants' as follows:



<--------RISK MANAGEMENT--- -->

This was an approach already adopted by the SLSCB but one which we agreed should be applied across all safeguarding improvement work overseen by the Safeguarding Improvement Board.

In addition to this overall conceptual framework it was intended that the quality and performance information should span the 'child's journey' as conceived through the Munro Review of safeguarding. This comprises: early help; contact, referral and assessment; child protection and; looked after children. It also included the range of local indicators that reflect key priorities in development/business plans formulated

by the three elements of the safeguarding improvement governance structure – this included areas such as workforce development, areas of specific concern in the Slough context (e.g. domestic abuse, child sexual exploitation and child trafficking, homelessness, e-bullying)

Finally the new framework included steps to address issues arising from the Peer Review undertaken in late 2012 including:

- Increasing the pace of improvement – supported by rigorous and robust scrutiny and challenge;
- Focusing on impact and evidencing the contribution of CSC, CYPPB and SLSCB to this impact
- Evaluating the effectiveness of both individual agencies and partnership working
- Ensuring effective practice and service delivery both within children's social care and across the partnership;
- Delivering effective early help
- Ensuring the voice of children and young people is heard and that it influences the development and improvement of services;
- Streamlining the QA and PM framework employed by the SLSCB
- Developing a QA and PM framework for the CYPPB
- Using audit – including multi-agency audit - more effectively to support learning & drive improvement in practice
- Securing synergy across CSC, CYPPB and SLSCB in their respective and different roles in securing safeguarding improvement
- Planning for the new multi-inspectorate child protection inspection framework
- Improving communication and engagement with both users and with front-line staff across the partnership.

The new framework was also intended to ensure that data was collected and analysed once – but that the outcomes of analysis would selectively be reported to the CYPPB and the SLSCB to enable them to monitor and scrutinise performance that is relevant to their key strategic priorities and objectives as set out in the Children and Young People's Plan and the SLSCB Business Plan. This was intended to enable the Boards to focus on actions required to improve performance particularly where this relates to partnership working – but will also include issues relating to individual service performance.

Children's Social Care

Other Council Services

CCG Children and Young People's Partnership Board

Community Provider Health Service --------→

Acute Health Services Slough Local Safeguarding Children Board

Police

Probation

Schools

In terms of reporting to both the CYPPB and the SLSCB the intention was to adopt a programme of Quarterly Reviews so that a comprehensive and focused analysis was available at the four Board meetings held each year.

The components of the new SLSCB scorecard were negotiated with partners across the summer of 2013 with a view to ensuring that data collected was based on agencies existing data collection arrangements and was not adding to the bureaucratic burden by creating new data sets. The final version of the scorecard was agreed in the autumn of 2013 with a view to the first reporting starting in the spring of 2014.

Work undertaken to reflect the 'Think Family' concept and to secure robust and rigorous inter-faces with key strategic commissioning bodies has been outlined earlier in this report most specifically in terms of the joint development session held in July 2013 between the SLSCB and SSAPB. A detailed report of this session is attached as Appendix 5 for further reference.

Between June and November the SLSCB engaged in a process of preparation for an impending Ofsted inspection based on the framework first published by Ofsted in the summer and launched in November 2013.

What has been the impact?

In terms of securing compliance with Working Together 2013 the SLSCB has secured positive outcomes. Indeed the Ofsted review of the LSCB, undertaken in November 2013 confirmed that the Board had 'made clear improvements in the last year from a low starting point'. It went on to confirm that membership met requirements and that:

> 'The LSCB ensures policies, procedures and the threshold for access to services are fit for purpose, kept under review and regularly updated to reflect statutory responsibilities and changes'

New arrangements for the performance management of the Independent Chair and for the inter-relationships between the SLSCB and other key strategic partnership bodies have all been put in place and again, were recognised by the Ofsted inspection.

There were other elements of the SLSCBs performance that were positively assessed by Ofsted including commenting that:

- The LSCB has taken effective action to address some of the shortfalls and weaknesses of the Board's operation which were identified at the last inspection;
- The LSCB has clearly identified priorities in the current business plan and regularly reviews its progress;
- The Executive Board scrutinises these decisions and actions
- The LSCB has brought a clear focus to shaping strategy, policy and practice across the partnership;
- The LSCB has revised thresholds and engaged with children and families to improve their involvement and participation across services in regards to domestic violence, child sexual exploitation and chld trafficking;
- Learning from serious case reviews is well established and suitably incorporates lessons from both local and national issues and relevant research;
- Learning and impact on practice is evaluated through audit activity and the board effectively monitors progress;
- Partners make appropriate financial contributions to support the business of the LSCB and members of the Board are at a sufficiently senior level to influence change in partner agencies;
- The LSCB ensures that policies, procedures and the threshold for access to services are fit for purpose, kept under review and regularly updated to reflect statutory responsibilities and changes;
- The workforce across the partnership is receiving appropriate safeguarding training. A well-defined learning and development strategy supports agencies to identify and address the safeguarding training needs of their workforce on a single and inter-agency basis;
- There are good quality assurance arrangements for the delivery of multi-agency training;

Despite these positive comments the overall judgement of the Ofsted team in respect of the effectiveness of the SLSCB was 'inadequate' and this must be recognised in this section of this Annual Report. This was a disappointing outcome particularly since the Board's self-assessment had deemed the Board to be operating at a level that would be judged 'Requires Improvement'.

The key reasons for the 'inadequate' judgement related to the inspectors view that the Board could not provide evidence of impact in performance in relation to early help and child protection. Paramount in this judgement was the view that the Board had not ensured effective partner engagement in a range of functional areas most importantly early help, child protection and the range of multi-agency groups that were in place to support these developments.

The challenge in securing partner engagement can be illustrated in reviewing the impact of the new Quality Assurance and Performance Management arrangements outlined above. Despite significant time invested in negotiating and agreeing partner agency contributions to these new arrangements delivery of the SLSCB scorecard and accompanying analysis has proved challenging with only one agency, the Berkshire Healthcare Foundation Trust, regularly submitting its contribution to these new arrangements. This has left the Board heavily reliant on children's social care data in monitoring and evaluating effectiveness.

The priority and immediate actions and the areas for development identified in the Ofsted review of the SLSCB have been clearly reflected in the new Business Plan for 2014/15 and can be seen in the developments and improvement required in the future set out below.

What developments and improvements are required in the future?

Ensure that agencies take full responsibility for their roles as set out in Working Together to Safeguard Children and that they commit to multi-agency strategies and working groups, including sharing responsibility and resources where necessary (Priority and Immediate Action in Ofsted Review of LSCB).

Secure a level of Board effectiveness that enables the SLSCB to assume the role of the Safeguarding Improvement Board.

The implementation of changes to Board arrangements to reflect and secure compliance with the new Working Together framework – including revised assessment, threshold and SCR/Learning and Development frameworks.

Robust and rigorous partnership arrangements at a time of organisational and structural changes in some partner agencies.

Implement the QA and PM framework in collaboration with CSC, individual partner agencies and the CYPPB and, as a result, enhance its ability to scrutinise and challenge safeguarding effectiveness and co-ordination of safeguarding services across the partnership.

Secure clarity and coherence in the SLSCBs relationships with other partnership bodies including: the Slough Well-Being Board, the Safer Slough Partnership, Safer Communities Partnership, DAAT, and the Safeguarding Adults Board.

Secure a 'Think Family' approach to safeguarding effectiveness through effective co-ordination and coherence with the SSAPB.

Secure assurance that children's services commissioning arrangements build in effective safeguarding arrangements.

Be assured that there is compliance with safeguarding policy and procedures across the partnership whilst promoting a learning culture.

Be assured that appropriate arrangements are in place to plan and prepare for an Ofsted Inspection of Child Protection and the multi-agency inspection of safeguarding should this be introduced.

5. COMMUNICATION AND ENGAGEMENT

Priority 4:

What was planned?

The SLSCB Business Plan 2012/13 set out a number of key objectives which were to:

- improve the engagement of children and young people in the work of SLSCB;
- Improve communication and engagement with communities in Slough – raising the profile of safeguarding;
- Improve communication and engagement with front line staff and operational managers;
- Improve communication and engagement with partner agencies.

Specific actions planned were:

A strong profile for the Board across the Partnership and the communities of Slough through:

- Implementation of the new SLSCB web-site
- Regular communication of key messages, Board decisions and learning from SCRs and other reviews/audits across the partnership primarily through existing agency communication channels;
- Raising the profile of the SLSCB through local media, events and other communication channels.

Securing evidence that the voices of children, young people and families are heard in planning, delivering and evaluating safeguarding in Slough

Securing evidence that views of frontline staff from across the Partnership are heard in planning, delivering and evaluating safeguarding in Slough.

What action did the Board take?

Following recommendations in the Peer Review undertaken in 2012 the Board agreed to split the former Communication and Participation Sub-Group to form separate Communication and Participation and Engagement Sub-Groups most importantly to secure greater focus on engagement and participation – and area on which insufficient progress had been made in the previous year. Both the Communication Sub-Group and the Participation and Engagement Sub-Group serve the SLSCB and the CYPPB to enable cohesion and co-ordination of the work and secure more efficient means of working.

With regard to communications a number of actions have been undertaken:

- The creation of a new SLSCB website, building on best practice adopted by other Board, through which key information and messages could be disseminated and promoted. This was launched in October 2013.
- The creation of a new cascade model for the dissemination of key information and messages across the partnership. This was launched in the autumn of 2013 and comprised:
    - producing text that could be included on both the website and for inclusion in each agencies usual staff newsletters/bulletins . Using existing newsletters was deemed a more effective way of reaching people rather than e-bulletins from the LSCB for example.
    - adopting an additional procedure through which those organisations that had team briefing cascades would send the information through their own cascading procedures but add to our text with text specific to their own organisation.
    - Seeking feedback through team briefing systems to Board members within their own organisations who would then feed back into our Board systems.

There has, in addition, been closer working with the communications leads of all partner organisations to ensure support in both media communications on key issues, including the Ofsted review of the SLSCB and in the production of key documents to be published on the website and in hard copy.

Significant progress has been made in extending the Board's engagement with children and young people.

An Engagement and Participation Strategy was developed in collaboration with the CYPPB and launched in September 2013. This set out the intentions of both Boards to extend participation and ensure the voice of the child was heard in the planning, delivery and evaluation of service and their impact. It also created a plan of action that has subsequently been oversee by the Participation and Engagement Sub-Group.

A range of engagement activities were undertaken with:

- The Slough Youth Council
- The Children in Care Council
- Schools Councils
- Pupils in Slough schools through a pupil survey undertaken in the summer of 2013.

These pieces of work are outlined in more detail in the impact section below.

What has been the impact?

The SLSCB website was launched in October 2013 and has been well used and well regarded according to feedback through the Communications Sub-Group.

The cascading of information has secured some success but use of the cascade model has been limited and we need to ensure wider use of this methodology to secure comprehensive coverage across the partnership.

Two meetings took place with the Youth Council, first to raise awareness of the work of the SLSCB and the CYPPB and then to seek from the Youth Council their views about safeguarding priorities to be fed into the Business Planning process for 2013/14. The key priority emerging from this process was risk arising from e-bullying and this was included as a priority in the Business Plan for 2014/15.

Creative Junction, a social enterprise entity, worked with our Children in Care Council to facilitate their contribution to the Participation and Engagement Strategy and to identify their priorities for safeguarding which were also fed into the business planning process for 2014/15. Creative Junction presented a report of the work to the SLSCB Board so that they could first-hand the feedback from young people that had been given during the event.

It has subsequently been agreed that this model of facilitated engagement should become a regular part of our engagement and participation work and that consideration will be given to commissioning a programme of such provision with key strategic forums in 2014/15. This will need to be considered by the Children and Young People's Partnership Board.

Two pilot surveys of pupils were carried out in Slough by the Children's Society and Foster & Brown. The findings were reported back to the Board and to the CYPPB and were also fed in to the business planning process for 2014/15.

The surveys were regarded as helpful but there was a view that further development would be required if these were to be adopted in the long term most importantly:

- that more qualitative questions were asked to determine what influences young people to access/choose to access services and what they find most helpful when accessing services
- that the surveys are made more bespoke to Slough and focus on priorities that have been identified by both the CYPPB and the SLSCB;
- that the survey might be more inter-active and available on-line to broaden engagement;
- there must be feedback to those that have participated in the survey both to enable young people to see what came out of the survey but more importantly to ensure that they see what action is taken by services as a result.

Consideration is being given to repeating these surveys on a more bespoke basis in 2014/15.

In addition the Participation and Engagement Sub-Group carried out an audit of engagement activity undertaken in agencies who were members of the SLSCB and CYPPB. The purpose of this was to raise awareness of work that already took place

to enable safeguarding to be included in these engagement activities rather than trying to develop additional activities that required additional capacity to run them. Initially the outcomes from this audit were disappointing in terms of the limited range of activity that was taking place. However, it has subsequently emerged that there is some activity taking place and this has led to the formation of a further group of engagement practitioners reporting to the Participation and Engagement Sub-Group to share information about engagement activity taking place, to ensure the inclusion of safeguarding matters in these agendas and to secure co-ordination between the various strands of activity.

What developments and improvements are required in the future?

The priorities set out in the Business Plan for 2014/15 remain essentially the same as those for 2013/14 since further steps are required to embed and extend our communication and participation activity. There is a particular focus on securing better engagement with staff, an area with which little progress was made in 2014.

6. A workforce able to deliver our priorities for action

What was planned?

The SLSCB Business Plan 2013/14 aimed to develop a workforce that is confident, competent and skilled to secure effective safeguarding and to deliver the expectations set out in this Business Plan.

Specific actions to be undertaken included securing assurance that:

- there was inclusion of appropriate safeguarding training and development within the overall Children's Workforce Development Programme;
- all agencies deliver appropriate levels of training at levels 1 and 2;
- multi-agency training is delivered at levels 3 and 4 to those that require it specifically in relation to key priorities in this Business Plan;
- the quality and impact of training in terms of building staff skills and competencies and in terms of improved safeguarding outcomes for children and young people;
- specific focus is given to: threshold awareness and implementation; awareness of and competence in addressing CSE and child trafficking; effective joint-working between children and adult services;
- there was extension of the range of training delivery models including e-learning approaches

What action did the Board take?

Actions are set out in the Pan-Berkshire Training Sub-Group report in Chapter 5

What has been the impact?

These are set out in the Pan-Berkshire Training Sub-Group report in Chapter 5

What developments and improvements are required in the future?

These are set out in the Pan-Berkshire Training Sub-Group report in Chapter 5

Safe Recruitment

A key element in ensuring that we have a workforce fit for purpose and able to deliver our priorities for action is the effectiveness of our arrangements for safe recruitment. The SLSCB has continued to receive reports from the Local Authority Designated Officer to enable it to monitor and evaluate performance in this arena.

Some headlines from the annual report are set out in this section of the Annual Report.

The LADO role in Slough is combined with the Safeguarding in Education Manager post to create a full-time position, located within the Safeguarding and Quality Assurance Unit of the Council's Children, Young People & Families Service.

The LADO is line-managed by the Head of Service for Safeguarding & Quality Assurance and works alongside the Independent Review Manager, Independent Reviewing Officers, Child Protection Conference Chairs, Complaints Manager and Quality Assurance Manager

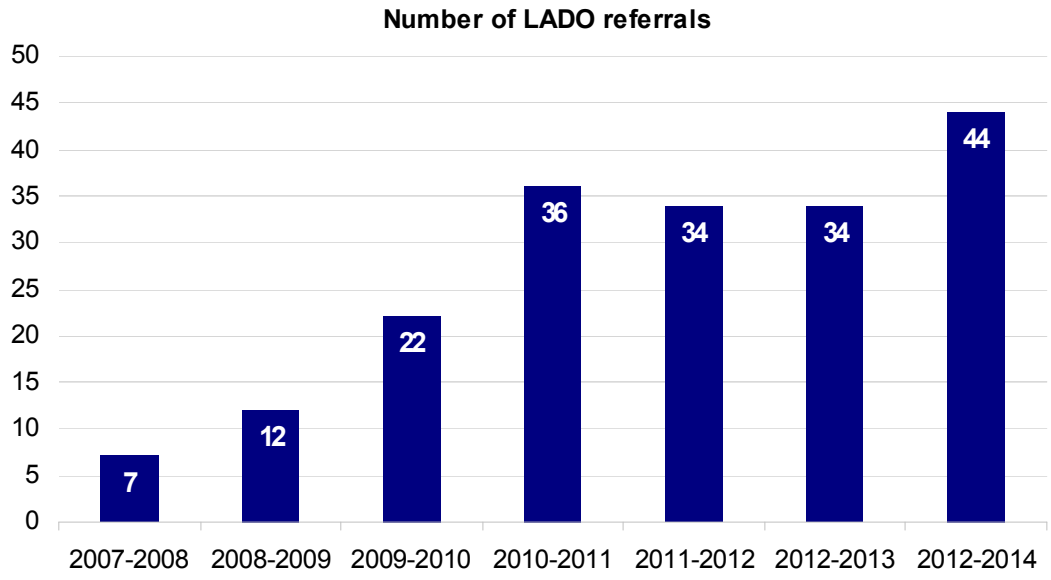
During this year the post has remained unfilled with key aspects of the allegations management function being undertaken by an interim Child Protection Conference Chair alongside responsibilities for chairing Child Protection Conferences. The Head of Safeguarding & Quality Assurance has held accountability for the full range of LADO responsibilities during this time. Several unsuccessful attempts have been made to fill the post on a permanent basis and a further attempt will be made during the financial year 2014-2015.

What is the data telling us?

Referral numbers:

During the year 2013-2014 the number of referrals to the LADO in Slough has continued to rise, a pattern that has become increasingly evident over the last 5 years as a wider range of data has been collected and collated.

A total of 44 referrals were received, spread consistently across the year when considered on a month by month basis.



Of these referrals 14 related to males and 25 related to females as subjects to the LADO enquiries. Where no gender is identified this indicates concerns that were expressed about the conduct of an organisation or agency rather than of a specific member of staff.

Work settings:

The most frequent agency setting for referrals were schools, with 18 referrals relating to staff based in schools. A further 10 referrals were associated with Early Years settings, including nurseries and childminders.

There were 7 referrals relating to foster care during the year. This marked a significant increase from the previous year when there were 2 referrals of this nature.

There were no referrals concerning Health staff or police during 2013-2014.

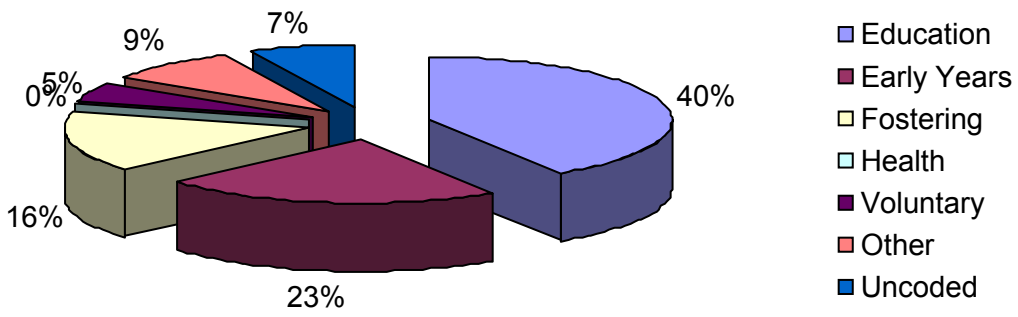
Referral source:

The majority of referrals were again received from school settings. A number of referrals were also received from Ofsted primarily following contact with them by

anonymous referrers or by parents dissatisfied by the response to concerns raised by them directly with schools or Early Years providers.

Referrals were also received this year from parents, substance misuse services, transport services for young offenders, housing providers, Armed Forces, Cafcass, Integrated Transport Unit, Sports clubs, faith groups and taxi licensing authorities. This is very encouraging and suggests that the knowledge and confidence of other agencies about the LADO role is increasing.

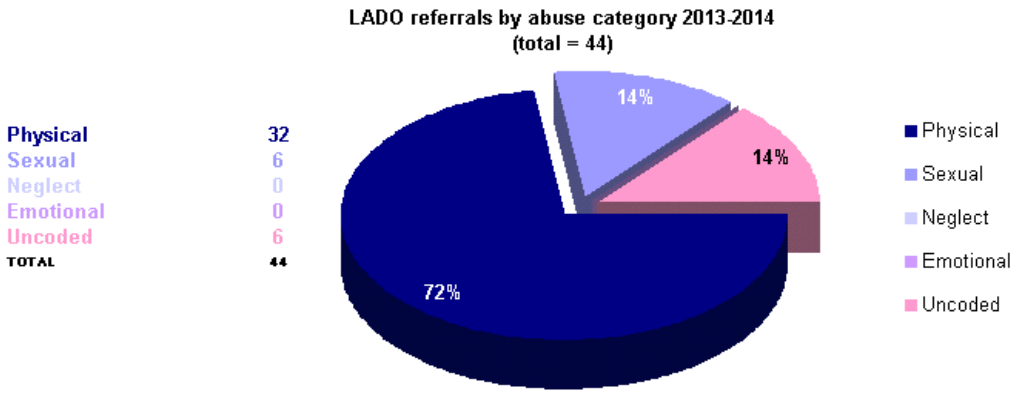
LADO Referrals by employer 2013 - 2014



Category of allegation/potential abuse:

The most frequently considered category of potential abuse identified by the referral or during the course of the investigations was Physical Abuse, in 32 of the cases reported. A significant proportion of these referrals related to the management of difficult or challenging behaviour exhibited by children or young people, with use of some form of physical restraint often involving teachers or other school based staff.

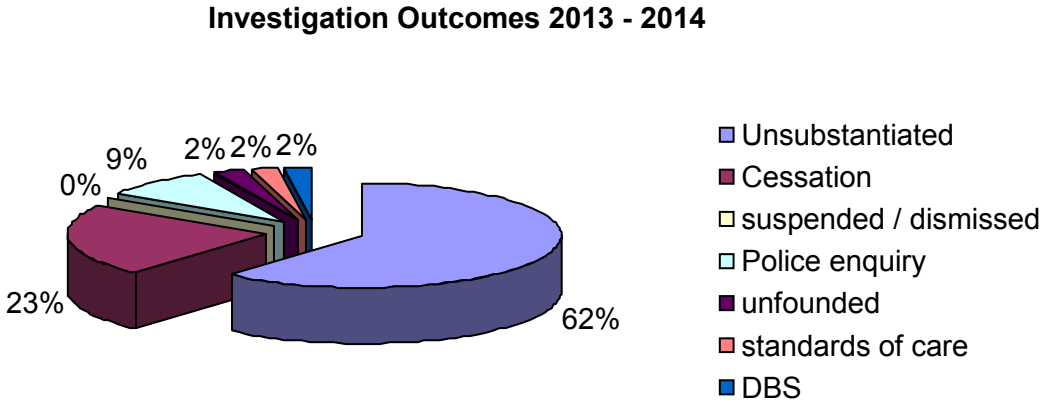
Sexual abuse was identified as the category of harm in 6 cases whilst a further 6 cases focused primarily on quality of care concerns or broader unsuitability of an individual to work in the children's workforce as a result of concerns relating to their personal or family circumstances rather than specific forms of harm. At present this aspect of concern is not easily captured by the record system.



Outcomes/Decisions

The majority of cases considered over the course of the year did not result in formal action by Police or employers once the investigations had been completed. Criminal investigations were initiated in relation to 4 cases and one referral was made to the Disclosure and Barring Service (DBS).

At the point of preparing this report the outcomes of 2 cases were unknown because investigations were still in progress. In these cases the adults of concern were subject to Police bail.



Investigation outcomes 2013 - 2014	
Unsubstantiated	27
Cessation	10
Suspended / dismissed	0

Police enquiry	4
Unfounded	1
Standards of care	1
DBS	1
TOTAL	**44**

Inter-agency working:

Communication between agencies continues to be constructive, particularly with the Police Child Abuse Investigation Unit (CAIU). Police and social care staff prioritise Allegations Management meetings with attendance at what are often short notice meetings consistently high.

Employing agencies have become more confident in their engagement with the LADO process and have ensured that they access appropriate Human Resource and other specialist advice and support.

This year's data show that the number of referrals has risen and that the cases progressing to a multi agency Allegations Management meeting are becoming more complex, requiring two or more meetings placing additional demands on all the agencies involved.

Freedom of Information:

During the course of the year 6 Freedom of Information (FOI) requests were submitted to the Council in relation to aspects of the cases referred to the LADO. The enquiries helped to identify some gaps and deficits on the type and extent of data recorded, serving to inform plans for developing the data collection and analysis in the future. In particular the absence of reliable historical data prior to the mid-point of 2012-2013 was highlighted by these enquiries, together with the availability of limited details about final outcomes of some cases.

The FOI inquiries serve to underline the increasing public interest in the investigation and outcome of allegations relating to members of the children's workforce, especially in the context of historic disclosures about well known individuals that have featured in the media. This presents a continuing challenge to ensure that responses to allegations are timely, comprehensive, robust and defensible in accordance with the legislative and statutory guidance framework.

Data quality:

It became evident during the course of the year that the newly developed database for recording LADO activity and referral outcomes was overly complex, with the consequence that not all the data was collated as intended.

The increase in demand for the LADO service coincided with a number of other responsibilities, most notably the management of complaints for the Children, Young People & Families service, being assigned to the Safeguarding & Quality Assurance Unit, placing considerable demands on the Business Support and administrative resources.

What developments and improvements are required in the future?

Action Points for 2014-2015 have been agreed as:

1. Permanent recruitment to the LADO & Safeguarding in Education Manager post
2. Structured review of the data requirements and recording systems to improve data capture and facilitate detailed analysis
3. Development of quarterly reporting to Children & Families Management Team and the LSCB of activity levels and emerging themes
4. Consolidation of arrangements with Adult Services Safeguarding lead for coordination of LADO activity with processes for addressing enquiries in relation to Persons in Positions of Trust (PIPOT)
5. Development of a structured training programme including targeted work with school settings as the primary source of referrals to the LADO service
6. Promotion of Safer Recruitment and Employment practice, including take up of recommended training packages

7. REPORTS FROM SUB-GROUPS

This chapter of the SLSCB Annual Report contains the annual reports of sub-groups and task and finish groups that have operated during 2013/14. Please note that the membership of each group is set out at appendix 1.

SERIOUS CASE REVIEW SUB-GROUP

As set out in Chapter 8 of Working Together to Safeguard Children, the serious case review sub group exists to review cases referred to the group, and if appropriate, recommend a SCR be undertaken. The group provides advice to the LSCB Chair on whether the criteria for conducting a SCR have been met and they should also recommend the scope and terms of reference for the review which are forwarded to the chair. Following a decision by the LSCB Chair to undertake a SCR, the SCR sub-committee should commission a SCR Panel to manage the process.

The SCR should:

- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result; and
- Improve intra- and inter-agency working and better safeguard and promote the welfare of children.

Summary of activity & achievement over the year April 2013 – March 2014

Assessment on the effectiveness of safeguarding arrangements

Challenges for the sub group

Future plans

To be added

CHILD DEATH OVERVIEW PANEL (CDOP)

The CDOP operates on a Pan-Berkshire basis but provides individual reports to each LSCB with the former county of Berkshire.

Every LSCB is required by law to establish a CDOP, in order that the causes of all child deaths can be analysed and recommendations made to reduce deaths in future. The Panel gathers and reviews data on the deaths of all children and young people from birth (excluding those babies who are stillborn) up to the age of 18 years who are normally resident within Berkshire. This enables themes to be extracted from a greater number of deaths and trends established regarding the circumstances leading to the deaths.

Work undertaken during 2013/14

In Berkshire as a whole, there was a 28.8% reduction in reviewed deaths from 80 in 2011/12, to 57 in 2012/13. This reduction in 2012-13 was fully investigated and coincided with a reduction in the numbers of multiple births that year, which are known to carry an increased risk related to low birth weight. It is difficult to attribute causes for the reduction however the panel took consistent action to promote;

- neonatal reviews and thematic risk factor monitoring;
- the 'one at a time' message for those undergoing IVF treatment
- a consistent set of recommendations for 'safe sleeping' – which all agencies adopted

It is pleasing to note a similarly low number of deaths has been sustained in 2013/14 and a total of 59 child deaths have been recorded and 42 reviewed.

Data for each local authority is obtained from the CDOP database.

Of the total number of deaths 21 occurred in Slough (of which 15 deaths have been reviewed in year). These comprised a case from 2010/11 held back due to a police investigation, 4 were cases from 2012-13 one of which was held back due to a serious case review and others due to late notification, leaving 10 cases that occurred in 2013-14. A further 6 cases notified at the end of the year and will be reviewed in 2014-15. This figure of 16 in year deaths is considered provisional (see below*)

12 of the deaths were infant deaths (in the first year of life) and within these 6 were neonatal (in the first 28 days of life). 2 of these occurred in the first seven days of life. Only one drowning incident had a modifiable factor. The remaining deaths

occurred at the end of the year and will be reviewed as part of the quarterly neonatal review.

None were subject to child protection plans or statutory orders. Five were white British, 2 were Asian British Indian, 4 were Asian British Pakistani, 1 was Black/Black British: African, 1 was Any other Black/Black British/African/Caribbean and 2 with unknown ethnicity.

Categories of death included; an apparent homicide, an abuse and neglect case, an infection, five had chromosomal medical conditions arising from genetic conditions, one accidental drowning, and five neonatal cases.

There are 21 actual deaths in Slough in the period 2013/2014: 7 were White British, 2 were Black African, 3 were Asian British Indian, 3 were Asian British Pakistani, 2 were Asian British Any Other background, 2 were White Any Other background, 1 was Any Other Black/African/Caribbean background and 1 unknown ethnicity.

Challenges

Child deaths in Slough although not statistically different to England have remained above the England average in the period 2008/9 - 2011/12 with a consistent number of neonatal deaths of around 8-10 per year. A review of neonatal cases is now undertaken quarterly and the advice of obstetricians is included.

Late notification has increased last years figures by a further four cases. This years figure must therefore be considered provisional e.g as a death might occur overseas or not be reported back to the panel within the financial year. Final validated figures are not produced nationally until two years after the event to allow for such delays.

In accordance with the plan a genetic conditions working group has been established to improve awareness of prenatal diagnosis and share the learning from the Bradford community learning project. This years' provisional results show a halving of cases in this category.

The approach taken in Bradford has been shared with local practices in protected learning time.

The death by drowning led to the panel recommending that a lamppost be removed and replaced with alternative lighting as it was used by young people as an aid to jumping into the river.

Appropriate health led multiagency rapid response was initiated in the cases of unexpected death, with home visits to the place of death when appropriate. As in previous years, almost all children were appropriately conveyed to hospital following deaths or collapse at home. In one case, however, death occurred outside hospital and the circumstances were such that it was inappropriate for the young person to be conveyed to hospital after death. In that case, a rapid response meeting was convened in the community, including all involved agencies, in order to coordinate the investigation into the death and support for the family.

From September 2013, a rota of rapid response health professionals has provided cover over weekends and bank holidays to enable timely health home visits within 24 hours of death when appropriate, and to initiate health led rapid response in those rare cases where a child is not conveyed to hospital. As predicted, the number of cases needing this out of hours response has been very small.

Work on genetic conditions that began in 2013-14 will continue in 2014-15 and an evaluation will inform wider county approaches..

Reducing rates of neonatal deaths remains a priority. Infections are more common in neonatal deaths where the child is born with a low birth weight and risk factors in the household such as smoking may be contributing factors.

Accidental deaths and in particular drowning accidents are preventable and the panel recommend use of the Health and Safety Executive swimming pool accident guidance available at **http://www.hse.gov.uk/pubns/books/hsg179.htm**

This adopts the 10:20 rule i.e

Scanning is the skill required by lifeguards to constantly watch a particular zone using a sweeping action. They will need to be able to scan their zone of supervision in 10 seconds and to be close enough to get to an incident within 20 seconds. This is an internationally recognised practice and is known as the 10:20 system.

This message should be cascaded by the LSCB to all parents and child minders.

What is planned for the future?

The priorities for the CDOP for 2014/15 are to:

- Promote access to prenatal advice to reduce congenital/chromosomal abnormalities
- Continue to tackle the causes of low birth weight at the antenatal stage
- Further reduce neonatal mortality through action on smoking in the home and infection control
- Continue to promote consistent guidance on optimum sleeping positions for newborns

- Share important learning and key messages more widely about child accident prevention. New guidance on local accident prevention profiles is available on the Public Health England website http://datagateway.pho.org.uk/ (select T for Topic guide and then select accident prevention). Maps on this site show where admission rates for injuries among children in Slough are higher

QUALITY AND PERFORMANCE SUB-GROUP

Role of Sub-group

The Sub-Group provides a quality assurance function, combining audit and scrutiny to ensure the effectiveness of safeguarding arrangements

The main responsibilities for the Quality and Performance sub-group are;

- To develop a Quality Assurance and Performance Management Framework for the SLSCB & present quarterly management information to the Executive and SLSCB at each of their meetings. Review performance management information quarterly and present to the Board, Identify themes and areas requiring action.
- To carry out audits agreed by the SLSCB according to a multi-agency audit programme and when it is necessary to drill below the data/statistics for further information and explanation.
- To feedback learning arising from the audit of individual cases to key staff involved in those cases.
- Audit and evaluate the safeguarding arrangements made by local agencies individually and together – Section 11 reviews

Key performance information is included elsewhere in this report

PAN-BERKSHIRE LSCBs' POLICY AND PROCEDURES SUB-GROUP

Eileen Munro's Final Report reminded us of the vital role of procedures in enabling people to work together safely, but also drew attention to the disabling role procedures can play when people are so concerned to be doing things 'by the book' that they lose sight of the principles and purpose of their work.

Eileen Munro's comments and the experience of the Policy and Procedures Sub-group tell us that the best revisions to the Berkshire child protection procedures have not been the procedures we have imported from TriX or the good practice guidance we have created links to, but the (often smaller) changes that have involved LSCB members in discussion and creative work to make the Berkshire procedures a useful and a practical tool enabling those on the front line to better protect children.

The Pan-Berkshire Policy & Practice sub-group exists to:

1. Develop policies, procedures and protocols in the areas of child protection and safeguarding.
2. Review research and central government guidance on the protection of children, along with issues arising from serious case reviews
3. Ensure (through Board representatives) that Local Safeguarding Children Boards are advised about revisions that are needed / underway to policies and procedures.
4. Act on feedback from workers on the translation of policies, procedures and protocols into practice and to revise existing guidance to ensure that practitioners are clear about what to do if they are worried a child is being abused.

Activity and Achievement: Changes to Procedures 2012-13

During the year 2013-2014 the sub-group met on four occasions, with the first three meetings hosted by Wokingham.

Arrangements for chairing, administration and hosting the sub-group changed during the year and Slough took on responsibility from the January 2014 meeting.

Attendance:

The attendance summary for the year was as follows:

		Attendance	Apologies
Local Authorities	Slough	4	0

	RBWM	2	0
	West Berks	2	1
	Reading	3	1
	Wokingham	4	0
	Bracknell	4	0
Health	H&WP NHS	2	0
	BHFT NHS	2	0
	RB NHS	4	0
	CCG	2	1
Police	TVP	3	1
Education	Schools	0	0
Adviser	TriX	2	2

Activity:

The sub-group addressed recommendations identified by Tri X and the Working Together 2013 Impact Checklist to achieve compliance with Working Together 2013.

It was agreed that hyperlinks for each authority's Threshold, Assessment and Learning & Improvement Framework documents would be inserted at the relevant points within the procedural guidance.

The sub-group began development of a new chapter relating to Child Sexual Exploitation utilising an example from Sheffield and incorporating learning from TVP involvement in Operation Bullfinch

Revised procedures, documentation and a flowchart in relation to Hospital Discharge following concealed pregnancies were approved, incorporating learning from a SCR within Berkshire.

Tri X updates:

Two regular updates to the Tri X procedures were progressed during the course of the year in July and November 2013, with details of the developments and changes identified for all users on the front page of the Berkshire SCB Procedures website.

Tri X Consultant:

A meeting in February 2014 between the new Chair of the sub-group, the Slough Business Manager and representatives from Tri X prepared the ground for a transfer of Consultant responsibility from Alan Torrance to David Walker who will take up the responsibility from Spring 2014. Alan has provided great support to the group since stepping in when his previous colleague sadly died.

Tri X contract:

The contract with Tri X for delivery of the on-line procedures was extended for 12 months. The tendering and contract management has been delivered on the sub-group's behalf by the Royal Borough of Windsor & Maidenhead to date. A proposal was made to explore joint commissioning of Children's and Adults' Safeguarding procedures as both services already use Tri X as the provider.

Contact us links:

The "Contact Us" hyperlinks were removed from the procedure website following experiences in other local authority areas where members of the public had attempted to use these to report concerns about children. The details of each local authority's Duty and Referral service are available on the procedure website so that referrals are correctly directed.

Challenges

Membership / representation

Changes in management appointments across services led to some changes in membership and variation in attendance at sub-group meetings, with an impact on progress with some actions.

It did not prove possible during the year to secure representation on the sub-group from Education. This represents a significant vulnerability in the development and take-up of the procedures

Reports for Initial Child Protection Conferences:

The group identified that discussions had commenced within authorities to consider whether Single Assessments should be used as the report for Initial Child Protection Conferences. To date authorities are at different points in this discussion.

Cross-authority variations:

The sub-group acknowledged variations between Threshold and Eligibility criteria for the six authorities, presenting challenges for partners who work across the county. This will be discussed further to establish whether greater commonality can be achieved but it was noted that there some differences are driven by demographics and local priorities, meaning that it will be difficult to achieve single criteria and documents across the county.

Child Sexual Exploitation:

Development of the procedural guidance and associated Indicator Tool has taken longer than was originally intended. TVP played a key role in consolidating guidance and developing drafts for consideration.

The development of a single CSE Indicator Tool across the six authorities has proved to be challenging, with a number of variations proposed. Slough and TVP have worked closely together to develop a suggested draft for further consideration and decision

Use of the on-line procedures:

The group identified that previously available data reporting about system uptake had not been sustained. It is very important to be able to identify which professionals are accessing the system as well as any agencies that are not consistently using the resource. Linked to this is the need to continually remind professionals that they can register for e-mail prompts when updates have been made to the procedures.

Future Plans

Priorities set for the Sub-Group for 2014/15 are as follows:

1. Monitor and review publication by each local authority of documents required for Working Together 2013 compliance

   a. Complete a comparative review of Threshold guidance to examine potential for greater commonality across local authority areas

2. Finalise and publish Child Sexual Exploitation procedures, including Indicator Tool

3. Review redesign of the procedures proposed by Tri X to better reflect the child's journey.

4. Establish consistent representation on the sub-group from colleagues in Education

5. Review and approve the sub-group Terms of Reference and refine arrangements for feedback from the sub-group to constituent LSCB Chairs

6. Finalise revision of procedural guidance in relation to Missing Children following revised ACPO guidance

7. Complete revision of procedures in relation to Child Protection Conference Complaints

8. Develop procedures in relation to Female Genital Mutilation

9. Complete review of the Tri X contract and re-tendering process for delivery of the procedures

10. Develop reporting mechanism for monitoring accessing of the procedures by practitioners across authorities and agencies to highlight good practice and any areas of vulnerability requiring training or other action

TRAINING AND DEVELOPMENT SUB-GROUP

The purpose and function of the training sub group is as set out within Working Together 2013 to support LSCBs in their duty to "monitor and evaluate the effectiveness of training, including multi-agency training. This is to ensure staff and volunteers have access to appropriate safeguarding training.

The Berkshire sub group is accountable to the six LSCBs across Berkshire.
It aims to:

- ensure that safeguarding training is monitored effectively and delivered to agreed standards;
- ensure that safeguarding training and learning provision is responsive to local and national needs;
- continually develop a consistent approach to training and learning in Berkshire;
- work flexibly to respond not only to the needs across the whole area but also to the individual needs of those Boards that it is serving.

Ensuring appropriate access to, and resourcing of, safeguarding training remains the responsibility of each agency represented on the LSCB.

The LSCB will retain strategic oversight of safeguarding training.

The Berkshire Training sub group will focus on the strategic oversight of safeguarding training and learning and development in the Berkshire area.
The Learning & Development Officers from the Local Authority areas, with support from wider Partner Agencies, will comprise an operational group that reports into the Berkshire training sub group and they will retain operational responsibility for training and learning development including producing an annual LSCB training programme. Meetings of the operational group will be held separately by arrangement with the training officers.

What has been done in 2013/14

The East and West Berkshire LSCB Training Sub Groups have been working together for the last year as agreed by the LSCB Chairs and the group have continued to meet to develop the LSCB Training Work plan and LSCB Training Strategy.

The combined Berkshire Group has raised standards of quality assurance, by sharing good practice across the two areas. The combined approach also allows for

the opportunity to consider consistency in practice, and look more closely at the impact safeguarding training has on the workforce. This includes reviewing and embedding the systems for evaluation.

The joining of the groups has also led to discussions to increase value for money in comparison of costs in providing some Berkshire wide courses.

A further strength of the group has been demonstrated in the standard agenda items of national and local reviews, including the sharing of serious case reviews, partnership learning and training events. This allows dissemination of lessons learnt for all agencies and to consider training implications. Sharing this with a wider audience and members of the group has been reported as useful. It allows all members of the training sub group to update their single agency training and for the training sub group to review the commissioned courses for the LSCB to include local learning.

DATA for 2013-14

Multi-agency training data submitted to the Sub group shows the West trained approximately 180 delegates within the 2013-2014 period.

The East trained 1,688 delegates in total within 2013-2014 period which included 1001 for basic awareness, 520 for targeted courses and 167 for specialist courses.

The variation in numbers is due to different processes used in the East and West. The East has a system of requiring each delegate to attend the targeted shared responsibility course before attending other LSCB targeted courses, however in the West you are only required to have attended a universal/level 1 course before attending any LSCB course. This means there is always a greater demand for the shared responsibility course in the East than the West.

Over 50 LSCB multi –agency courses have been provided across Berkshire in 2013-2014 covering a wide variety of learning themes, including children with disabilities, safer care for children with parents with mental health, domestic abuse, disguised compliance, e safety, Child sexual exploitation and substance misuse. All of the courses have been in accordance with and based on the six LSCB business plans and agreed priorities. The overall evaluation of courses and attendance has been positive. The representation for multi -agency has been maintained however the group have raised concerns about particularly partner agencies representation on courses.

Partner agencies have utilised the LSCB to promote and disseminate specialist training courses, learning events and forums to open up the opportunities for increased multi-agency training. Berkshire Healthcare Foundation Trust opened their invitation to their safeguarding children forum 2014 and perianal training 2014 across Berkshire and provided training on serious case review learning, concealed pregnancy, fabricated and induced illness, long term impact of sexual abuse and looked after children and attachment. Local authorities across Berkshire have provided various learning events disseminating learning from both local and national case reviews and this has widened the opportunity for multi-agency learning.

This provides clear evidence of a shift in the approach to learning and that some of the LSCB partner agencies are embracing a more flexible model of learning to improve outcomes for children. The challenge remains for some areas in opening the learning up to other areas due to the current demand within their own localities.
In 2013-2014 the training officer for each LA has continued to provide additional courses to meet demand as required. The training sub group have supported agencies to access courses by adapting there application process and providing timely responses to requests for training.

The training sub group in 2013-2014 has offered agencies an opportunity to share any courses they are providing in house to the group to have advice on standards of training and to allow content to be considered for multi-agency courses. The Acute hospital in the West has accessed this support from the group and in 2013-2014 they were able to provide an in-house multi-agency level course to their workforce.

Guidance on observation

The group has been pro-active in introducing guidance on observation of training courses, together with a quality assurance pro forma. The observation guidance is given out as part of our quality assurance process when quality assuring a LSCB training course. Courses across Berkshire are being observed and quality assured by Sub-Group members and any concerns about LSCB courses are raised firstly with the host LSCB training officer and then escalated to the strategic sub group for action. This process provides an opportunity to address any concerns in relation to training quality in a timely manner.

Agency compliance with training requirements

The Training Sub-Group has worked closely with the Pan Berks Section 11 Panel to identify any gaps in agency safeguarding training or refresher training. This includes the section 11 panel now requesting training strategies from agencies as part of their section 11 which is an area recommended in the Research in Practice (RiP) Ensuring Effective Training a briefing for LSCBs publication Research in Practice briefing Ensuring Effective Training, Briefing for LSCB's.

Review of e-learning packages

Training officers continue to promote and review the current e-learning safeguarding training packages. However with so many other providers on the market, this provides a real challenge to monitor quality assurance. This means the quality assurance remains with the organisation that purchases and uses these forms of learning. Data collection on e-learning varies considerably across agencies and therefore cannot always provide the LSCB with accuracy. The Kwango safeguarding e-learning package used across Berkshire West was updated in line with Working Together 2013 and continues to provide an accessible and value for money provision. Managers in each organisation should ensure they are following their own training strategies to ensure the e- learning meets the development needs of their staff.

Child Sexual Exploitation, an e learning package was launched in January 2014, to raise awareness, the LSCB calendar provides additional multi-agency courses on this subject, and local authorities may provide additional courses for their staff. The Berkshire LSCB Training sub group have been asked to develop a CSE Training Pathway so that it is clear for practitioners what training is available and where. The Bracknell LSCB Business Manager is leading on this piece of work.

Joint work with the Adult Safeguarding Partnership Boards

Work was undertaken to produce a pathway showing training available for both adults and children's services staff on safeguarding. The main findings were that courses across Berkshire for children and adults have a consistency in training programmes and methods, which is reassuring for all boards. The area that the boards may wish to explore with partner agencies appears to be around mandatory training on safeguarding children for adult services and vice versa, mandatory training for children's staff on adult safeguarding. Health services provide a more consistent approach to training in that all staff in their organisation receives safeguarding training for both adults and children. Increasing attendance from adult services is a priority objective for LSCB's. The joint Adult and Children's Safeguarding Annual Conference continues in Berkshire West.

Designated named professionals training

The training officers from Berkshire West and Berkshire East continue to meet to plan and produce LSCB training programmes. They have also benefited from joint meetings and found the sharing of working practice, knowledge of course content and information on training providers very useful. An example of the shared learning led to a co-ordinated review of the shared responsibility course being redesigned and renamed; the designated person training will also be reviewed.

Conferences

All LSCBs have run conferences in the last year and the attendance was excellent at all events and reached a very diverse multi-agency audience. Many of the conferences reach between 80-130 delegates which is a real achievement.

Impact of Safeguarding Training

Members of the sub-group met to undertake an evaluation on the impact of safeguarding training through follow up evaluations; this was reported on in September 2013. The resulting report is included as Appendix 2. This important area is regularly reviewed by the group to ensure that training is effective and that evaluations are reported on at the strategic group and any areas for development are dealt with at the time.

This report was very interesting and a credit to the group in addressing a key priority with limited guidance. The report is consistent with the Kirkpatrick Model and methods described in the Research in Practice (RiP) Ensuring Effective Training a briefing for LSCBs publication, combining a quantitative and qualitative approach.

This audit will need to be built upon and a recommendation from the group is that this is undertaken annually.

The training sub group historically requested the boards to consider undertaking training audits within the Quality Assurance sub groups, however the decision at the time was that this work would remain with the training sub group. In more recent times the Chairs have encouraged a closer working relationship between the sub groups. Training is an area that should be embedded throughout audits and a suggestion from the sub group would be that audit programmes and scope include a reference to training to maximise the opportunity to review and monitor front line practice and how if at all any training impacted upon the findings. This is an area that requires more development. In April 2014 the Training Sub Group Chair met with the Berkshire West QA sub group Chairs to discuss how to improve links between the sub groups. It was agreed that using the audits and including a standard question about training and SCR learning was potentially another way to capture outcomes. The chair acknowledges that this had not yet not been extended to Berkshire East and thus is an area to take forward or be considered in order to achieve a Pan Berkshire standard.

A summary of the achievements to date;

- Observation guidance developed to monitor the quality assurance of training.
- Work undertaken with the Section 11 Panel to identify gaps in agency training or refresher training. Section 11 panels agreed an amendment to the S11 self-assessment tool to request that Agencies provide evidence of their training strategies and comments on training compliance in relation to issue of diversity.
- E-learning packages continue to be reviewed but use of these lies with the relevant organisation
- The Kwango e-learning safeguarding training has been updated in line with Working Together 2013
- Safeguarding Training pathway has been produced, for adults and children's services staff
- Joint meetings held with Berkshire East and Berkshire West Training Officers to produce the Berkshire East and Berkshire West LSCB Training Programmes
- Managing Allegations, identified as a need amongst practitioners and training courses arranged in the East and the West
- Evaluation of training for LSCB courses and outcome audit completed.
- Review of LSCB training sub group work plan
- Launch of CSE e learning training was agreed by 5 of the 6 Berkshire LSCB's. This has been disseminated and used widely. The remaining LSCB has made suitable alternative arrangements.

The introduction of the learning and improvement framework agreed across Berkshire, and in the Child Protection procedures, has improved dissemination of learning from reviews, this is now a standing item on each strategic training group agenda – where key messages from reviews in each of the LSCBs can be shared.

Challenges

Amalgamating the training sub group as a Berkshire wide group has proved to be a challenge. The expectation that six Local Authorities with six different systems can successfully have a co-ordinated approach has not always been achievable.

Other challenges include:

- CSE Training Pathway – There has been a challenge in ensuring all relevant agencies are attending the meetings arranged in order to progress this.
- Concerns in relation to Partnership participation in the Training sub group has been raised annually and there is still a significant gap in some LSCB partners contribution to the group. Work has been done to try and improve this but to no avail. The Training Group remains in a position that they have no representation from Police, Housing or Probation. Historically and currently, information is received from Probation and TVP and the group have linked with the section 11 panel to obtain more information. We understand and acknowledge the resource pressures for services; however, absence of physical representation at the group from these sectors has been a long standing issue. The RiP Ensuring Effective Training a briefing for LSCBs publication identifies the need for LSCBs to evidence within inspection that "*opportunities for learning are effective and properly engage all partners*". This is currently not being achieved by the absence of significant LSCB partner agencies.
- There remains an issue with TVP accessing multi-agency LSCB courses across Berkshire. This has been escalated to the Berkshire LSCB Chairs. Police attendance at multi-agency courses also varies nationally. It is worth noting that the police do provide in house training including specialist areas that they may benefit from considering opening access to other agencies to improve multi-agency practice
- Receiving data in a co-ordinated way from the operational team to strategic group in a timely manner has proved to be a difficulty for the group at times.
- Monitoring of single agency training is a requirement of the LSCB's and additional resources will need to be identified to ensure this function is carried out sufficiently by the Training Sub Group
- Many of the tasks required of the Training Sub Group are Resource intensive, including the Training Needs Analysis and outcome evaluations. Adequate resources need to be identified.
- Some agencies are providing their own specialist single agency safeguarding training e.g. Local Authorities for their social work teams, probation and the police, these courses at present are not currently being offered to a multi- agency audience. This could be an opportunity for more coordination of these courses if the agencies bring them to the attention of the training sub group. This may be a missed opportunity for all practitioners to learn in a multi- agency context. The sub group acknowledges that organisations are complex systems and it has come to the sub group attention that different teams within one organisations may be commissioning or identifying a need for safeguarding children for a specific groups of staff and providing training internally to meet that need. Whilst this is good practice, it highlights that this need is not shared or reaching the LSCB sub group via the membership to maximising the opportunity for potential joint commissioning of courses.

- Keeping Safe – new DfE guidance for schools, doesn't mention the three year refresher period, as the sub group have agreed this as a standard, members will have to work with schools to ensure this stand is met.

Priorities for 2014/15

The training sub group will be hosted by Wokingham LSCB and the chair will handover on 19th May 2014 where all 2013-2014 data and records will be electronically transfer to the new Chair.

The training needs analysis (TNA) is planned for 2014-2015 however the group are reassured that the framework they used in the last TNA is in accordance with research but will require more of a focus on the analysis of enhanced skills and staff development programmes within partner organisations. The emphasis is about process rather than an event.

CSE AND TRAFFICKING SUB- GROUP

Role of sub group

The Child Sexual Exploitation (CSE) & Trafficking sub-group brings key partners together to make sure an effective response is delivered to children and young people at risk of, or being abused, through CSE and child trafficking. This includes preventative and awareness raising initiatives.

Membership

Over the course of the year, membership has included TVP, YOT, Young People's Service, BHFT, Children's Social Care, Probation Service, SBC Training, LSCB Business Manager, Garden Clinic and Haybrook College.

What did the sub group plan to do and achieve over the last year?

The CSE sub group prioritised their work in to 4 key areas and developed small splinter groups to progress the necessary work in that area:

- Training
- Community Awareness
- Education
- Audit / Risk Assessment

In addition to this the CSE sub group had a small task and finish group that were instrumental in the planning of the LSCB CSE conference held in April 2013.

The CSE coordinator came in to post in November 2013 and became the Chair of the Sub-Group. Within the work that she has been doing from November – March she has involved the CSE sub group members, this has included: Developing a CSE indicator tool and the formulation of a CSE Pathway.

What did the sub group do and achieve over the last year

In securing the CSE Coordinator Post, capacity was increased to develop key pieces of work. The Co-ordinator and the Sub-Group has driven forward key elements of the CSE and Trafficking Action Plan as follows:

To update the CSE action plan

The Co-ordinator and Sub-Group has rigorously and robustly monitored and evaluated progress on the action plan and reporting back to the SLSCB and Executive on a regular basis.

To develop a CSE indicator tool as part of the Risk Assessment priority

CSE Indicator Tool was developed:

- As a tool to aid referrals and information sharing in relation to young people who may be at risk of CSE or who are being exploited.
- Slough shared this tool with the other five Berkshire Authorities who have agreed to adopt the tool, and it will soon be live within the CSE chapter of the Berkshire Child protection Procedures.
- In addition the NWG have requested that they share the tool within their resource page to all of their members as a good example.

To develop a multi-agency CSE Training Programme

A multi-agency training programme at three levels: basic awareness; intermediate and specialist has been designed and commissioned on an East Berkshire basis. An agreement has been made across Berkshire in relation to consistency with regards to outcomes and aims of CSE training to aid transfer of courses across Pan Berkshire colleagues.

In relation to the Basic training this is being provided by the NWG e-learning tool and CSE sub group members helped to test and quality assure this.

In addition the below has also been achieved.

- Chelsea's Choice delivered to approximately 500 multi-agency professionals
- Purchased the National Working Group LSCB Membership and added over 300 practitioners onto the account which has allowed for the basic CSE training to be implemented using the NWG e-learning tool.
- Multi-agency Targeted and Specialist Training commissioned for summer / autumn 2014.
- LSCB CSE & trafficking webpage developed as an information source and sign posting mechanism.
- Developing a specialist CSE seminar for Berkshire wide Chief Executives, Lead Members and Directors of Children's Social Care for June 2014. (this was more the CSE co-ordinator than the sub group)
- A multi agency session held in March 14 with the Secondary designated CP leads in relation to CSE.
- A multi agency session delivered to the Slough Voluntary Sector Leads in relation to CSE In January 14.

To increase CSE awareness within Education settings in Slough and to increase the sub groups understanding of what in relation to CSE is being delivered within schools.

- Multi-agency workshop delivered to secondary school child protection leads.(as mentioned above)
- In September 2013 Chelsea's Choice productions were held. 1 member of staff attended the production from Haybrook College. Eton & Slough & Herschel School bought in sessions as part of the LSCB Initiative. Subsequently, 2 more schools have bought in the production: Westgate School and Baylis Court School. Upton Court Grammar purchased production after the CSE Conference and are re-commissioning it from 2014

To continue to develop Community Awareness in relation to CSE

- Adopted NWG 'say Something if you See Something' Campaign and coordinated delivery of an LSCB letter signed by the Independent Chair, a Barnardos leaflet and the Children's Commissioners indictors flyer which has been distributed to 250 premises in Slough.
- Article about CSE was published in the SBC Paper 'Citizen' which is a Slough resident magazine.
- Multi-agency workshop delivered to Voluntary Sector Providers (as mentioned above)
- CSE was a feature within the Private Hire and Taxi Drivers newsletter

What has been the impact of the work of the sub group over the last year?

Training

- e-learning, targeted and specialist CSE training is now going to be available to practitioners. Practitioners are able to attend local training and learn about CSE amongst local partners.
- Chelsea's choice was well received by those that watched the performance and a result has been re-commissioned in some schools for young people.
- NWG Membership enables many practitioners access to information, guidance, training opportunities, resources and updates on CSE via the NWG newsletter and resource bank.
- As a result of Chelsea's Choice, **X** referrals were made to the CSE Engage Project.

Community awareness:

- Awareness has increased in relation to CSE, this includes within the licensed premises trade, within the voluntary sector partners and through the messages to Taxi drivers.
- Approx 3 phone calls to 101 were made by Hotel staff regarding possible concerns of CSE after receiving information regarding CSE
- Profile of CSE has been raised via initiatives and invites to attend meetings / sessions to discuss CSE has increased.
- Examples of Hoteliers contacting the police about CSE demonstrates an increase in understanding.
- Workshop with a voluntary sector provider generated a referral to Engage.

Education:

- As a direct result of the Education Workshop referrals concerning CSE risk were made.
- Gradual increase Sub-group in engagement with secondary school based individuals and child protection leads.

What have been the challenges for the sub group over the last year?

- Lack of attendance and engagement from Children's Social Care in key pieces of work.
- The CSE Sub-group only accessing finance via the LSCB
- Engagement with partners in coordinating a second multi-agency CSE audit and the accessibility of a method to undertake this in a timely, recursive manner.
- Strategic oversight of CSE across slough from a Senior Management perspective which would then feed into the work plan of the CSE Sub-group, the scope of the Sub-group and CSE panel and a more problem focused led year.
- For all members making an active contribution to the sub group priorities and actions.

Examples of good practice

Secondary school child protection workshop

In March 2014 multi-agency partners facilitated a workshop for child protection leads.

Referrals to Engage made in March, April and May 2014 were **XXX**

As a result it was agreed that a proposal would be made to SASH to request that child protection leads are enable to gather together once a term to discuss improving safeguarding initiatives with schools. This will include the development of CSE been included within each schools safeguarding training.

Voluntary sector awareness workshop

In January 2014 multi-agency partners facilitated a workshop for voluntary sector providers, in conjunction with Slough CVS.

As a result of the workshop, the CSE Coordinator & Engage are scheduled to facilitate a further awareness rising session to 40 young volunteers. 2 young people were identified as at risk of CSE and have been referred to Engage for preventative support.

CSE Coordinator Inputs

CSE Coordinator led CSE Pathway Improvements

In February 2014 a multi-agency meeting was held to explore the developments and clarification of the child sexual exploitation pathway which fits within existing pathways and assessments.

Key areas of development were identified as the focus for development and improvement:

- A CSE Pathway diagram
- Embedding the CSE Indicator Tool
- Consider specialist assessments as part of the child protection process
- Develop a CSE specific information sharing protocol
- Develop awareness of boys and young men and service offer
- Develop support available to affected parents

In March 2014, a specialist member of the National Working Group for Tackling CSE was invited to present a CSE information sharing model.

Raising awareness of boys and young men has been agreed as a priority need. The CSE Coordinator and YOT CSE Sub-group member met in December 2013 to discuss the key role that YOT could play in raising awareness with professionals and directly with young people. It is anticipated that YOT will lead on raising awareness of boys and young men at risk of CSE and champion this strand of work.

The intention of the Pathway meeting is to create a streamlined, comprehensive offer of support to identified families and to practitioners. This is anticipated to have the impact of each family receiving the right levels of support and will be presented with a range of support choices to meet their specific needs.

Report Input

CSE is now featured within the Joint Strategic Needs Assessment and Crime and Disorder Strategic Assessment 2014/15

Multi-agency CSE Panel

The CSE Coordinator and Thames Valley Police lead the way to develop a Slough Multi-agency CSE Panel.

As a result of this work, CSE profiles of young people are now reviewed monthly by the multi-agency CSE panel and actions are implemented to increase the safeguarding against CSE. The CSE multi-agency panel discussion has enabled clearer understanding or roles and responsibilities. Implementing the panel enables the LSCB to have an overview of the volume of children and young people discussed.

The first panel met in March 2014 as was chaired by Children's Social Care and discussed 22 individual children and young people.

What remains to be achieved?

- Completing all actions on the CSE Action Plan including the implementation of the CSEPathway
- Consistent Children's Social Care input into the CSE Sub-group
- Raising awareness of the CSE Indicator Tool within services and teams
- Including Targeted Family Support and Housing within the Sub-group.
- For the sub group to plan the implementation of raising awareness of the risks of CSE for boys and young men
- For the sub group to consider and plan progressing mapping trafficking and needs analysis
- For the sub group to consider and plan how best to evaluate of commissioned CSE training thinking about follow on evaluations
- For the sub group to consider how to audit the prevalence of CSE with a systematic and recursive way
- Requesting individual agency business plans to find out whether or not CSE is featured as a priority
- All agencies sharing relevant CSE audit findings and learning with the sub group.

LOOKING FORWARD

I trust that this Annual Report provides a comprehensive account of the work, performance and impact of the SLSCB in 2013/14.

Clearly it has been a year of mixed experience. Progress has been made in many of the areas that we identified as priorities a year ago. Ofsted, in their review of the SLSCB in November 2013 did recognise that we had 'made clear improvements in the last year' and recognised a number of strengths in our work – which have been covered in the course of this report.

It remains the case however, the overall the Board was judged to be 'inadequate'. As identified earlier in the report the critical factors behind this disappointing judgement were our inability to evidence clear and positive impact on the delivery or early help and child protection services in terms of the quality of these services and their impact on safeguarding outcomes for children and young people. In addition there were concerns about the extent to which we have ensured partner engagement in the delivery of early help and child protection services and in the wider partnership arrangements that exist in Slough.

Ofsted did not challenge our key priorities for action. Indeed they recognised that our priorities were appropriate and clearly identified. For this reason our priorities for 2014-17 remain unchanged from the previous year and are as follows:

STRATEGIC OBJECTIVE 1:

To be assured of the effectiveness and co-ordination of safeguarding practice in Slough through

1A Effective early help that reduces the proportion of children requiring formal child protection interventions

1B Quality support to children that require formal child protection or local authority care

1C Responding to the new Working Together Framework 2013

STRATEGIC OBJECTIVE 2

To target areas of particular safeguarding risk in Slough which have been identified as:

- CSE and Child Trafficking
- Domestic Violence
- FGM
- Homelessness

- Mental Health – both children and parents/interface with implementation of Mental Capacity Act in Adult Services
- E-Safety – and building resilience to e-risk
- Drug and Alcohol Abuse
- PREVENT/Channel

STRATEGIC OBJECTIVE 3

To improve the effectiveness of the Slough Local Safeguarding Children Board

STRATEGIC OBJECTIVE 4

To improve communication and engagement between the SLSCB and children and young people, wider communities, front-line practitioners and partner agencies

STRATEGIC OBJECTIVE 5

To develop our workforce to enable it to deliver the improvements and outcomes sought.

The key priority must now be to secure greater evidence of impact through the stronger engagement of all partners in implementing the Business Plan and securing intended outcomes.

Safeguarding is everyone's business. We hope that colleagues across the SLSCB partnership of agencies will support our overall objective to improve safeguarding outcomes for children and young people in Slough. I also hope that this Plan presents a clear direction of travel and a focused set of priorities and supporting actions that will enable everyone to understand their particular role in delivering the ambitious programme of improvement that aims to keep children and young people and Slough safe.

Paul Burnett

Independent Chair, Slough Local Safeguarding Children Board

Appendix 1

SLOUGH LOCALSAFEGUARDING CHILDREN BOARD

(SLSCB)

BUSINESS PLAN 2014-17

FOREWORD FROM INDEPENDENT CHAIR

I am pleased to present the SLSCB Business Plan for 2014-17.

The Plan sets out an ambitious programme of improvement to secure improved outcomes for the children and young people of Slough specifically in relation to their safeguarding and well-being.

The Plan forms part of a family of plans aimed at improving the quality and effectiveness of services and improving outcomes for children, young people and their families. Other key plans include the Slough Well-Being Strategy, the Slough Children and Young People's Plan and the Slough Safeguarding Adult Partnership Plan.

Clearly the SLSCB focuses on the safeguarding and well-being of children. A key objective of this particular plan is to secure evidence of greater impact of Boards work on the quality and effectiveness of safeguarding in Slough and on safeguarding outcomes for children, young people and families. In addition it focuses on the key recommendations and improvements identified in the Ofsted Review of the LSCB carried out in November/December 2013.

The Business Plan has been formulated with the engagement of all agencies in the SLSCB partnership and will be the subject of formal consultation not only with those agencies individually but collectively through other key strategic partnerships that have a role in safeguarding and the well-being of children and young people – including the Children's Partnership, the Safer Slough Partnership and the Health and Well-Being Board. It is critical that the Plan has universal buy-in and commitment from all partner agencies if it is to achieve its goals. The engagement of partners at formulation stage aims to ensure priorities are relevant to all and support individual agency objectives as well as shared areas of priority. Most importantly the aim has been to secure ownership from all agencies, whether statutory or voluntary

The Plan identifies the key strategic objectives that will underpin our work over the next three years and sets out the actions, primarily those to be undertaken over the next twelve months that we will take to address a range of national and local drivers for improvement. These include:

- National policy drives to strengthen safeguarding arrangements and the roles of LSCBs including the implementation of Working Together 2013;
- Recommendations from regulatory inspections, particularly the Ofsted Review of the LSCB and their inspection of the local authority, both of which were carried out in November/December 2013
- The outcomes of Serious Case Reviews – emerging from both national and local reports;
- Evaluations of the impact of previous Business Plans and analysis of need in Slough;
- Key areas of safeguarding specific to Slough – as evidenced by quality assurance and performance management data;
- Priorities for action emerging from Quality Assurance and Performance Management arrangements operated by the SLSCB;
- Responses to the views of stakeholders including the outcomes of engagement activities with children and young people;
- Best practice reports issued by Ofsted and ADCS.

Our priorities for 2014-17 remain unchanged from the previous year and are as follows:

STRATEGIC OBJECTIVE 1:

To be assured of the effectiveness and co-ordination of safeguarding practice in Slough through

1A Effective early help that reduces the proportion of children requiring formal child protection interventions

1B Quality support to children that require formal child protection or local authority care

1C Responding to the new Working Together Framework 2013

STRATEGIC OBJECTIVE 2

To target areas of particular safeguarding risk in Slough which have been identified as:

- CSE and Child Trafficking
- Domestic Violence
- Homelessness (16-19 year olds)

- Neglect
- Mental Health – both children and parents
- E-Safety
- Drug and Alcohol Abuse

STRATEGIC OBJECTIVE 3

To improve the effectiveness of the Slough Local Safeguarding Children Board

STRATEGIC OBJECTIVE 4

To improve communication and engagement between the SLSCB and children and young people, wider communities, front-line practitioners and partner agencies

STRATEGIC OBJECTIVE 5

To develop our workforce to enable it to deliver the improvements and outcomes sought.

Safeguarding is everyone's business. We hope that colleagues across the SLSCB partnership of agencies will support our overall objective to improve safeguarding outcomes for children and young people in Slough. I also hope that this Plan presents a clear direction of travel and a focused set of priorities and supporting actions that will enable everyone to understand their particular role in delivering the ambitious programme of improvement that aims to keep children and young people and Slough safe.

Paul Burnett

Independent Chair, Slough Local Safeguarding Children Board.

SLOUGH LOCAL SAFEGUARDING CHILDREN BOARD (SLSCB) BUSINESS PLAN 2013/16

STRATEGIC OBJECTIVE 1:

To be assured of the effectiveness and co-ordination of safeguarding practice in Slough

1A Effective early help that reduces the proportion of children requiring formal child protection interventions

Action No.	What do we want to achieve?	How are we going to do it?	Who will lead on this?	How will we know what we have achieved?	When are we going to do this?	Progress

1A.1	Assurance that there is effective and co-ordinated early help in place that secures: • equality of access to support services and an increase in the number of CAFs/TACs; • early intervention in response to need; • avoids children's social care involvement. Specifically we want to be assured by the CYPPB/Early Help Board that: • thresholds for access to early help and referral processes are	Through quarterly reports from the CYPPB that will include: • Quantitative data reporting on the agreed Early Help scorecard; • Qualitative performance reporting based on multi-agency auditing of early help co-ordination and effectiveness including audits specific to the provision of early help to Children in Need • The views of children, young people and families about the quality, effectiveness and impact of early help; • The views of	The CYPPB theme lead for Early Help (currently Viv Murray) will report quarterly on progress and on the impact of Early Help arrangements in line with the agreed Early Help scorecard used by the CYPPB	The SLSCB is assured that those children and young people at risk of harm (but who have not yet reached the 'significant harm' threshold and for whom a preventative service would reduce the likelihood of that risk or harm escalating) are identified by local authorities, youth offending teams, probation trusts, police, adult social care, schools, primary, mental, community and acute health services, children's centres and all Local Safeguarding Children Board partners, including	Timescales for this element of the Business Plan are set out in the Early Help Action Plan project currently being led by Viv Murray.	

	understood and effectively implemented by all; • all partners are engaged in the delivery of early help, co-operating in the delivery of the early help interventions and actively supporting integrated service provision at the point of delivery. • early help provision incorporates appropriate safeguarding arrangements • quality assurance and performance management arrangements are in place to test the effectiveness of cross-agency working and impact on outcomes for	staff in relation to their understanding of early help arrangements, their capacity and ability to operate within the early help arrangements, the effectiveness of co-ordination between agencies and the impact of the early help arrangements on both service users and on achievement of individual agency and shared service objectives and priorities.		the voluntary sector where services are provided or commissioned. That the impact of Early Help is securing positive outcomes for children and young people. Evidence that Early Help reduces the number of children that reach the 'significant harm' threshold (though initially there may be an increase in referrals). Confidence in the effectiveness of		

	children and young people, including impact on referrals into formal child protection arrangements and the effectiveness of CAF in securing improved outcomes for children, young people and families; • Assures coherence between Early Help and the 'Troubled Families' programme. During 2014/15 the SLSCB will look to be assured specifically on the impact of early help on 'Children in Need' so that we are			Early Help results in more children being appropriately 'stepped down' from child protection to Early Help interventions.		

	confident that those most at risk of child protection referral benefit from early help and avoid referral into formal child protection arrangements					

STRATEGIC OBJECTIVE 1:

To be assured of the effectiveness and co-ordination of safeguarding practice in Slough

1B Quality support to children that require formal child protection or local authority care

Action No.	What do we want to achieve?	How are we going to do it?	Who will lead on this?	How will we know what we have achieved?	When are we going to do this?	Review of Achievements
1B.1	To be assured that arrangements for	For Children's Social Care through delivery of	For CSC, the Assistant	For CSC, this will be as set out in the	Scrutiny and challenge	

	child protection and looked after children in Children's Social Care, in other individual services across the partnership and in multi-agency working are effective. To be assured that the improvement priorities for CSC in the safeguarding improvement plan are secured and specifically that: • Children and young people are safe and feel safe and feel safe as a result of improved social care practice; • Outcomes for children are	the five service improvement projects: 1. Identification, Contact and Referral 2. The child's journey in the children's social care system; 3. Confident and competent workforce 4. Quality and Performance 5. Partner Engagement and Working Together Reporting will be: • through quarterly reports from the Assistant Director, Children, Young People and	Director for Children, Young People and Families For Partner agencies the lead will be the SLSCB Board member for that agency – or a nominated performance lead. For multi-agency reporting the Quality Assurance and Performance Sub-Group will be the lead forum through which the	safeguarding improvement plan i.e. • continued and sustained improvement in performance measures in the Improvement Board data set; • consistent delivery of adequate and better case work as shown by audits; • positive service user feedback • Improved feedback from staff and partner agencies	against all actions in this part of the Business Plan will occur quarterly and in line with timescales set out in the Safeguarding Improvement Plan	

	improved through management oversight and good planning; • The children's socal care workforce are able to carry out high quality work with children, young people and families, leading to improved outcomes; • Recruitment, induction, training and management of social work staff results in a workforce capable of carrying out the required standards of work and retention of skilled staff.	Families on performance against priorities set in the Safeguarding Improvement Plan including: the CSC performance scorecard; outcomes of audit exercises; views of children and young people; views of staff For Partner Agencies: • through quarterly reporting against their own agreed safeguarding QA and PM arrangements again spanning quantitative and qualitative data, service user	Executive and Board will receive QA and PM information to enable it to scrutinise and challenge performance.	For partner agencies this will be determined through the agreed SLSCB and CYPPB scorecards.		

	Specifically to be assured that there is: • efficient and effective safeguarding practice when children are in the child protection and care services both in terms of adherence to working together requirements, timeliness of action and quality of provision • quality assure partner contributions to services/support to children who have a child protection plan or are in	views and staff views For multi-agency working: • through regular reports from the IRO service and the LADO to support our scrutiny and evaluation of multi-agency performance. To monitor agency attendance at key statutory meetings including Initial Child Protection Conferences, Strategy Groups, Core Groups and CP Reviews, to challenge agencies where attendance and/or quality of contributions				

	the care of the local authority. • effective partner contributions in securing improved outcomes	cause concern and secure consistently high levels of attendance and quality.				
1B 2	To be assured that contact, referral and initial assessment arrangements through the 'One Front Door' are understood and are effective. To be assured that the engagement of Police personnel on the 'Front Door' improve both the quality of referrals and secure effective triage of cases.	QA and PM Framework – specifically audits of practice Scrutinise and challenge proposals for the development of a MASH and, if implemented, to be assured of its				

		effectiveness and impact				

STRATEGIC OBJECTIVE 1

To be assured of the effectiveness and co-ordination of safeguarding practice in Slough

Cross cutting 1A and 1B – Responding to the new Working Together Framework 2013

Action No.	What do we want to achieve?	How are we going to do it?	Who will lead on this?	How will we know what we have achieved?	When are we going to do this?	Review of Achievements
1AB.1	To secure the implementation of: • The Threshold Protocol; • The Learning and	Formulate plans of action to implement these frameworks	Independent Chair of SLSCB, AD, Children, Young People and Families, Head of QA and	Threshold document implemented with QA and PM arrangements in place to enable the SLSCB to scrutinise	All elements to be completed by December 2014	

	Improvement Framework	Review the QA and PM framework to test the impact of these frameworks particularly in relation to: • Understanding and application of thresholds for early help; • Criteria for when a case should be referred to the local authority's CSC for assessment under Section 17, 47, 31 and 20. • Secure assurance that appropriate information sharing arrangements are in place across the partnership	Safeguarding	and challenge implementation. Assurance provided that appropriate information sharing arrangements are in place and appropriate framework for monitoring their effectiveness is in place. Learning and Improvement Framework implemented with QA and PM arrangements in place to enable SLSCB to scrutinise and challenge implementation, effectiveness and impact.		

1AB 2	Be assured that the Single Assessment Framework is implemented	Receive from CSC and partner agencies reports on the effectiveness and impact of the single assessment framework on safeguarding outcomes	Head of Safeguarding and Quality Assurance	Arrangements in place to scrutinise and challenge implementation of the Assessment Framework.		

STRATEGIC OBJECTIVE 2

To target areas of particular safeguarding risk in Slough which have been identified as:

- **CSE and Child Trafficking**
- **Domestic Violence**
- **FGM**
- **Homelessness**
- **Mental Health – both children and parents/interface with implementation of Mental Capacity Act in Adult Services**
- **E-Safety – and building resilience to e-risk**
- **Drug and Alcohol Abuse**
- **PREVENT/Channel**
- **Young People engaged in gangs and violent crime**

Action No.	What do we want to achieve?	How are we going to do it?	Who will lead on this?	How will we know what we have achieved?	When are we going to do this?	Review of Achievements
2.1	**CSE and Child Trafficking**	• Repeat risk audit to determine levels of potential CSE prevalence in Slough. • Formulate and implement the CSE pathway which clearly outlines multi-agency responses and interventions, setting out how risk will be continually reviewed on individual cases and set within the context of the wider service provision pathway; • Further develop specific QA and PM framework for CSE that will incorporate quantitative and qualitative data	CSE Task and Finish Group/CSE Co-ordinator when appointed	Risk audit completed, analysed and used to inform provision pathway implementation. CSE strategy and action plan launched and subsequent workforce development programme in place. CSE provision pathway developed, agreed across the partnership and		

		(including multi-agency audit) and engagement/feedback from service users and front-line staff; • Secure appropriate links and coherence between work on CSE and that on: children missing; children receiving services from the YOT; gang and youth violence; PREVENT and Channel (vulnerability to extremism and radicalisation)		implemented. SLSCB assured of positive impact and outcomes of CSE strategy and action.		
2.2	**Domestic Violence**	Agree with the new Domestic Abuse Strategic Group the interface between their role in leading the Domestic Violence and the SLSCB and SVAB roles in scrutinising and challenging performance on DV – and then to put in place arrangements that enable	Independent Chairs of Safeguarding Boards and Chair of Domestic Abuse Strategy Group to agree interface and	Clear protocol defining interface between SLSCB and DA Strategic Group including QA and PM framework		

		the SLSCB to be assured that: • there is a reduction in the number of children facing safeguarding risk as a result of Domestic Abuse. • there is improved capability to identify risk and secure multi-agency responses to the risks presented as a result of report Domestic Abuse • responses to domestic abuse are effectively managed by partner agencies individually and in partnership	relationship Quality Assurance and Performance Sub-Group to lead on scrutinising and analysing performance supplied by the Safer Slough Partnership	Reduction in the number of children at risk as a result of DV Improved capability to identify and respond to risk Evidence of effective impact of DV services through quantitative and qualitative performance information, service users feedback and staff feedback.		
2.3	**Homelessness (16-**	SLSCB to receive an assessment of the	AD, Housing	SLSCB will have received the		

	19 Year Olds)	impact of new housing policies and practice in response to the Southwark Judgement on levels of homelessness amongst 16-19 Year Olds specifically in relation to safeguarding risk. SLSCB to receive report on the new Borough Housing Strategy to assess its impact on safeguarding and to determine any changes/mitigation it may wish to see in place to protect children and young people. This to include reference to; the impact of benefit reform; out of borough housing placement policy	Quality Assurance and Performance Sub-Group	assessment of impact, identification of key safeguarding risks and assurances of actions to mitigate these risks. Agreement to a QA and PM framework through which the SLSCB can continue to scrutinise performance and challenge any future safeguarding risk.		

		Negotiate, agree and secure the implementation of risk mitigation to reduce and manage safeguarding risk				
2.5	**Mental Health of both children and adults**	SLSCB and SVAB to devise plan for better integrated approach to assessing impact of mental health assessments across children and adult services Boards to agree QA and PM framework to scrutinise and evaluate impact. SLSCB to be assured of	Independent Chairs of SLSCB and SVAB Quality Assurance and Performance Sub-Groups	Evidence of improved co-ordination between children and adult services Evidence of improved outcomes for service users as specified in QA and PM framework.		

		performance of CAMHS in contributing to effective safeguarding arrangements at both universal and specialist levels				
2.6	**E-Safety**	Gain assurance that there is a 'Safeguarding in Education' lead. Be assured that prevalence audit of e-bullying incidents is undertaken and that strategy and action plan to reduce levels of prevalence is agreed and in place Appropriate interventions in place to address needs of both victims and perpetrators	CYPPB/Safeguarding Lead for Schools	Level of prevalence known Strategy and action plan in place Evidence of impact being presented by CYPPB		

		Be assured that there is a e-resilience strategy and action plan in place to support reduction in impact of e-bullying				
2.7	**FGM**	Deliver annual conference focused on FGM. Establish a task and finish group to formulate Slough FGM strategy and action plan				
2.8	**PREVENT/Channel**	Secure more effective links between the SLSCB and PREVENT/Channel activity across the				

		Borough				

STRATEGIC OBJECTIVE 3

To improve the effectiveness of the Slough Local Safeguarding Children Board

Action No.	What do we want to achieve?	How are we going to do it?	Who will lead on this?	How will we know what we have achieved?	When are we going to do this?	Review of Achievements
3.1	Ensure that agencies take full responsibility for their roles as set out in Working Together to Safeguard Children and that they commit to multi-agency strategies and working groups, including sharing responsibility and resources where necessary (Priority and Immediate Action	Board needs to develop a framework within which to test these issues based on WT2013.				

	in Ofsted Review of LSCB)					
3.2	A level of Board effectiveness that enables the SLSCB to assume the role of the Safeguarding Improvement Board.	Secure a focus on our scrutiny and challenge role. Ensure that responsibility for commissioning and delivery of safeguarding functions is clearly understood and that appropriate reporting arrangements are in place to assure the SLSCB of improving performance	Independent Chair of SLSCB in collaboration with other key partnership leads.	Performance reaches levels that enable Ofsted to judge provision to be at least adequate. The Safeguarding Improvement Board is no longer required and the SLSCB assumes this role.		
3.3	Implementation of changes to Board arrangements to reflect and secure compliance with the new Working Together framework – including revised	Implement the Assessment, Threshold and Information Sharing arrangements referred to in 1AB2 above. Review the constitution,	Policy and Procedures Sub-Group	SLSCB will be Working Together compliant.		

	assessment and SCR/Learning and Development frameworks.	terms of reference and modus operandi of the Board against the expectations of Working Together and implement any changes required to secure compliance Review SCR arrangements in light of Learning and Development section of Working Together, identify changes required and implement these.	Independent Chair of SLSCB SCR Sub-Group of SLSCB	SLSCB will achieve at least adequate judgement in any inspection of child protection undertaken during 2014. Board is deemed to be Working Together compliant by Ofsted As above New Learning and Development arrangements are in place		
3.3	Robust and rigorous partnership arrangements at a	Be proactive in ensuring that major organisational and	Independent Chair of SLSCB	Section 11 process	Ongoing	

	time of organisational and structural changes in some partner agencies.	structural change includes consideration of safeguarding and be assured that individual organisations are managing related risk/need for coherence and co-ordination. Key areas for focus are: • Changes to provision of Probation Services • Relationships with Academies and Free Schools (this to include consideration of the impact of school place planning on safeguarding of children) • FE provision • Relationship with GPs including Named GPs	Individual Board Members	Individual agency and multi-agency QA and PM reporting Further refine the Schools Safeguarding Audit process Develop a GP safeguarding assurance tool		

3.3	Implement the QA and PM framework in collaboration with CSC, individual partner agencies and the CYPPB and, as a result, enhance its ability to scrutinise and challenge safeguarding effectiveness and co-ordination of safeguarding services across the partnership.	Implement the QA and PM framework that cross-cuts individual agency reporting, CYPPB business and SLSCB scrutiny and challenge Be better sighted on audits of day-to-day practice from both individual agencies and multi-agency working Review the SLSCB multi-agency audit arrangements to ensure that they: • involve front-line practitioners from across all partner agencies; • impact on practice and improvements	Quality Assurance and Performance Sub-Group	New framework in place and operational	July 2013	

		in service quality and safeguarding outcomes • evaluate the quality of interventions in order to draw the key lessons for improving management decision-making and oversight of cases; • individual agencies own the findings of audits and use this information effectively to promote improvement Include in the QA and PM framework an evaluation of the effectiveness of arrangements for children who are missing from home and education and include in the Annual Report.				

3.4	Secure clarity and coherence in the SLSCBs relationships with other partnership bodies including: the Slough Well-Being Board, the Safer Slough Partnership, Safer Communities Partnership, DAAT, and the Safeguarding Adults Board.	Further improve coherence and co-ordination between SLSCB and CYPPB Implement new protocol between SLSCB/SVAB and Slough Well-Being Board Formulate and implement protocol between SLSCB/SVAB and other partnerships including Safer Slough Partnership and other relevant PDGs Secure clear arrangements for holding to account	Independent Chair and chairs of relevant partnerships	Clarity in respective roles of CYPPB as commissioning body and SLSCB as scrutiny and challenge body is secured. Dynamic relationship between SLSCB and Slough Well-Being Board in place Relationships between SLSCB and other partnership bodies clear and understood.		

		those partnership entities responsible for key risk areas: domestic violence; drug and alcohol services; youth crime and gangs		Improved outcomes for children and young people particularly in areas of risk identified in this Business Plan. Survey of partnerships to test impact of new protocols and agreements		
3.5	Secure a 'Think Family' approach to safeguarding effectiveness through effective co-ordination and coherence with the SVAB.	Hold joint planning meeting with SVAB to agree joint priorities. Formulate plan of action to secure delivery on co-ordinated activity	Independent Chairs of SLSCB and SVAB	Joint Action Plan in place QA and PM framework to monitor and evaluate performance Evidence of		

				improved safeguarding outcomes as set out in QA and PM framework		
3.6	Secure assurance that children's services commissioning arrangements build in effective safeguarding arrangements.	Audit range of agencies/partnership that commission children's services. Secure from these agencies/partnerships assurance and evidence of their effectiveness in securing safeguarding through commissioning	Chair of CYPPB Independent Chair of SLSCB Leads from other commissioning bodies	Evidence of effective safeguarding through commissioning .		
3.7	Be assured that there is compliance with safeguarding policy and procedures across the partnership whilst promoting a learning culture.	Undertake Section 11 process to test compliance Monitor agency action plans arising from previous Section 11 to	Pan-Berkshire Section 11 Group Quality Assurance and Performance	Improved compliance against Section 11 audit		

		be assured that levels of compliance are increased. Implement new Learning and Development frameworks set out in Working Together 2013	Sub-Group SCR Sub-Group			
3.8	Be assured that appropriate arrangements are in place to plan and prepare for an Ofsted Inspection of Child Protection and the multi-agency inspection of safeguarding should this be introduced.	Secure engagement of all partners in inspection preparation and planning. Formulate and agree cross-partnership plan for inspection Contribute to updating of self-assessment through scrutiny and challenge of safeguarding	Slough Executive Partnership Group	Contributions to Ofsted inspection in place in a timely manner and to appropriate level of quality. Inspection outcome that matches self-assessment at time of inspection		

		performance.				

STRATEGIC OBJECTIVE 4

To improve communication and engagement between the SLSCB and children and young people, wider communities, front-line practitioners and partner agencies

Action No.	What do we want to achieve?	How are we going to do it?	Who will lead on this?	How will we know what we have achieved?	When are we going to do this?	Review of Achievements
4.1	COMMUNICATION A strong profile for the Board across the Partnership and the communities of Slough	• Further develop the SLSCB web-site • Ensure regular communication of key messages, Board decisions and learning from SCRs and other reviews/audits across the partnership primarily through existing agency communication	Communication Sub-Group of the SLSCB	Web-site in place together with evidence of increased usage. Evidence of Increased positive media coverage Evidence of more	July 2013	

		channels; • Raising the profile of the SLSCB through local media, events and other communication channels.		effective engagement with partners and communities of Slough through measuring feedback from relevant forums/surveys		
4.2	PARTICIPATION AND ENGAGEMENT Evidence that the voices of children, young people and families are heard in planning, delivering and evaluating safeguarding in Slough Evidence that views of frontline staff from across the Partnership are heard in planning,	• Assuring the Board that the views of children and young people are gauged at strategic, community of interest and service delivery levels – primarily using existing forums and processes but, where necessary, securing additional activity to reach those not currently engaged; • Ensuring that the CYPPB as the key integrated children's commissioning body delivers an effective Participation Strategy as part of its	Participation Sub-Group of the SLSCB	Assurance provided that engagement activities at all 3 levels are in place and functioning. Consider ways in which the views and opinions of CYP can be more effectively presented at Board meetings Participation Strategy scrutinised		

	delivering and evaluating safeguarding in Slough.	commissioning process; • Better utilising Healthwatch, the voluntary and community, Council Members and other community facing organisations/individuals to support this priority; • Assuring the Board that the views of front-line staff feature in the development of policy, procedures, service developments – including reviewing SLSCB sub-group and task and finish group membership to include front-line managers and staff		and monitored by SLSCB Arrangements in place to draw on these sources of engagement Staff survey evidence presented to SLSCB as part of its business planning process.		

STRATEGIC OBJECTIVE 5

To develop our workforce to enable it to deliver the improvements and outcomes sought.

Action No.	What do we want to achieve?	How are we going to do it?	Who will lead on this?	How will we know what we have achieved?	When are we going to do this?	Review of Achievements
5.1	A workforce that is confident, competent and skilled to secure effective safeguarding and to deliver the expectations set out in this Business Plan.	• Be assured of the inclusion of appropriate safeguarding training and development within the overall Children's Workforce Development Programme; • Be assured that all agencies deliver appropriate levels of training at levels 1 and 2; • Be assured that multi-agency training is delivered at levels 3 and 4 to those that require it specifically in relation to key	Pan-Berkshire Training Sub-Group	SLSCB scrutiny of children's workforce development plan assures Board that safeguarding training appropriately covered. Evidence presented by agencies in both Section 11 and annual training audit Evidence presented		

		priorities in this Business Plan; • Be assured of the quality and impact of training in terms of building staff skills and competencies and in terms of improved safeguarding outcomes for children and young people; • In 2014/15 to ensure specific focus is given to: • Cultural change across the partnership that secures collective ownership of safeguarding • threshold awareness and implementation; • awareness of and competence in addressing CSE and child trafficking; effective joint-working between children and adult services; • To extend the range of training delivery		by agencies in both Section 11 and annual training audit Evidence presented in annual training audit Specific outcome indicators and		

		models including e-learning approaches • To be assured that appropriate training and development across children and adult services is taking place to generate 'Think Family' approaches to safeguarding practice and their impact on service quality and safeguarding outcomes is monitored and evaluated		processes for evaluation will need to be agreed for these specific strands of activity as they are implemented. Evidence presented by annual training evaluation		
5.2	To be assured that the capacity of the workforce is appropriate to deliver safeguarding expectations – particularly in terms of the expectation of SLSCB policies and procedures and in relation to the expectations of this	Through the QA and PM framework monitor indicators such as caseloads, engagement in early help, attendance and quality of contributions at statutory meetings.	All partner agencies to be responsible for reporting caseload information, Early Help Board to be responsible for reporting on early help engagement,			

	Business Plan		IRO service to report on attendance and quality of contributions			
		Gauge partner capacity required to deliver Business Plan and negotiate appropriate commitment e.g. multi-agency audit programme	Independent Chair and SLSCB Business Manager			

Appendix 2

SLSCB SCORECARD 2013/14

Full version of SLSCB Scorecard to be inserted here.

Appendix 3

CHILDREN'S SOCIAL CARE SCORECARD 2013/14

We need to insert pages 1-3 of the Redbook PDF that I included in my email here.

Appendix 4

PRIVATE FOSTERING ACTION PLAN 2014 to 2015

Objective	Actions	By whom	Timescale
1. To reduce unknown private fostering arrangements in Slough	• Raise awareness within the community and in all services working with children and families to ensure that private fostering arrangements are identified and appropriate referrals made to children's social care. In particular, to identify 'key contact' points and for those working with children and families to undertake the relevant on line training • Publish the Private Fostering Annual Report on the LSCB and CYPP websites and seek agreement from partners to ensure the Annual Report is discussed at relevant management meetings within organisations	• All LSCB Partners to agree Awareness Plan • To take to relevant manager meetings and set targets for training • SBC	• September 2014 – agree the Plan • Discuss at management meetings by end December 2014 and report compliance and agreed training targets to LSCB in January 2015. • By October 2014 and annually.

2. Target 'key' contact points:	• To identify language colleges within a 10 mile radius of Slough and initiate contact with these colleges in respect of any arrangements in place for students that might constitute private fostering within Slough. • To consider with other LSCBs the benefits of undertaking this on a Berkshire wide basis	• SBC (Private Fostering senior manager) • LSCB Chair and Business Manager	• By December 2014 • Report to LSCB in January 2015. • Report to LSCB in January 2015
3. A scorecard that will help measure progress	• Develop and agree a Slough scorecard for Private Fostering, taking account of the recommendations in the Ofsted report referenced above	• Performance and Quality Sub-Group	• Make recommendations to LSCB by January 2015.

Appendix 5

SLOUGH LOCAL SAFEGUARDING CHILDREN BOARD (SLSCB) AND ADULT SAFEGUARDING PARTNERSHIP BOARD (SASPB)

JOINT BUSINESS DEVELOPMENT EVENT – 10 July 2013

1. Introduction

1.1 The SLSCB and SASPB held their joint Business Development Day on 10 July 2013.

1.2 The key purposes of the event were to consider:

- Areas of common interest for children and adults that are relevant to all partners
- How we can improve safeguarding outcomes and services through greater collaboration across children and adult services
- How we might collectively develop and share infrastructure and business support

1.3 The agenda for the event is attached as Appendix 1.

1.4 The purpose of this paper is to report the outcomes of the day and to highlight areas of joint working that we propose to take forward as a result.

2. Common Areas of Service Focus

2.1 Discussion Group 1 focussed on the identification of areas of service in which the Boards had a joint interest and the steps that needed to be taken to develop co-ordination in these areas. The following areas and actions emerged from the discussions.

2.2 **Domestic Violence**

- secure clarity about the relative roles of the SLSCB, SASPB, Safer Slough Partnership (SSP) and Children and Young People's Partnership Board (CYPPB);
- At both strategic and operational levels agree a process through which commissioning partnership boards consult with the safeguarding boards on domestic violence strategies and action plans;
- Partnerships collectively agree key priorities for action e.g.
    - Effectiveness of DV co-ordination
    - Staff 'thinking family'
    - Better quality reporting of DV incidents

- Agree arrangements for quality assurance and performance management that will assure the safeguarding boards of the effectiveness and impact of strategies and action plans. To secure this the safeguarding boards will need to be clear about what they are looking to be assured of.

2.3 **Drugs and Alcohol**

- secure clarity about the relative roles of the SLSCB, SASPB, Safer Slough Partnership (SSP), Children and Young People's Partnership Board (CYPPB) and the Health PDG;
- At both strategic and operational levels agree a process through which commissioning partnership boards consult with the safeguarding boards on drug and alcohol strategies and action plans;
- Partnerships collectively agree key priorities for action e.g.
    - Chaotic lifestyles – are there effective responses from services in terms of safeguarding e.g. alerts, preventative action;
    - Effective safeguarding through effective commissioning – the Boards need to be assured that commissioners are achieving this both individually and collectively;
    - Workforce development re 'ThInk Family' for those delivering drug and alcohol services
- Agree arrangements for quality assurance and performance management that will assure the safeguarding boards of the effectiveness and impact of strategies and action plans. To secure this the safeguarding boards will need to be clear about what they are looking to be assured of.

2.4 **Mental Health**

- secure clarity about the relative roles of the SLSCB, SASPB, Safer Slough Partnership (SSP), Children and Young People's Partnership Board (CYPPB) and Health PDG;
- At both strategic and operational levels agree a process through which commissioning partnership boards consult with the safeguarding boards on mental health strategies and action plans;
- Partnerships collectively agree key priorities for action e.g.
    - Understanding the impact of individuals' mental health on those around them
    - Staff 'thinking family'
    - Improved co-ordination of service delivery across agencies
- Agree arrangements for quality assurance and performance management that will assure the safeguarding boards of the effectiveness and impact of strategies and action plans. To secure this

the safeguarding boards will need to be clear about what they are looking to be assured of.

2.5 Transitions

Transitions between children and adult services (particularly in relation to people with learning disabilities) was identified as an area that the two Boards should focus on. Indeed, work has already begun in this area but we need to consider how the two Boards engage in this – and what the role of other key partnerships, particularly the CYPPB and the Health PDG, should be in securing improvements in this area.

It was proposed that this work should also focus on issues related to young people with low self-esteem specifically where they might be members of 2nd/3rd generation families known to social services. This might be linked the Troubled Families programme.

2.6 Generic issues arising from Discussion Group 1

A number of generic issues were raised during discussion group 1 on which it was suggested the Boards should act. These included:

- The need for a mapping exercise, commissioned at CEO / Wellbeing Board level, to be undertaken to clarify, provide leadership and direction an address probable areas of duplication and/or omission. There is a particular need, as clear from the 2.2, 2.3 and 2.4 above to clarify the relative roles and responsibilities of key partnership bodies;

- The need for clarity about lines of responsibility and accountability for specific initiatives such as Troubled Families and the identification of who (both at individual and board levels) is taking responsibility for what, how are they communicating this, monitoring achievement and progress;

- The difficulty in securing consistent and appropriate representation from all agencies (including specific parts of the Borough Council). The resource pressures faced by all agencies clearly affects this, but it will often mean that discussions are incomplete with a lack of coherent consideration of a situation which may lead to either a lack of effective intervention or the need to repeat the process. In both situations the effect is a probable increased demand for more expensive resources in the future or ineffectual process;

- The lack of consistent attendance is compounded by attendees claiming, rightly or wrongly, that they do not have the authority to commit their agency/resources. This is perceived as a cultural problem with people not taking responsibility or seeking to shift responsibility upwards. To secure effective partnership working representatives must have the authority to take decisions and commit their organisation to both action and investment;

- The need to secure greater coherence and co-ordination in the use of thresholds for access to service. There are challenges in this arena within both children and adult services but the issue becomes even more complex in a combined children/adult service model. Partner agencies and individual services with the Council work to different thresholds and this inhibits the extent to which they engage together when there are common concerns such as the wellbeing/education attainment/level of risk experienced by a child in a family where there is, say, a mental health or alcohol problem.

- The need for a collective workforce development strategy that develops a 'culture of responsibility and ownership and supports a 'Think Family' model of service intervention. There is a view common in the group that there is a widespread culture of staff not taking responsibility. This may be something that can be tackled through training or by Slough developing greater devolution to encourage professionally sound judgements and a less constrained risk averse tick-box approach. This would require a concerted programme and approach.

2.7 In conclusion, the key strategic issues arising from this session included:

- The need for strategic co-ordination across partnership boards that clarifies respective roles, responsibilities and accountabilities;
- Clear identification of lead responsibility and accountability for key strands of partnership and individual service activity;
- Securing consistent commitment to partnership meetings from people that have the authority to make commitments and secure action from their organisation;
- Developing collective agreement to coherent, co-ordinated thresholds for access to service that enable a 'Think Family model of delivery to be achieved;
- A collective workforce development strategy that secures a 'culture of responsibility and ownership' and supports a 'Think Family' approach to service delivery

3. **Joint Infrastructure and business support issues**

3.1 Discussion Group 2 focussed on the identification of areas in which the Boards could secure efficiencies and greater effectiveness through working together. The areas emerging from these discussions are set out below. In identifying these areas the groups specified 'quick wins' and areas for later development.

3.2 Develop an **integrated back office** and support function, including the development of common agendas and standardised processes as applicable.

3.3 **Combine sub-groups** where there is common business and potential for collective action for example in relation to **Communications and Participation and Engagement**. It was proposed that we should convene a meeting of communication leads to consider this.

3.4 Consider the formulation of a **combined 'Learning and Improvement' framework** and the alignment of the Serious Case Review sub-groups.

3.5 Develop a common **Safeguarding "micro-site"** for Slough covering both children and adult safeguarding. This could be followed up within the framework of the Communications work referred to above.

3.6 Set up a joint sub-group on e-safety, probably time limited and giving an opportunity to involve young people in its approach and content.

3.7 In the longer term it was proposed that the following could be considered:

- The creation of a combined quality assurance and performance management framework including a combined 'Think Family' QA and PM framework;
- The creation of a combined workforce development strategy

4. Conclusion

4.1 This paper sets out the outcomes of the Group Work undertaken at the Joint Business Development Day. The content should now be considered by the SLSCB and the SASPB to agree:

- Common areas of service focus and the actions to be taken to progress these is agreed;
- Joint infrastructure and business support functions and the action to be taken to progress these if agreed.

4.2

Appendix 1

SLOUGH LOCAL SAFEGUARDING CHILDREN BOARD AND ADULT SAFEGUARDING BOARDS

JOINT BUSINESS DEVELOPMENT EVENT

Wednesday 10th July 2013

The Centre, Farnham Road, Slough, SL1 4UT

1.0 – 5.00 pm

AGENDA

1.00 pm	Arrival and Networking Lunch
1.30 pm	Welcome and Purpose of the event
1.45 pm	Introduction to the Boards – Paul Burnett and Nick Georgiou
2.15 pm	Wider Partnership Geography – Jane Wood
2.30 pm	Discussion Group 1 – To identify common areas of service focus and how we wish to progress these shared priorities
3.15 pm	Coffee
3.30 pm	Discussion Group 2 – To identify joint infrastructure and business support issues and consider how to progress these.
4.30 pm	The way forward

This event is intended to bring together members of the children and adult safeguarding boards in Slough to consider:

- Areas of common interest for children and adults that are relevant to all partners
- How we can improve safeguarding outcomes and services through greater collaboration across children and adult services

- How we might collectively develop and share infrastructure and business support

Outline for discussion groups

Discussion Group 1 – To identify common areas of service focus and how we wish to progress these shared priorities

The purpose of this session is to identify areas of service in which the two Boards have a joint interest and to identify how we might secure co-ordination of activity across the two Boards.

In this Discussion Group we want participants to:

1. Identify service areas that have been prioritised in our Business Plans on which joint working could improve our capacity to safeguard children and adults.
2. Outline what steps could be taken to secure greater co-ordination of activity in this area.
3. Identify any other groups with which we may need to consult to take this work forward.

Discussion Group 2 – To identify joint infrastructure and business support issues and consider how to progress these.

The purpose of this session is to consider whether there would be value in the two Boards sharing infrastructure and business support. For example would there be value in working together on areas such as communication and publicity, participation and engagement, training, risk management, business support.

In the Discussion Group we want participants to:

1. Identify areas on which they believe the Boards could secure efficiencies and greater effectiveness through working together.
2. Outline the steps that could be taken to achieve this joint working.
3. Identify the advantages of working collaboratively on these issues and any risks that would need to be managed.