



## **Slough Local Safeguarding Children's Board**

**Annual Report 2014 - 2015**

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**Phil Picton – Independent Chair, Slough LSCB**

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## 1. Foreword – Independent Chair’s Summary of Safeguarding Progress

Partnership working in Slough is a more complex business than in many other areas. A very diverse population is ‘safeguarded’ by agencies, such as the Council, which are relatively small and potentially lacking in resilience, particularly in management and support functions. Larger partners have to balance the demands of different authorities with trying to avoid the duplication created by similar meetings in different geographical areas.

Within this context, last year (2014-15) was a challenging year for the Safeguarding Children Board in Slough. In March 2014, Ofsted published the results of its 2013 inspection which judged both Children’s Services in Slough and the Board as ‘inadequate’. This was the second successive inadequate judgement for Children’s Services and not surprisingly, the Secretary of State for Education decided to take proactive action over the situation. Following further investigations, the Minister announced in Autumn 2014 that the provision of Children’s Services would be removed from the Council and placed with an independent organisation. Following this decision, extensive negotiations have taken place to establish this new organisation which will be launched in Autumn 2015 as ‘Slough Children’s Services Trust Ltd’.

During Summer 2014, the Board’s Independent Chair, Paul Burnett, its Business Manager and administrator left for a variety of reasons. An interim staff was appointed to manage the Board’s work and I was appointed in November 2014. Whilst the Board and its Executive Group continued to meet regularly through this period, the loss of the management team and Chair led to a significant loss of knowledge, understanding and continuity in its work. Normally such a hiatus in a Safeguarding Board is balanced by leadership from the most prominent and influential member of the Board – the Council’s Director of Children’s services. Unfortunately, the Director was taken ill in the Autumn and was herself replaced with an interim Director early in 2015. With such significant changes in personnel and structures, the leadership on improvement which can follow an inadequate judgement from Ofsted was disrupted.

The lack of effective quality assurance by the Board had been criticised by Ofsted. Efforts to improve the multi-agency aspects were floundering and in September 2014 the Board accepted a recommendation to dissolve the Quality Assurance sub-group, transferring its responsibilities to the Executive Group. However, this did not resolve the Board’s long-standing weakness in failing to ensure that analysed performance data is received and effective multi-agency auditing of partner casework takes place. Some progress has now been made to develop these processes and multi-agency audits recommenced in the last quarter of 2014-15.

The Board’s longer term viability was challenged by the decision of Thames Valley Police to reduce its financial contribution by 80% from 2015-16. Fortunately the local Slough police commander used his devolved budget to temporarily reinstate this funding. Surprisingly the other partners did not challenge the police decision. Without a funded, robust administrative process, the Board will be unable to ensure improvements in safeguarding. Partner contributions to the Board need resolving for the long term in the interests of all agencies.

The latter months of 2014-15 were spent reviewing plans and structures. Sub-groups on communication and participation which duplicated the responsibilities of the Slough Children and Young Persons Partnership Board were dissolved. The Board clarified its involvement with Child Sexual Exploitation (CSE), reinforcing its role as evaluating progress and coordinating strategic direction, rather than being involved in the management of operational cases. The 2014 -17 LSCB Business Plan, which was written in response to the Ofsted inspection, was very long and ambitious. With transition in Children’s Services and the disruption to the Board’s administration, many of the ambitions proved unachievable. Following review, a shorter and more focused business plan was developed for 2015-16 in anticipation that the new Children’s Trust, together

with stability in Board administration and membership would enable a clearer focus and significant progress for both Children's Services and the Board from Autumn 2015.

During the year, the Board only carried out one multi-agency audit (into 'Section 47 cases'). Although this did not highlight serious concerns about service delivery in safeguarding, there was significant learning for the Board about the development needs of effective multi-agency auditing processes. In November 2014, a team of LGA peer reviewers examined practice and processes in Children's Services. It showed significant improvement in performance, albeit on a relatively small sample of cases. The review also highlighted issues where faster progress was needed and Children's Services responded with increased focus on these issues, including establishing an embryonic Multi-Agency Safeguarding Hub (MASH) with the police and reinvigorating its recruitment campaigns for social workers. The peer review also highlighted that the commitment of partners is critical to the speed and level of improvement in the longer term.

The question remains: ***'How well are children safeguarded by agencies in Slough?'***

The data and case details coming before the Chair and the Board's Executive show two things:

- that the vast majority of children in Slough are safe and
- that problems are being effectively addressed in the vast majority of cases.

The work of the Board and its partners suggests that there has been some improvement from Ofsted's assessment of inadequate performance.

The following pages set out some of this work and the commitment of professionals to improving children's lives. With two judgements of inadequate combined with a very significant structural change programme, it could be expected that morale amongst staff would be very low – this does not appear to be the case. Levels of permanent staffing amongst professionals such as social workers and health visitors are increasing and this brings more stability and better networking within teams. Commitment to issues such as Child Sexual Exploitation and Early Help is good with attendance at meetings showing the willingness to work together to tackle individual cases. The introduction of the concept of MASH, although only in its early stages, will also enhance information sharing and good decision-making. However, there is significant progress to be made before such changes are embedded and the lack of strong quality assurance processes has caused real concern – if the partners do not know how effective their efforts are for children, it is very difficult to know if work to improve is being directed to the right place.

In summary, below are the key issues which in my view need to be addressed by the Board's partners if the Board and Children's Services are to reach sustained reliable performance and be able to guarantee effective safeguarding of all children:

- Partners need a much stronger commitment to quality assurance and show a greater willingness to resource the processes within their agencies which make performance management and auditing a benefit for everyone.
- Overall, the Board is not sufficiently resourced bearing in mind the improvement journey which is needed to convince the public and stakeholders that children are well protected in Slough. Partners need to address this issue and agencies, such as the police need to give a stronger undertaking to resource both the Board and the staffing needs of functions, such as multi-agency auditing in the long term.
- The new Children's Trust should give an impetus to improvement across Slough but it could also lead to confusion for partners about roles and responsibilities, duplication of effort and increased bureaucracy. The approach to this new commissioner-provider approach therefore needs determination to ensure that it does not make safeguarding more complex in a way

which distracts professionals from their key role.

- The culture of agencies working within the Board needs to be one of ‘can-do’ and a willingness to challenge and be challenged at all times. Making commitments in meetings and then failing to deliver on them undermines confidence between partners and breeds a culture of failure rather than success. Accepting others failures without challenge enables poor commitment or performance to continue.

These issues need to be tackled and guarded against, but I am far from pessimistic about the future. In the last year, I have seen considerable commitment to improve services by individuals at all levels. It is this which makes children in Slough safer and I would like to take this opportunity to thank staff in all agencies for their determination to improve the lives of individual children in 2014-15.

**Phil Picton**  
**Independent Chair, Slough Local Safeguarding Children’s Board**

## **2. Background to Slough**

Slough is situated within 10 minutes of London's Heathrow Airport and with 3 exits off the M4 motorway which gives easy access to both London and the West Country.

The 2011 Census has indicated

- There are more young children (aged 0 to 9) living in Slough than the national average and overall 28% of the population is under 20. Coupled with a high proportion aged 25 to 44 living in the area, the prevalence of young families in Slough is significant.
- Population growth is also significant, with projections from 2011 to 2021 showing a 14% increase.
- The majority of the population is Asian or Asian British (39.7%) followed by White British (35.7%). The proportion of black and minority ethnic groups is higher amongst Slough's child and younger adult populations than amongst Slough's older population.
- Approximately 67% of households in Slough have all members of that household with English as their first language. This is a lower proportion than the national and South East regional averages. Over 15% of households in Slough have no-one living in them who have English as their first language, which is a much higher proportion than the national and regional averages.

Slough has long enjoyed good relations amongst its various communities and seeks to build on this and ensure that the diversity which characterises. Slough's goal is to encourage a town where all communities, irrespective of background, have a chance to succeed and prosper and where they have an equal stake in shaping the future direction of the town

Poverty risks are highest for children in lone parent families and Slough has a slightly higher rate of lone parents (1.5%) than the regional (1.0%) and national average (1.3%).

### **Summary of key data on Safeguarding Children in Slough Borough Council**

In March 2015 the number of children who were subject to a Child Protection Plan was 237. This is equivalent to 60.7 per 10,000 children under the age of 18 in the Borough. This is 45% higher than the national position. At the end of March 2015, 62% of protection plans had been in place less than six months, 12% had been in place for one year or longer and none had been in place for two years or longer. These rates are very close to the national picture. The majority of plans (57%) were in the category of neglect, compared to a national figure of 42.1%. 33.5% of the plans were in the category of emotional abuse, which is similar to the national rate of 33% and 0.9% were in the category of sexual abuse, compared to a national figure of 5%.

Slough initiates a much higher volume of enquiries under Section 17 of the Children Act (1989) than similar areas. These are enquiries undertaken when there is reasonable cause to suspect that a child is suffering, or is likely to suffer significant harm. At 243 per 10,000 children in the population, the rate is almost double the national average in 2013/14 of 124 per 10,000 children in the population. However, the proportion of these enquiries that result in an Initial Child Protection Conference is slightly below the average seen elsewhere. Social care managers are examining the reasons behind this data.

In 2014/15 153 young people were the victims of violent offences that caused injuries, 193 were victims of violent crimes that did not cause injury and 103 were victims of sexual offences.

Data from Berkshire Healthcare Foundation Trust indicates that number of children subject to a Child Protection Plan who was also a patient of the Child and Adolescent Mental Health Service remained at a similar level to that of the previous year at 16 young people.

### **3. Slough Local Safeguarding Children's Board**

#### **Governance**

The functions of the Board are set out in primary legislation (sections 14 and 14(a) of the Children Act 2004) and statutory regulations (Local Safeguarding Children Regulations 2006). The work of the Board during the period covered in this report was governed by the statutory guidance in Working Together to Safeguard Children issued in March 2013, although this was updated with a new version issued in March 2015.

Along with Slough, all local authorities are legally obliged to have a children's safeguarding board which has two statutory objectives and functions:

- (a) To coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and
- (b) To ensure the effectiveness of what is done by each such person or body for those purposes.

The SLSCB seeks to achieve these functions by:

- monitoring the effectiveness of what is done to safeguard and promote the welfare of children
- establishing effective communication and information sharing across agencies
- undertaking reviews of individual cases, including 'Serious Case Reviews'
- collecting and analysing information about child deaths, and agreeing procedures to ensure a co-ordinated response to unexpected child deaths
- developing policies and procedures for safeguarding and promoting the welfare of children
- evaluating the effectiveness of agencies working together and advising on ways to improve these crucial relationships
- developing, coordinating and delivering relevant multi-agency training.

#### **Accountability**

In keeping with the guidelines, SLSCB is independently chaired by Phil Picton, who is accountable to the Chief Executive of the Council, Ruth Bagley, for fulfilling this role effectively. They meet regularly to discuss progress and issues in safeguarding. In addition, Phil has access to Directors of all the partner agencies and meets with them as appropriate on a one to one basis to discuss safeguarding issues and where necessary to challenge them on progress within their own sphere of influence. In the role of Chair of the Safeguarding Board, Phil is also a member and active participant in the Children and Young People's Partnership Board which also takes forward a range of work related to the safeguarding agenda, such as 'Early Help'.

A protocol exists with the Slough Health and Wellbeing Board and the Safeguarding Adult Board to ensure that the work of these Board complement each other rather than duplicating effort. The



Safeguarding Board's Annual Report is discussed at the Health and Wellbeing Board and provided to the Police and Crime Commissioner and the Chief executive of the Council..

The interim **Director of Children's Services** (DCS), Krutika Pau, has the delegated professional responsibility for the leadership, strategy and effectiveness of local authority children's services. She leads for the Council on Safeguarding Children. Krutika meets frequently with the Chair to discuss the progress of safeguarding and sometimes individual cases which have caused concern.

The elected councillor who is **Lead Member for Children's Services, Pavitar Mann**, is a 'participating observer' of the SLSCB. She attends Board meetings and receives all of the Board papers. This enables her to join fully in Board discussions and to challenge the DCS and Board members on appropriate issues. She is also the Chair of the Children and Young Persons Partnership Board and is through this partnership active in ensuring progress on some of the key themes in safeguarding.

The work of SLSCB is reviewed annually by the SBC Overview and Scrutiny Committee. At that meeting, the Chair, key Board members and sub-group chairs explain the issues and risks to safeguarding children and what has been and will be achieved by the Board. The minutes of that meeting are publicly available through SBC's website: <http://www.slough.gov.uk/moderngov/mgCommitteeDetails.aspx?ID=105>

In addition the Chair occasionally attends other Children's Services Scrutiny meetings to give evidence to the Panel or to observe discussions on safeguarding issues.

## Finance

### Partner Agencies SLSCB Financial Contributions

<i>Partner</i>	<i>Contribution</i>
Slough Borough Council	45,700
NHS	
Berkshire East CCG Federation	21,000
Berkshire Healthcare NHS Trust	1,000
CAFCASS	550
Thames Valley Probation	150
Thames Valley Police	
Police Corporate Contribution	2,000
Slough Local Police Area Contribution	8,000
Schools Funding	30,000
<b>Total Contributions</b>	<b>108,400</b>

The Board managed its expenditure within the £108,400 contribution in 2014/15. A significant part of its costs is the employment of its full time business manager and part time administrator. The Board retains a contingency of £15,000 which is likely to be used in 2015/16 to fund its current Serious Case Review and Annual Conference.

During the year the Slough Strategic Partnership made a one off contribution to fund a CSE coordinator. This money had been partly used by the end of the financial year and as a result £34,800 was 'rolled forward' into 2015/16 to pay for the remainder of this person's contract.

In addition to its financial contribution, the Council also provides resourcing 'in kind' for the Board through its hosting of the Board's administration and the provision of 50% of a training officer to



deliver multi-agency training. This training officer commitment is estimated as being the equivalent of £22,800.

The Child Death Overview Panel is funded through a central agreement with all six Berkshire Local Authorities. The service is commissioned by Bracknell Forest on behalf of all six Authorities. The service is hosted in Slough and all six Local Safeguarding Children’s Boards have oversight of the work through the LSCB Business Managers. The Child Death Overview Panel Coordinator is funded as part of this agreement.

In Autumn 2014, Thames Valley Police announced that it would be reducing its contribution to the Board from £10,000 to £2000. This reflected a review by the Force of its commitment to LSCBs. Recognising the pressure the Board was experiencing, the Local Policing Commander, who sits on the Board, has agreed reinstate the £10,000 from local devolved police budgets for the 2015-16. The uncertainty on the police long-term financial commitment to the Partnership is of concern and will need to be resolved in 2016-17.

#### 4. Slough Local Safeguarding Children’s Board Structure

##### Structure of the LSCB

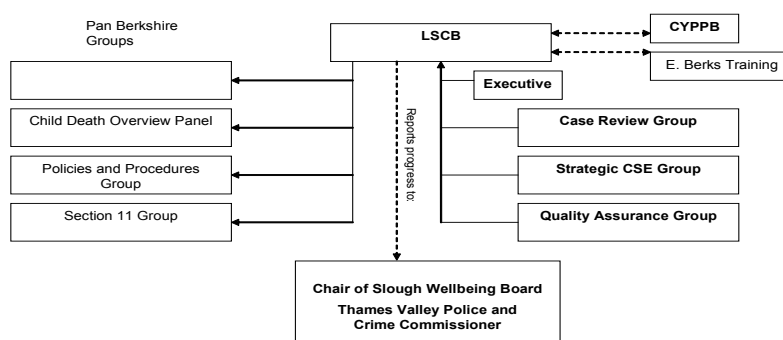
In March 2015, Slough Local Safeguarding Children’s Board comprised of the main Board, an Executive Group and two Sub – Committees which focus on;

- Case Reviews,
- The Strategic Aspects of Child Sexual Exploitation and Missing Children.

In addition, it is represented on with the other Berkshire LSCBs in sub-groups addressing;

- Child Death Overview Panel, (across Berkshire)
- Section 11 Responsibilities, , (across Berkshire)
- Policy and Procedures. , (across Berkshire)
- Training and Development sub group (across East Berkshire).

##### **Slough Local Safeguarding Children’s Board**



In Autumn 2014 the Board dissolved its Quality Assurance Sub-Group which was struggling to make effective progress and re-allocated its responsibilities to the Executive Group. This decision was reviewed towards the end of the year and the Quality Assurance group will recommence during 2015/16 with refreshed membership and terms of reference.

At the start of 2014/15 the Board also had three standing sub-groups which reported jointly to the Safeguarding Board and the Slough Children and Young Person's Partnership Board (CYPPB). These three groups had an overlapping remit to address communication, participation and engagement issues. During the year, the Board and the CYPPB reviewed their roles and responsibilities in order to reduce duplication in their work. As a result of this review the Board's decided to dissolve these three groups and consider participation, engagement and communication as a facet of other group's work rather than as a separate specific theme. From the Safeguarding Board's perspective this change released resources which will become available to support a stronger quality assurance function for the Board.

The Board also works closely with other Slough multi-agency partnerships particularly the Slough Children and Young Persons Partnership Board (CYPBB) which developed from the previous Children's Trust arrangements. The Chair of SSCB, DCS and Lead member sit on both Boards along with some other representatives of partner agencies. This enables close coordination of the work of the two Boards.

## **Membership; Attendance and Participation**

In 2014/15 the Board met four times and the executive group met six times, to progress work between Boards.

For a list of attendance, please see Appendix A

## **5. Slough Local Safeguarding Children's Board (The following pages summarise the work of the Board during 2014 – 15)**

### **Child Sexual Exploitation (CSE) and Missing Children**

The work of the Board on Child Sexual Exploitation and Missing Children is managed by a well attended sub-group of the Board. The purpose of the sub group is to bring together key partners to ensure an effective, co-ordinated response to children and young people at risk of CSE, and to educate and inform those who may encounter CSE in their personal or professional lives.

At a lower level a separate Sexual Exploitation Risk Assessment Conference (SERAC) meets to discuss the circumstances of individual children and how risks can be managed and countered. This Group is not part of the Board, but a specialist operational case conferencing and strategy. The Board's role is to monitor the impact and effectiveness of this Group's work on a regular basis.

Over the last twelve months, the strategic group has overseen awareness raising visits to 24 Hotels and Bed & Breakfasts in the Slough Area with the "Say Something If You See Something (SSIYSS)" Campaign. In addition, visits to 250 Business Premises with CSE Awareness Campaign, SSIYSS, Barnardos and other CSE Awareness literature. In December 2014, the "party season" saw visits to licensed premises and major fast food premises (including hotels, B&Bs etc) re-emphasising the SSIYSS.

Successful Taxi Driver Campaign with cabs now displaying stickers regarding Human Trafficking and regular updates in their “news letter”.

The work of the Licensing splinter group was featured as best practice in an article in an LGA publication

The updated action plan ensures that data can be collated from agencies regarding, for example, training compliance, number of referrals made and how many become SERAC cases. This has not been collected in the last 12 months. There is anecdotal evidence that new referrals of CSE concerns have been made following awareness raising visits to hotels and guest houses

- Ensuring greater engagement and involvement from individuals and groups within our community so that we can be sure that our messages, training and education materials are reaching the right people and places
- Engage with more boys at risk of or potential risk of CSE through targeted input to schools. (Education splinter group setting plan)
- No return interviews for child missing persons are taking place and intelligence and evidence may be being lost. (CSC devising solution)
- Delayed implementation of the MASH is delaying the introduction of the CSE referral pathway. A work around interim solution may be implemented if the delay is likely to be significant.
- The sub group has two splinter groups; the Licensing and Education groups. These are currently chaired by a Police Inspector but this arrangement is under review to ensure that ownership of the sub and splinter groups is appropriately shared amongst partners.

## **CSE Priorities**

- The strategy, work plan and group membership is currently under review and near to finalisation. The work of the sub group over the last 12 months, in particular Education and Licensing, is also under review to enable accurate planning for the next 12 months.
- The CSE communications plan has been re-written and should enable information to be made available to the public, parents and carers and professionals to educate them about CSE and the action to take should they identify the risk factors.

The purpose of the sub group is to bring together key partners to ensure an effective response to children and young people at risk of CSE and child trafficking or those that are being abused via CSE and trafficking.

The CSE sub group also hosted a Slough LSCB multi agency CSE conference and instigated the creation of a CSE co-ordinators post.

SLSCB Business Plan for 2015 includes CSE as an issue of particular concern and this report intends to bring you up to date on the work of two groups of professionals; the strategic group and the operational group, of which Inspector James Cosham is co-chair.

The original terms of reference of the CSE sub group are being revised and updated and will give rise to the new Slough CSE strategy, led by our CSE co-ordinator.

The strategy will be formed under headings which will allow us to set actions to Prevent CSE occurring through education and awareness raising activity, Protect children at risk of CSE through effective referral pathways and management of risk, Disrupt and Pursue people and locations where CSE may exist and ensure recovery pathways for victims.

Our aim is that we can ultimately engender the identification and response to CSE as core business for all the partners involved in dealing with crimes and concerns falling under the banner of Child Sexual Exploitation.

The revised strategy is currently in draft form and will include learning from serious case reviews, the NWG and other local, regional and national bodies.

The current action plan is also being refreshed and updated to include actions to ensure that we deal effectively with CSE, by that I mean that we all know what it is, we know what to do about it, and we commit to taking action to address concerns.

The revised and updated strategy and action plan will be ready for sign off by the board in the coming weeks.

### **CSE Challenges:**

There are three new key areas of work that need to feature in the action plan; the need for greater engagement and involvement from individuals and groups within our community so that we can be sure that our messages, our training and education materials are reaching the right people and places, secondly to include actions in the plan to raise awareness of child trafficking, which we know has and is possibly happening in Slough but for which I want specific actions for agencies to be aware of the signs of trafficking, and third, to engage with more boys at risk of or potential risk of CSE.

Current concerns centre on the low number of return interviews for missing children, particularly those at risk of CSE.

### **Quality Assurance and Performance**

#### **Audit and Challenge -- External Inspection and Audit**

As part of its desire for improving performance, the Board regularly contributes to and discusses a wide range of reports from external auditors, inspection authorities and peer reviewers on the safeguarding performance of both individual agencies and their partnership work.

In March 2014, Ofsted published the results of its 2013 inspection which judged both Children's Services in Slough and the Board as 'inadequate'. The Review of the effectiveness of the Slough Local Safeguarding Children Board is attached as Appendix B.

In November 2014, a team of LGA peer reviewers examined practice and processes in Children's Services. It showed significant improvement in performance, albeit on a relatively small sample of cases. The review also highlighted issues where faster progress was needed and Children's Services responded with increased focus on these issues, such as establishing an embryonic Multi-Agency Safeguarding Hub (MASH) with the police and reinvigorating its recruitment campaigns for social workers. The peer review also highlighted that the commitment of partners would be critical to the speed and level of improvement in the longer term.

#### **Audit and Challenge Internal Auditing**

LSCBs and Partners achieve internal quality assurance by carrying out multi-agency audits, single agency audits and by monitoring performance information. During 2014-15 Slough LSCB has struggled with this aspect of LSCB work. Although there were good intentions to carry out multi-agency audits at the start of the year, staffing issues led to a lack of progress on bringing the plans to fruition. As a result, no multi-agency audits were completed in the first nine months of the year.

A multi-agency audit of children who are subject to strategy meetings and enquiries in accordance with S47 of the Children Act was carried out in February and March 2015, and its findings were reported to the Board in March 2015. This audit highlighted some areas for improvement in Children's Services which will be used as learning as the Services move into the new Children's Trust during 2015/16. The work also highlighted difficulties in the approach to multi-agency audits

and audit reporting which led the Board to recognise that future audits would need to be overseen by a reconstituted Quality Assurance sub-group for the Board. This group will start work in 2015/16.

A new programme of potential multi-agency audits has been identified for 2015/16 which will include an audit of the effectiveness of partner working on Child Sexual Exploitation.

Although single agency auditing, particularly within health partners and Children Services' took place during the year, they were not reported in detail to the Board. In future, the Quality Assurance Group should receive the results of single agency audits and enable partners to understand the areas for improvement in each other's work.

## **Performance Management**

The Board has received significant routine performance information from police, health and Children's Services partners. One of the challenges for the Quality Assurance Group before its dissolution was the attempt to build this into a coherent data set for the Board. Unfortunately, the movement of this responsibility to the Executive followed on shortly after the loss of the Chair, business manager, and administrator for the Board. Combined with difficulties in the information management within the Council, this led to the process for the regular monitoring of performance information breaking down. By the start of 2015, information was once again starting to come through, although initial discussions in the Executive focussed on identifying a pragmatic set of indicators and the process for receiving them rather than interpreting the data which was available.

By the end of 2014/15, the Executive Group had agreed an approach to the collection and presentation of data and in early 2015/16 it is anticipated that members will focus their discussions on analysis of data rather than developing a refined performance monitoring data set.

In the absence of an in-depth discussion within the partnership of multi-agency performance, since his appointment the new Chair of the Board has discussed performance in a number of meetings with individual directors of partner organisations, raising challenges and suggestions as appropriate.

## **Section 11 Self-Assessments**

Section 11 of the Children Act places a statutory duty on key partners to ensure that they achieve national safeguarding standards. The Board receives assurance from these partners that they are achieving or improving to achieve these standards. Several partners of the Board such as Thames Valley Police and the NHS Trusts deliver services across a number of local authority areas and need to give assurance to a number of LSCBs. In order to reduce duplication, the Berkshire LSCBs have a joint s11 Audit Panel to receive the assurances for cross border agencies. This assurance is currently required from agencies on a three year cycle.

Partners, such as Slough Borough Council, which only deliver services in one LSCB area give this assurance to their local Board. In 2013-4 Slough Safeguarding Board did not request such assurance from the Council, but it will be doing this during 2014/15 once the new Slough Children's Trust structures are in place.

The terms of reference and membership of the Pan Berkshire Section 11 Audit Panel subgroup were reviewed at a workshop in December 2014. The panel now has an ongoing role in improving the self-assessment process for organisations. The self-assessment tool has been updated and will be used from 2015/16 onwards. The panel also decided to strengthen the process with organisations presenting their Section 11 audit results so that they can be more effectively scrutinised. In addition to receiving the results, the panel monitors progress against the action

plans at a mid-cycle (18 month) point and ensures processes of review are effective and thorough. New commissioning arrangements in health have proved to be an ongoing challenge. The plan is for the Panel Chair to write to the NHS England Local Area Team to clarify assurances of its compliance with s11 standards.

The priorities for the year ahead include commencing the new three-year audit cycle; implementing the agreed process; rolling out new assessment format and sharing learning across the six LSCBs through improved reporting processes.

## **Serious Case Review Strategic Group**

### **Learning from Reviews**

A Critical Case Review was completed in October 2014, following an allegation of a possible non-accidental fracture to a child of nursery school age. The review incorporated learning from historical professional involvement with the child and the investigation and intervention of agencies at the time the injury was diagnosed. A multi-agency practitioner learning event has been arranged to disseminate the lessons from the case.

The Board instigated a Serious Case Review in October 2014, following the death of a mother and son on a railway line. The report will be published 2015 – 2016.

## **6.**

### **Policy and Procedures (Joint Working with other Berkshire Local Safeguarding Children's Boards)**

The Sub - Group has met on four occasions during the year and was hosted by Slough Borough Council.

New procedures for responding to Child Sexual Exploitation, including a Pan Berkshire CSE Indicator Tool, were completed and implemented during the year, providing consistent guidance for all agencies which has linked to the continued development of SERAC (Sexual Exploitation Risk Assessment Conference) panels across the county.

The subgroup has remained sighted on the work of the Health-led FGM Task & Finish group, awaiting the conclusions of this piece of work before considering substantial changes to the existing procedural guidance in this area in 2015-16.

Similar to the previous year changes in management appointments within constituent agencies led to changes in membership and variation in attendance at subgroup meetings. This has a direct impact on the ability of the group to progress, complete and sign-off specific pieces of work.

The group identified the need to seek a greater steer from the constituent LSCBs to ensure that the group's activity is consistent with the priorities in each LSCB's business plan. To begin resolution of this the Chair of the group attended the Pan-Berkshire LSCB Business Managers and Chairs meeting to secure commitment to a more active engagement with the subgroup's activities and work programme

Whilst there are clear benefits from coordinated and similar policies across the LSCBs, a pan Berkshire approach challenges the ability of LSCBs to develop policies quickly and flexibly. This has been aggravated by changes in membership of the Group as it reflects turnover in the various partner organisations.



The subgroup faces a number of challenges for the year ahead, including the need to renegotiate the contract for producing the policies and procedures manual and reviewing a wide range of policies to ensure that they are both up to date and appropriate in content.

### **Child Death Overview Panel (Joint Working with other Berkshire Local Safeguarding Children's Boards)**

The Child Death Overview Panel comprises of all six Berkshire LSCBs operating together as a single panel.

In Berkshire as a whole, there has been an overall reduction in reviewed deaths from 58 in 2012/13 to 60 in 2013/14 to 50 in 2014/15. 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 have been sustained in 2014/15 and a total of 59 child deaths have been recorded and 42 reviewed. (Deaths waiting for post mortems or police investigations may be delayed)

The annual number of child deaths reported in Slough in 2014-15 was 18 which compares with a total of 21 deaths in 2013-14

7 were classified as 'chromosomal, genetic and congenital anomalies'

5 were classified as 'perinatal/neonatal deaths'

2 were classified as 'malignancies' and 4 remain to be reviewed.

10 children were male and 8 female

Ethnicity: 3 Asian or Asian British: Any other background; 1 Mixed: White and Asian; 1 Mixed: White and Black Caribbean; 6 Asian or Asian British: Pakistan; 2 White British; 2 Black African; 1 Asian or Asian British: Indian; 1 Black: Caribbean and 1 Unknown.

The work of the multiagency subgroup set up to analyse the register of all child deaths related to neonatal anomalies has informed a paper reported at the National CDOP conference in December 2014. This made the following recommendations:

- Ensure continuing collection of data on ethnicity and consanguinity in the dataset
- Consider including collecting indices of deprivation in the dataset
- Continue existing genetic working party and educational initiatives
- Continue sharing information and learning with other CDOPs
- Continue to contribute to regional/national collaborations/meetings

The genetics programme has been disseminated through Slough secondary schools and an audit will be carried out in 2015-16 to explore whether this has been adopted into school curricula

As reported in the mid year report the panel has responded to two accidental drownings sharing advice from the Health and Safety Executive. Follow up work with the Environment Agency has



promoted improved signage at a range of bridges over the Jubilee River when young people may be tempted to jump in.

The panel have shared learning from the Thames Valley Cancer Network on culturally appropriate ways of marking a child's death. This has been circulated to social care and health staff and shared with education colleagues.

The panel are assured that work on reducing pre term births is also a regional health priority as many of the risk factors relates to the health of the mother antenatally and the care she receives within that period. Thames Valley Children's and Maternity network has been promoting training to increase awareness of the optimum way to measure fundal height through the midwifery services. This is one of many further actions that the Oxford Health Sciences Academic network will take forward which is also focussed on standard setting and the introduction of screening for cervical length. The aim is to achieve a consistent screening and treatment programme in all hospitals in the Thames Valley.

The service is effective in identifying the key priorities for action to prevent child deaths by:

- Reporting on risk and preventative factors for infant and child deaths through the CDOP newsletter and JSNA
- Facilitating the development of an asthma and viral wheeze website/ app for the Thames Valley as a response to two local child deaths in Berkshire in 2013-14. This is now live at [www.puffell.com](http://www.puffell.com)
- Facilitating the review of the school guidance on the use of emergency inhalers through the school nursing service
- Facilitate improvement in recognition and management of sepsis in response to a Berkshire death in 2013 – 14 by reviewing sepsis pathways across primary and secondary care and SCAS
- Designing and testing an emotional health and wellbeing website/app which includes sections on self harm, anxiety and depression, antibullying and domestic abuse as part of the public mental health approach to CAMHS service redesign.
- A paper was presented at the national CDOP conference based on a detailed analysis of all child deaths in relation to congenital anomalies and is planning to audit the implementation of the consanguinity programme in secondary schools this year
- All cancer deaths have been reviewed by an external expert panel and no trends of common modifiable factors have been found
- The service continues to promote safe sleeping advice
- The service is supporting the recommendations for improving nutrition and support to stop smoking among pregnant women to reduce pre term births through a pilot programme called Metime

### **Strategic Learning and Development (Joint Working with other Berkshire Local Safeguarding Children's Boards)**

In January 2015, the existing Pan - Berkshire sub-group separated to smaller groups covering East and West Berkshire. East Berkshire LSCBs commenced planning for the new arrangements from January 2015, with a key decision being to have separate strategic and operational subgroups to ensure concerns about the lack of strategic direction were addressed and progressed as a matter of urgency.

The agreed aim of the East Berkshire arrangements is to ensure the provision of sufficient high-quality learning and development opportunities that are appropriate to local needs and have a positive impact on safeguarding outcomes, and holding partner organisations to account for operational delivery and uptake.

### **Training Programme 2014-15**

The training programme was created by the Operational L&D Sub-Group, based on past trends and emerging needs, as identified by the L&D Sub-group Members and LSCBs through their LSCB Business Managers. As in previous years, the first courses of the year did not obtain sufficient numbers of candidates and had to be postponed until later in the year. This was despite no courses being planned for April. The rescheduled events had sufficient numbers to be held successfully.

The programme was delivered bar two courses which had insufficient interest and so were cancelled. These were both related to CSE. This could be due to other opportunities for such learning and development being available elsewhere, for example through the e-learning offer.

The headline figures associated with the programme include;

- 22 courses were run through the LSCB programme, equating to 92% of the planned programme
- 355 candidates attended the courses, which equates to over 16 candidates per course
- 46% of the places were taken by Local Authority workers, with 21% from Health and 33% from others (12% of these being from PVI)
- Allegations management was the most popular course for other agencies, including schools (32 candidates)
- 53% of people felt the immediate impact of the training was significant or very significant with 45% stating there was some immediate impact.

The figures show that awareness seems to be reasonable and attendance healthy, but that there may be issues in terms of course types or the times of year, due to two course cancellations. The courses appeared to offer sufficient places and opportunities as only one appeared to be challenged for sufficiency, this being the allegations management offer.

These figures would suggest another successful programme which has had a benefit to the workforce and as such an inferred positive impact on outcomes for Children and Young People. Furthermore, given the limited resources available to the sub-group, it would seem that the programme offers excellent value for money to all who use it.

### **e-Learning Programme 2014-15**

The e-Learning offer for the LSCB Programme focused on two main learning opportunities, this being CSE (Child Sexual Exploitation) and USC (Universal Safeguarding). Both of these courses are provided through our contract with Kwango, an external provider, and due to cost limitations have limited management information available. However, a review has been undertaken of the courses and both were felt to remain relevant and appropriate.

The headline figures for the programme include;

- 1034 candidates completed the USC e-learning
- 73 candidate completed the CSE e-learning
- 21% of candidates who started the course completed it

The figures have highlighted an issue in the management information as well as behaviours, relating to candidates starting the courses but not completing them at the first attempt. This could be for a number of reasons, for example; not being fully aware of how long the course will take, not

being fully aware of the nature of the course and content, not providing sufficient space to complete the course in one attempt due to work commitments etc. This will be considered for the coming year, 2015-16.

SCR learning has been successfully shared within the subgroup and used to inform revisions to learning and development interventions (e.g. training courses or e-learning content). This has meant that candidates were aware of current cases and the learning they provide, thereby influencing work practices and behaviour and so having a positive impact on the outcomes for Children and Young People.

These figures would suggest the learning and development programme has had an impact on a significant number of attendees, meaning that that candidates work practices and behaviour are influenced, leading to a positive impact on the outcomes for Children and Young People

A criticism of the pan-Berkshire arrangements was a lack of focus on strategic direction and delivery of priorities. Moving to East/West arrangements created a timely opportunity to refocus this area of work. Development of the East Berkshire Strategic Learning and Development subgroup was based on the critical tasks at hand, including addressing a historic lack of Training Needs Analysis reports from partner agencies, and the commissioning of training comprising the East Berkshire Training Programme. The group developed a robust Terms of Reference for the group, which provided a clear structure and focus for the sub group going forward.

Past issues and different working practices within the cross-county sub-group were understood and addressed through separating the groups in to two providing greater geographic focus as well as accepting and fully utilising differences.

Partners have agreed to be active on the sub-group e.g. Thames Valley Police, Probation Service and the Fire Authority. However, after chasing several times it has not been possible to determine who was to be the lead from these partners or what their involvement would be. It is proposed that further work will be done through escalation, as necessary to define roles, responsibilities and membership.

The strategy has been revised by using examples from good and outstanding LSCBs across the country as well as the previous Berkshire strategy. This has been rewritten and released for comment and will be passed to all LSCBs for formal approval at the next available opportunity.

All agencies have actively engaged in communicating the training opportunities across their organisations, as well as sharing useful information as appropriate. The main route was through forwarding emails or adding the programme to existing websites, which relied on sound mailing list and the good will of agency representatives. However, this is not proving very successful as courses within the training programme had low numbers. Therefore, a revised approach is being proposed for the future to make better use of proactive engagement and marketing, as well as modern electronic communication methods.

Limited information has been available, with no regular reporting in place within the group or its draft Terms of Reference. Work on this stalled during 2014-15 due to the change in direction of the sub-group, however, it has been identified as a priority for 2015-16. This data will include the delivery of assurance to the LSCB with regards to the learning and development provision within agencies across Berkshire East. This has included a revised and well-received format for subgroup reporting to the main LSCBs at each meeting.

At present, S11 statements would appear to suggest compliance with required training, and indicative feedback from agencies at L&D Sub-group meetings provide such assurance across all

agencies. However, empirical evidence would provide a more robust demonstration of this hence the prioritisation of activity in 2015-16.

### **Key Training Priorities for 2015-18**

Key priorities have been established in accordance with the priorities identified in East Berkshire LSCB Business Plans. Consequently, the priorities for this subgroup are:

- Receive and scrutinise Training Needs Analysis reports
- Undertake a strategic review the current provision of universal, targeted and specialist training provision in light of the Needs Analysis
- Develop and implement a Learning and Development Strategy for East Berkshire LSCBs
- Improve the awareness of the range of training available through the East Berkshire training programme
- Prioritise and agree jointly commissioned training across the region
- Evaluate the delivery model for training across East Berkshire, making recommendations for improvements as required
- Consider the findings provided by the Operational Learning & Development Subgroup's review of the evaluation processes for commissioned training
- Identify opportunities to increase multi-agency participation at learning and development opportunities across partner agencies
- Consider how to measure the return on investment and the impact of training on frontline practice and management

## **7. Other Specific Safeguarding Themes**

### **Female Genital Mutilation (FGM)**

National research carried out by City University has estimated that just fewer than 1100 women in Slough are likely to have been subjected to FGM in childhood. This reflects the demography of Slough and is one of the largest percentages of female population experiencing FGM outside London. Whilst it is not appropriate to presume from this data that girls living in Slough are very likely to be subjected to FGM now and in the future, the Board considers that the risk of FGM taking place for a Slough child is higher than in many other areas. Its FGM priority is led by the Director of Nursing for the CCG and is coordinated across East Berkshire

#### ***Bracknell, RBWM and Slough LSCB FGM Task and Finish Group***

The group has met three times since the last report for the LSCB and has made some significant progress in the key areas of work it has been undertaking. The purpose of this report is to report progress to the three LSCBs and make recommendations for next steps.

The task and finish group has been working under the three key principles underpinning the national FGM strategy: that FGM is a violation of human rights, a form of violence against women and girl and that it is child abuse.

#### **Local identification**

Currently the acute trust is identifying approximately 6 women per month through the mandatory antenatal reporting route, this has also led to the identification of 3 young girls that had already had FGM prior to coming to live in the UK; CP procedures were followed and the new baby is subject to CIN plan.

The group is not aware of any women or children identified as have been subject to FGM outside of the antenatal route.

This information could indicate that there are other woman and girls that have had or at risk from FGM across East Berkshire, however the identification of cases has been mapped to a small geographical area within one of the three local authority boundaries.

Mandatory reporting for Primary Care is due to commence from October 2015, the CCG safeguarding team is raising awareness of this new requirement with GPs, it is anticipated that this will continue to raise the profile of this abuse and lead to greater reporting.

### **Key FGM areas of work and progress to date**

The group has developed pathways for FGM and seeks approval from the LSCB for these to be included in the Berkshire procedures. In addition to the LSCBs in Berkshire East receiving the pathways the Chair of the FGM group has met with representatives in the West of the county who have agreed to take them to their LSCBs for approval.

<b>Area of work</b>	<b>Progress</b>
Antenatal/ postnatal Adult Pathway	Pathway completed and being used at Frimley health Wexham and Frimley sites.
Adult Pathway	Pathway Completed- needs sharing awareness raising
Children's Pathway-	To use existing Child protection procedures
Social Care referral process	The FGM Task and Finish group sent representatives to view how other areas have tackled this issue (Oxford and London); the group then reviewed and narrowed it down to two risk assessments for referral, the Oxford and national tool. The group agreed that the national tool should be the recommended tool for use. The three local authorities worked together to develop a referral process and flow chart.
Staff Training	This is being reviewed by the relevant disciplines and feedback is due at the July meeting
Information for Children, families and victims	TBC

### **Next steps**

To create local strategies that encompasses the national aims of Prevention, Provision and Protection.

Plan for the International zero tolerance for FGM awareness day, 6<sup>th</sup> February 2016.

Continued Working with the LSCBs in the West of the county to share work completed with the aim of common procedures and pathways for inclusion within the Berkshire procedures.

### **Extremism and Radicalisation**

In response to the increasing threat from extremism and terrorism, and in line with its statutory responsibilities under the Counter Terrorism Act (2015), the local area has specific safeguarding arrangements in place to protect those who may be vulnerable to extremism and radicalisation.

Slough Borough Council chairs a multi-agency Channel Panel, which supports individuals who may be at risk of becoming involved in extremist or terrorist activity and offers appropriate interventions.

Through Slough Borough Council's Corporate Induction and on-line learning resources, all council staff are made aware of the current terrorism risks that affect the UK and the processes that are in place to support staff who may have a concern about an individual or group. Additionally, all front line staff, attend the Home Office approved *Workshop to Raise Awareness of Prevent* courses. The council has a single point of contact for all Prevent –related referrals and staff are made aware of a range of local and national reporting systems.

Local partners, including schools, youth services, voluntary groups, health services, probation and police also work together through a Preventing Violent Extremism Co-ordination group, which meets regularly to address local issues and deliver a joint action plan.

An intensive period of staff awareness raising around the issues of radicalisation commenced in 2015, with the council and partners holding a Community Cohesion Conference to address local concerns around such subjects as CSE and extremism. A workshop on 'travel to Syria' considering the way to minimise the risks of individuals or families travelling into the Syrian war zone is planned for July 2015 with a follow up conference planned for October 2015.

## **Early Help**

Progress on Early Help is led by the Children and Young People's Partnership Board (CYPPB) with the Safeguarding Board's role being to evaluate and monitor that progress. In 2014/15 this was achieved by performance reporting and in depth reports to the Board and Executive. In addition a number of the LSCB Board's members sit on the CYPPB Board and have a regular opportunity to scrutinize progress in those meetings.

Current objectives and progress within the Early Help Strategic Priority CYPPB Children and Young People's Plan 2013-15 are set out below

### **1. Multi-Agency Early Help Assessment process.**

#### **Each board member to be responsible for their agency using the EHA and system**

Over the past 12 months this responsibility has been extensively reiterated through the Early Help Board, operations sub-group, engagement visits and activities coordinated by Head of Early Help. The majority of partner agencies are supportive of the EHA process and use of the system. Following concerted efforts during Q3 and Q4, Targeted Family Support, Children's Centres and Youth services now have all cases on the system.

#### **Training programme rolled out across agencies**

There has been a good uptake with over 180 multi-agency staff attending training since the roll out in July. There has been a direct correlation between training and increase of EHAs from particular agencies- notably schools.

#### **Explore barriers to access and solutions**

Users of the electronic system outside of SBC have found the system clumsy and time consuming. A system review has been undertaken which gave limited solutions, and 'workarounds' are being used to try and streamline access. Paper versions of the EHA can be used and members of SBC EH team have been made available to enter the information onto the system. This is not believed to be sustainable, and Head of Early Help is reviewing the impact of this workaround, as well as reviewing solutions identified elsewhere.



### **Early Help Champions Network**

Front line 'Champions' have been identified from most agencies across the partnership and there is a regular membership of 20+ attending monthly network group. Where successful, champions have been able to act as a focal point for information and advice within their service, and support colleagues with practicalities of using the EHA system.

### **EHA Quality**

16 Early Help Assessments were audited across all agencies, using East Sussex Audit tool, in November 2014. The quality was noted to be variable. At the time numbers were low and attention has been focused on increasing numbers. A second audit is due to be completed in March 2015 and audit action plan and cycle will be implemented.

### **Early Help Panel**

Established July, the panel meets monthly to review complex cases where there are specific multi agency issues arising. Core attendees include Psychologists, Targeted Family Support, Youth services, Duty manager, Primary Mental Health, and Health Visitor.

### **Marketing and publicity**

Leaflets and website have been updated; newsletter circulated.

### **Threshold document**

This has been distributed and highlighted across agencies through the training roll out.

## **2. Integrated working processes and protocols between partner agencies,**

### **Early Help Operations Group**

This group is meeting regularly and has been instrumental in reviewing and embedding processes.

### **Engagement and awareness**

Head of Early Help has led on an 'engagement and awareness' workstream, and with team members has visited agencies, attended team meetings and undertaken a troubleshooting role where there have been particular issues with the EHA system.

### **Pathways into Early Help**

Pathways and flow chart have been devised and shared with all agencies. This will be re-defined through the MASH development. CAMHS pathways have also been reviewed and completed.

### **Data set**

An Early Help scorecard was devised, intended to allow collation of data across the partnership, but has proved to be large and unwieldy and has not been regularly populated. Instead, key data items are regularly reviewed at the Early Help Board, and at each meeting a single agency data set is also selected and reviewed.

## **3. Impact Assessment Tool**

### **Outcomes STAR**

Representatives from services reviewed potential Impact tools and it has now been agreed that the STAR tool will be used from 1 April 2015. This is one of the suite of Outcomes Stars, widely used



and recognised as able to support and measure change with families. Training and licenses are being procured for key agencies.

### **Thresholds audit**

A 'Threshold' audit is in train and due to be completed by end of March 2015. The intention is to audit 20 cases close to either side of the Children in Need threshold, to review what would have made the difference to hold the cases effectively within 'early help' and prevent the needs escalating.

### **Family Impact**

Child and family feedback from closed cases will be gathered in a forthcoming review at year end March 2015.

## **4. Commissioning**

### **Mapping and gap analysis**

This is in train and has included review of current commissioning documentation and needs assessment. Partners have contributed to updating and mapping of available activity, and gaps have been highlighted. 'Parenting Programmes' was highlighted as a gap during 2014, and limited funding has now been identified in order for parenting programmes to be commissioned for Q4 2014-15 and from 15-16.

### **Needs assessment**

Review of needs has been collated by Policy Team, drawing on existing needs assessment including the Child Poverty Needs assessment. This will be taken forward during 2015-16 and will link to 'Families First' programme and investment.

## **5. Families First**

Slough has successfully achieved requirements of Phase1, i.e. has 'turned around' the required number of families (75%) from the original cohort of 330.

Progressing to Phase 2 means that Slough will receive a guaranteed attachment fee of 1.2m with the potential of a further 1.6m if outcomes are achieved. Work is in progress to define the outcomes against six problem/outcome areas.

A significant piece of analysis is being undertaken to review the outcomes from Phase 1, and test whether the appropriate range of interventions is available to support Slough families. This analysis will feed into commissioning, outcomes and partnerships work as outlined above.

### **Data monitoring**

In the past quarter, data has been cleansed and we can now more reliably see the numbers of EH assessments being completed. Data shows that there is an increase in numbers completed in 2014-15 compared to 2013-14.

### **Early Help assessments completed:**

	<b>2013-14</b>	<b>2014-15</b>
Q1	50	59
Q2	29	46
Q3	30	91
Q4	15	111
<b>Total</b>	<b>124</b>	<b>307</b>

## Source of EHA by Agency – 2014-15

Agency	Q1	Q2	Q3	Q4	
Children's Centre - Early Years	11	2	7	40	60
Schools	7	7	23	22	59
Targeted Family Support	37	36	31	24	128
Health Visitor	4	0	1	1	6
Youth Service	0	0	29	19	48
Other	0	1	0	5	6
<b>Total</b>	<b>59</b>	<b>46</b>	<b>91</b>	<b>111</b>	<b>307</b>

### Benchmarking

Benchmarking data shows that in Q1 we would have ranked lowest performer amongst 14 other Local Authority areas in SE England. By Q4 Slough's performance has increased but still within the lower quartile based on the available benchmark data.

Investigation has shown that Local Authorities count different data for this submission and so the rankings may not give a true reflection. However we are aware that whilst we are moving in the right direction, Slough still has a significant challenge to increase and sustain numbers, as well as maintain quality and outcomes.

### CIN and CP numbers

It is to be expected that an effective Early Help offer will impact on numbers of Children in Need and Child Protection numbers. No decrease in numbers has been observed to date.

### Total numbers trained with breakdown by agency, July 2014– March 2015

Agency	Numbers trained
Voluntary sector (6 organisations)	21
Children's Centres	6
Health visitor	21
Youth service (SBC)	26
Housing (SBC)	3
Early help (SBC)	25
YOT (SBC)	1
Schools (34)	56
Other	30
<b>Total</b>	<b>189</b>

A workshop was held in December 2014, for the EH Board to review progress and agree next steps.

## **Private Fostering**

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 Council's 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 2014 to 2015.*

The table below sets out the activity in 2014 -15 and shows comparison with the 2013 -14 activity

	2013 - 2014	2014 – 2015
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	1
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	1
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	0
Number of new arrangements that began during the year :	2	1
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	1
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	1	1

2014 where scheduled visits in the survey year were completed in the required timescale 1 :		
Number of private fostering arrangements that ended during the year :	1	1
Number of children under private fostering arrangements	2	2

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

**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

**Managing Allegations concerning persons who work with Children and Young People**

In accordance with guidance, Local Authorities should have a Designated Officer or Team of Officers (previously referred to as LADO) to be involved in the management and oversight of allegations against people that work with children.

Slough LSCB has the responsibility to ensure there are clear Policies and Procedures within Slough in relation to the management of allegations concerning Staff, Carers and Volunteers who work with children and young people. Organisations and individuals working with children should have in place clear policies for dealing with allegations against people who work with children.

The Designated Officer in Slough is currently a vacant position, covered by an officer on an interim basis. It remains a priority for Slough to permanently recruit to this position.

***Allegations for the period 2014 – 2015:***

- 51 referrals were made during this period. An increase of 7 referrals from the previous year
- Education remains the sector with the highest number of referrals; which reflects national statistics.
- 72% of referrals falls within the category of Physical Abuse
- 45% of Investigations had an outcome of unsubstantiated
- No member of staff was suspended or dismissed
- 1 referral was made to the DBS

### *Progress 2014 – 2015*

- Timescales for strategy discussions and meetings have improved
- Minutes of strategy meetings are distributed within 2 weeks and agreed actions are provided on conclusion of each meeting.
- Referrals are accurately recorded and monitored. Outcomes for each case are documented.
- A secure and restricted electronic database has been developed to assist accurate and timely recording of all allegations.
- Designated Officer attended Designated Teacher forum for Schools

### *Priorities for 2014 – 2015*

- Permanent recruitment to the Designated Officer position
- Develop a mechanism to acquire feedback and evaluation from service users and professionals.
- Develop a dataset for Allegations Management
- Promote guidance and procedures to organisations that have not referred to the Designated Officer; to include all religious establishments and denominations.
- Prioritise delay in the resolution of allegation investigations is to be undertaken

## **8. Child's Voice**

### **Corporate Parent Panel (CPP)**

#### **Children in Care Council (CiCC) Outcomes and Achievements 2014**

As evidence of the way in which partners 'hear the Voice of the Child' in their work, the following paragraphs provide an overview of the outcomes and achievements of the Children in Care Council throughout 2014. They detail specific projects that young people have been involved in and how their views have contributed to the development of the CiCC and the services they receive.

#### ***Children in Care website***

*Young people presented their action plan to the Corporate Parent Panel in November 2013 which included the development of a website specifically for Slough's looked after children and care leavers.*

- *The CiCC have been involved in all stages of the development of the site from the design to the content. Young people initially researched other similar sites to find out what information they offer and what information we should provide.*
- *Young people were involved in the launch of the website that took place at the 2014 award ceremony.*
- *Young people continue to be involved in the development of the site. One example of this is making the 'Staying Put' policy available to download from the site. - the group would now like to make a short film about the role of Slough's CiCC and use animation so that it can be viewed via the website.*

#### ***On-line looked after children's form***

*The Independent Reviewing Officer (IRO) service has consulted with the group about looked after children's reviews and what could make their reviews better.*

- *Young people felt that if the current booklet was made available as an electronic form, that this would be more appealing to young people and encourage them to complete it.*
- *Following the groups recommendation, a new on-line form was developed and has been piloted with a cohort of young people, including the CiCC. Young people have been involved in testing the new form and providing their views on the questions, instruction details and whether*



they would continue to use the on-line form or the existing paper booklet.

- Overall, young people recommended the on-line form for all future reviews but the form should have a printable option.  
- once the changes have been made to the new on-line form it will be available for young people to use via the children in care website.

## **Development of the children in care council**

### **Marketing**

During 2014, young people agreed to a new design for the CiCC branding.

- the purple image now appears on all documents that are produced for the CiCC.
- young people wanted to change from the traditional style of minutes to something more colourful that captured the main discussions and decisions made at their sessions.
- young people agreed that the main outcomes of their sessions should be made available on the children in care website so everyone can see what they do and this will also promote the importance of their group.

To engage all children and young people in the CiCC, the group wanted a designated area on the website for the CiCC to share details on getting involved, what the CiCC does and a link to the contact form for children and young people to share their ideas.  
- this was created and the group are continually involved in the development of this area.

At each annual award ceremony, the CiCC group always put together a short performance or presentation to showcase their achievements from that year. The group also suggested that a CiCC flier is put into each child/young person's pack.  
- this was arranged for the 2014 ceremony, to promote the CiCC and provide details on how children and young people can get involved.

### **Recognition**

- Young people attended Corporate Parent Panel in September 2014 and shared their request for a 'children in care council offer' which detailed what young people would receive for being part of the Children in Care group.  
- the 'offer' is now in place.  
- following the groups request for a residential workshop; this has been agreed and will be taking place towards the end of 2015.
- Young people's dedication and commitment to the CiCC is recognised and celebrated at each annual award ceremony.

### **Review of the Contact Centre**

This project was initiated by the young people having a general discussion about their contact and contact workers. The group all agreed that the equipment and décor was more suitable for younger children aged under 8. They also agreed that the centre needed to have areas that were more appealing and suitable for those older children and young people.

- The group began their review of the centre and its facilities at the beginning of this year by inviting the Contact Centre Manager, to their CiCC session. Young people were able to share their thoughts and comments direct to her. The project is now at a stage where the group have begun to create some artwork to display in the centre where they would like to base themselves as a group and transform a room, not only for their use, but for older teenagers that need a comfortable space for contact.  
- this project is still on-going.



### **Mind of My Own (MOMO) application**

The CiCC were involved in testing this app and were asked to share their feedback.

- Overall, the group liked the app but raised important questions, for example, the security of information, that needed to be investigated before we signed up to MOMO.
  - as MOMO is a form; a decision was taken that we would develop our own existing consultation system and trial this before purchasing the app.

### **Corporate Parent Panel (CPP)**

Members of the CiCC group currently attend each CPP to feedback and present on outcomes of their sessions and represent the views of all Slough's looked after children. Following December's CiCC session, the group decided that young people who would like to sit on the CPP should nominate themselves.

- Three young people nominated themselves to sit on the CPP.
- Young people also requested that the Chair of the CPP meet with them 30 minutes before a panel.
  - this arrangement is now in place.

### **Taster days to recruit new young people**

To engage more young people in the CiCC and ensure it is more widely represented, it was suggested to hold a number of taster sessions during the summer holidays, one in Slough and one in Kent. Young people would have time to relax with one another as well as take part in some consultative activities.

- Both days encouraged new young people to get involved.
  - as a result three new young people were recruited to the group and seven young people, currently placed in Kent, were able to get involved and find out more about the CiCC.
- Young people also created the 'CiCC offer' during this session. (see recognition below for details)

### **Other projects and consultations that the children in care council have been part of:**

#### **Annual Award Ceremony**

The group are involved in the planning of each annual event and also involved in the evaluation. Over the past few years, the event has flourished and this is due to young people's feedback.

- Young people really liked the fact they could relate to the speaker/celebrity as he had also experienced being in foster care.
  - young people agreed that the outstanding achievement award was a good idea and definitely should be arranged for the 2015 event.

#### **Young people's interview panel**

- Some members of the CiCC group were involved in the young people's interview panel to recruit the Chief Executive of the new organisation.

#### **Participation and engagement consultation day summer 2014**

- Young people took part in a day of activities as well as a consultation to find out about their experiences of being in care.
  - two young people, who took part in this day, then joined the Children in Care Council.

#### **Focus groups**

- Young people took part in a focus group for the Department for Education.

### **Youth Voice and Youth Parliament**

- *Young people took part in an activity to share their views on the Youth Voice; what should be offered to young people living in Slough and shared their comments on the branding.*
- *Following the Youth Voice group work, young people then took part in an information session to find out how they can get involved in the Youth Parliament either as a representative of the CiCC or via their secondary school.*  
*- one young person took up the opportunity to be part of the Slough Youth Parliament.*

## **9. Priorities for 2015 - 2016**

The detailed priorities for the LSCB in 2015-16 are contained in Appendix C. They can be summarised under four themes:

- 1. Theme 1: Evaluating the Impact of Early Help particularly for children:**
  - Involved in substance abuse or with mental health issues,
  - in families who have recently moved to Slough or
  - living in families where domestic abuse is a factor
- 2. Theme 2: Issues of Particular Public Concern – Child Sexual Exploitation (CSE) and Female Genital Mutilation (FGM)**
- 3. Theme 3: Developing the Capacity of Partners and the Board,** particularly regarding auditing of services and performance management, identifying risks, sharing information and hearing the voice of the child and professionals
- 4. Theme 4: Learning and Improvement from case reviews.**

**Appendix: A**

**Partner Agencies SLSCB Attendance**

<b>LSCB Executive Board</b>	<b>% of Attendance</b>
<b>Organisation:</b>	
BHFT	100
CCG	83
SBC	100
Primary Education	50
Secondary Education	67
Thames Valley Police	100
<b>Slough LSCB</b>	<b>% of Attendance</b>
<b>Organisation:</b>	
Adults Safeguarding	50
BHFT	100
CAFCASS	50
CCG	75
CSC (SBC)	100
College	75
HWPB	25
Healthwatch	0
Home Start	50
Housing (SBC)	50
Lay Member	75
LSCB SBC	100
NHS England	50
Primary Education	50
Probation	50
Secondary Education	50
Slough Borough Council	100
TVP	100
Voluntary (VOL)	50
YOT (SBC)	75

**Appendix: B**

**Ofsted Review of the effectiveness of the Slough Local Safeguarding Children Board:**

**Inspection date: 19 November 2013 – 11 December 2013.**

**The effectiveness of the SLSCB was judged “inadequate”**

<b>Priority and immediate action</b>	<b>Progress</b>
<p>Ensure all partner agencies are engaged in the delivery of the early help strategy that children and families have equal access to the services they need as early as possible.</p>	<p><b><i>The Annual Report shows the increasing commitment of partners to the work of the Board. Whilst this has progressed, it is anticipated that the establishment of the Slough Children’s Trust in Autumn 2015 will bring new clarity to partnership working and enable significant further progress in 2016..</i></b></p>
<p>Ensure that agencies take full responsibility for their roles as set out in Working Together to Safeguard Children (Department for Education 2013) and that they commit to multi-agency strategies and working groups, including sharing responsibility and resources where necessary.</p>	
<b>Other Areas for improvement</b>	<b>Progress</b>
<p>Include an evaluation of the effectiveness of arrangements for children who are missing from home and education in the LSCB annual report. This information should be accompanied by an overview of private fostering in order to help make decisions and plan service improvements.</p>	<p><b><i>An update regarding Child Sexual Exploitation and missing from home and education is included within this Annual Report.</i></b>  <b><i>An overview of Private Fostering arrangements is also included within the main context of the report</i></b></p>
<p>Complete and implement a pathway for young people at risk of sexual exploitation, which clearly outlines multi-agency responses and interventions, setting out how risk will be continually reviewed on individual cases.</p>	<p><b><i>Details of the work to improve partnership performance on Child Sexual Exploitation is included in detail within this Annual Report. The work includes the adoption of new pathways to ensure that cases are proactively managed</i></b></p>
<p>Improve auditing activity and focus on evaluating the quality of interventions in order to draw the key lessons for improving management decision-making and oversight on cases.</p>	<p><b><i>During 2014-15 Slough LSCB has struggled with this aspect of LSCB work. Although intentions to carry out multi-agency audits were good at the start of the year, staffing issues led to a lack of progress on bringing the plans to fruition. As a result, no multi-agency audits were completed in the first nine months of the year. However by the end of the year a process for carrying out such audits had been established and the first audit into section 47 cases had taken place. Further details of progress are within the report.</i></b></p>
<p>Ensure operational staff are included in multi-agency audits to provide the required expertise to ensure rigorous scrutiny. Individual agencies must own the findings of audits and use this information effectively to promote improvement.</p>	

## **Appendix: C**

### **Slough Local Safeguarding Children's Board Business Plan 2015-16**

Slough Local Safeguarding Children's Board (SLSCB) Business Plan 2015 -16 was agreed by Members of the Board on 19 March 2015.

Members of the Board are required to provide outcome performance measures on actions for which they hold lead responsibility.

The Business Plan incorporates the priority areas identified at the SLSCB Executive Meeting held in December 2014 and considered by Members of the SLSCB during the same month. It is designed to be concise and based on SMART principles. It is work in progress and Board Members are expected to amend or add to it when they meet.

This Plan replaces the 2013 -17 SLSCB Business Plan and the Board will revert to an annual planning cycle for the foreseeable future.

This Plan addresses four themes:

- **Theme 1: Impact of Early Help**
- **Theme 2: Issues of Particular Public Concern – Child Sexual Exploitation (CSE) and Female Genital Mutilation (FGM)**
- **Theme 3: Developing the Capacity of Partners and the Board**
- **Theme 4: Learning and Improvement**

**Slough Local Safeguarding Children's Board Business Plan 2015-16**

**Theme 1: Impact of Early Help**

<b>What is the issue</b>	<b>What will SLSCB do</b>	<b>Who will lead it</b>	<b>Received or Completed By/ When</b>	<b>How will we know the SLSCB action is effective</b>	<b>Outcome Performance Measures</b>	
<ul style="list-style-type: none"> <li>Working Together (WT) 2015 requires LSCBs to evaluate the impact of Early Help</li> <li>Early Help is Coordinated by Children &amp; Young People Partnership Board (CYPPB)</li> <li>SLSCB needs to understand how effective early help is and therefore needs to evaluate its impact</li> </ul>	<b>Monitor Progress on Early Help</b>	<b>Susannah Yeoman – Deputy Locality Director (Health)</b>	<b>Quarterly</b>	SLSCB discussions will assess the progress of Early Help and comments from the Board will be fed back to CYPPB for action	Professionals across the partnership appropriately apply the LSCB Threshold Document (April 2014)	
	Receiving from CYPPB and discussing regular reports of progress of the Early Help Project				There is a significant increase in the number of Early Help Assessments undertaken with good representation from all agencies. Early Help Assessments are appropriately stepped up or down	
	<b>Commission and consider the conclusions of evaluation work on the impact of early help on particular target groups of children</b>	<b>Chair of SLSCB Quality Assurance Group</b>				
	1. Adolescents involved in substance abuse and/or with mental health issues			<b>October 2015</b>	Evaluation work completed and action plans implemented by SLSCB or CYPPB as appropriate	DNA Rates Waiting Times A and E attendances National Indicators re Adolescent Drugs and Alcohol Service % of children who

**Theme 1: Impact of Early Help**

What is the issue	What will SLSCB do	Who will lead it	Received or Completed By/ When	How will we know the SLSCB action is effective	Outcome Performance Measures
					attend following action by professionals % of children who self harm % decrease in incidents of self harm Number of children referred to CAHMS Tiers 3 and 4
	2. Families who have recently moved into Slough		<b>March 2016</b>	Evaluation work completed and action plans implemented by SLSCB or CYPPB as appropriate	No's of New Families registering with GP CAF outcome data v length of residency
	3. Children living in households where Domestic Abuse (DA) is a known factor.		<b>December 2016</b>	Evaluation work completed and action plans implemented by SLSCB, CYPPB or Safer Slough Partnership (SSP) as appropriate	DA Incidents DA incidents with child in household Repeat DA incidents with child CAF Outcomes for DA Households MASH data re DA



Theme 2: Issues of Particular Public Concern – Child Sexual Exploitation (CSE) and Female Genital Mutilation (FGM)					
What is the issue	What will SLSCB do	Who will lead it	Received or Completed By / When	How will we know the SLSCB action is effective	Outcome Performance Measures
<ul style="list-style-type: none"> <li>Nationally and locally there is considerable public and professional concern about the risks to Children from Child Sexual Exploitation (CSE), Female Genital Mutilation (FGM) and Domestic Abuse (DA).</li> <li>SLSCB needs coordinate strategic multi-agency responses to these issues and evaluate the outcome of those services.</li> </ul>	<b>CSE:</b> <b>Coordinate the development of services addressing CSE by:</b>	<b>Simon Bowden – Supt Local Police Area (LPA) Commander</b>			<p>Children at risk of CSE are effectively identified and protected by a clear referral pathway</p> <p>Children who go missing are interviewed by an independent and skilled practitioner on their return</p> <p>Victims of CSE are appropriately and effectively supported</p> <p>Perpetrators are prosecuted</p>
	<ul style="list-style-type: none"> <li>Reviewing and implementing the multi-agency CSE Strategy</li> </ul>		<b>July 2015</b>	Strategy Approved by SLSCB Strategy used to decide activity by partnerships and agencies	
	<ul style="list-style-type: none"> <li>Reviewing the CSE Action Plan for Slough Agencies</li> </ul>		<b>July 2015</b>	Action Plan approved by CSE Strategic Group	
	<ul style="list-style-type: none"> <li>Implement the CSE Action Plan for Slough Agencies</li> </ul>		<b>March 2016</b>	Action Plan used to implement activity	

	<ul style="list-style-type: none"> <li>Evaluate the impact of CSE measures in specific cases through multi-agency audit</li> </ul>	<b>Chair of SLSCB QA Group</b>	<b>March 2016</b>	Outcomes for general public, CSE victims and perpetrators are achieved	
	<b>FGM:</b>	<b>Sarah Bellars – Director of Nursing</b>			
	Develop and implement a Slough Multi-Agency Strategy for FGM		<b>July 2015</b>	Strategy Approved by SLSCB and used to decide activity by partnerships and agencies	<i>Children at risk of FGM are identified and subject to a safeguarding referral pathway</i>
	Develop and implement a Multi-Agency Action Plan for FGM in Slough		<b>July 2015</b>	Action Plan approved by LSCB and referred to across relevant partnerships and operating safeguarding groups.	<i>Potential criminal activity is referred for criminal investigation</i>
	Evaluate the impact of FGM measures in specific cases through Multi-Agency audit		<b>March 2016</b>	Outcomes for general public, FGM victims and perpetrators are achieved	<i>Victims receive appropriate services</i>

Theme 3: Developing the Capacity of Partners and the Board					
What is the issue	What will SLSCB do	Who will lead it	Received or Completed By/ When	How will we know the SLSCB action is effective	Outcome Performance Measures
<b>Audits/Performance</b> SLSCB needs to be assured that safeguarding performance is following procedures, managing risks appropriately and achieving good outcomes for children. In addition to Multi-Agency auditing (see above) this is achieved by: <ul style="list-style-type: none"> <li>Monitoring performance information</li> <li>Discussing the findings of Single-Agency audits, and s11 audits within agencies.</li> </ul>					
	<b>Performance Monitoring</b> Working with CYPFB, develop and receive regular performance reports containing relevant analysed data	<b>Chair of SLSCB Audit Group</b>	<b>Quarterly</b>	SLSCB receives and discusses regular performance reports which inform decision-making and actions by the Board and Executive	Risks identified, decisions made and actions initiated as a result of performance reports  <i>The Board receives regular performance information from all partners</i>  <i>All partners contribute to the work of the Board by means of regular attendance at Board and sub group meetings and contributions to actions</i>
	<b>Single-Agency Audits</b> SLSCB receives the findings of performance audits carried out by single agencies as part of their own assurance processes	<b>Chair of SLSCB Audit Group</b>	<b>Regularly as per audit timetable. Audits completed; 1)Strategy meetings and s47 enquiries(March</b>	Findings are received and discussed.  Themes from audit findings are used to develop actions for partners	Risks identified, decisions made and actions initiated as a result of single agency audit reports

			2015) 2) CSE (June 2015) Programme for the year has been sent to partners		
	<b>Section 11 Audits</b>				
	SLSCB participates in joint s11 processes with other LSCBs and, if appropriate, requires other s11 audits to take place	<b>Chair of SLSCB Audit Group</b>	<b>As per agreed timetable</b>	Section 11 Audits reports and progress on action plans are received and discussed by SLSCB	Risks identified, decisions made and actions initiated as a result of s11 audit reports
<b>Impact of Multi Assessment Service Hub (MASH)</b>	<b>Evaluation of Mash Impact</b>				
SLSCB should ensure that MASH arrangements are reducing risk to children	SLSCB carries out or receives a report evaluating Slough MASH against its desired outcomes	<b>Simon Bowden</b>	<b>January 2016</b>	Evaluation Report received and used to decide further MASH improvements	<b>MASH has working arrangements that enable more effective risk assessment and information sharing.</b> % of repeat referrals No of s47 enquiries per 10 k of the population under 18 % of s47 enquiries that led to Initial Child Protection Conference (ICPC) No of children subject to a CP Plan per 10k of the population
<b>What is the issue</b>	<b>What will SLSCB do</b>	<b>Who will lead it</b>	<b>Received or Completed By / When</b>	<b>How will we know the SLSCB action is effective</b>	<b>Outcome Performance Measures</b>
<b>Child's and Professional's Voice</b>					

In keeping with its assurance framework, SLSCB should ensure that the child and professionals' 'voice' is used to improve service delivery	SLSCB ensures that auditing and evaluation reports include analysis of the contribution that the child's and professionals' voice is making to service delivery	<b>Chair of SLSCB Audit Group</b>	<b>As per agreed audit timetable</b>	The voice aspects of audit reports are used to decide future actions by the Board and agencies	Evidence of Childs Voice leading to improved outcomes
<b>Risk Register</b>					
In order to manage strategic safeguarding, SLSCB needs to ensure that strategic decisions fully consider risks to children.	Develop and use a strategic risk register	<b>Phil Picton</b>	<b>July 2015</b>	SLSCB will regularly review the risks and their mitigation and use the risk register to assist in strategic decision-making.	Evidence of outcomes changing as a result of actions taken on specific risks

**Theme 4: Learning and Improvement**

What is the issue	What will SLSCB do	Who will lead it	Received or Completed By / When	How will we know the SLSCB action is effective		Outcome Performance Measures
SLSCB needs to ensure that agencies fully learn from: The Serious Case Review (SCR) commissioned in January 2015	Identify appropriate action for improvement from the SCR findings	<b>Kitty Ferris Assistant Director Children &amp; Young People</b>	<b>September 2015</b>	Actions will have been identified		
	Implement or monitor the implementation of these SCR actions	<b>Kitty Ferris</b>	<b>December 2015</b>	Actions will have been implemented		
	Evaluate the impact of the SCR actions	<b>Kitty Ferris</b>	<b>March 2016</b>	Outcomes of actions will have been evaluated and discussed by SLSCB		
SLSCB needs to ensure that the lessons are learned from the Significant Incident Learning Process (SILP) Case Review which reported in January 2015	Identify appropriate action for improvement from the SILP findings	<b>Kitty Ferris</b>	<b>July 2015</b>	<b>Learning events scheduled for July 2015 and September 2015</b>		
	Implement or monitor the implementation of these SILP actions	<b>Kitty Ferris</b>	<b>September 2015</b>	Actions will have been implemented		
	Evaluate the impact of the actions from the SILP review	<b>Kitty Ferris</b>	<b>December 2016</b>	Outcomes of actions will have been evaluated and discussed by SLSCB		
SLSCB should understand the impact of the Single and Multi-Agency training programme on performance	SLSCB will consider evaluation reports coming from the East Berks Strategic and Operational training groups, using them to decide the future direction of Multi-Agency training	<b>SLSCB Business Manager</b>	<b>October 2016</b>	Evaluation reports will have been discussed, with appropriate decisions about future development		<b>Agencies will have completed Training Needs Analysis (TNA)</b>  <b>Agencies will ensure</b>

**Theme 4: Learning and Improvement**

What is the issue	What will SLSCB do	Who will lead it	Received or Completed By / When	How will we know the SLSCB action is effective		Outcome Performance Measures
						that learning outcomes are incorporated into practice
	SLSCB will receive reports from single agencies explaining the impact of their training programmes and plans for future development.	<b>SLSCB Business Manager</b>	<b>March 2016</b>	Evaluation reports will have been discussed, with appropriate decisions about future development		