Annual Report

Slough Local Safeguarding Children's Board

2015 -16

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Introduction: Slough LSCB Independent Chair

The vast majority of children in Slough lead safe healthy lives and are well cared for. However, as in all communities, a minority of families need additional support at times and a number of children require specific action by agencies to ensure that they do not suffer abuse or neglect. It is the role of the Safeguarding Board to coordinate these approaches to intervening in families and to assess how effective actions have been, so that improvements can be made. More about the structure and membership of the Board can be read in Appendix A.

During 2015-16, the Board had a challenging time. As it started the year, its lead partner, Slough Borough Council, was transferring Children's Services into a separate independent organisation. This was launched in October 2015 as the Slough Children's Services Trust. As this change approached, a number of key players who ensured the efficiency of the Board left Slough. These included the Board's manager, its administrator, the Child Sexual Exploitation Coordinator and the council's lead for quality assurance work. These changes very significantly hampered the progress the Board had planned to make during the year.

Very shortly after the start of the Trust, Ofsted inspected Children's Services and the LSCB and both were judged as inadequate. Whilst this judgement was not surprising bearing in mind the structural changes and previously well documented weaknesses, it was however disappointing that the improvements in the Board's work were insufficient to improve its grade. Ofsted did acknowledge the improving situation for the Board and the early positive impact of the new Trust. Six recommendations were made for the Board to act on and these are set out later in this report.

Since the inspection, which was published early in 2016, Board partners have made a number of improvements as the staffing issues have been resolved. For example, the Board has completed an effective multi-agency audit of cases where families are experiencing domestic abuse; it is regularly receiving performance information from partners; a new partnership approach to child sexual exploitation has become normal working practice; the 'threshold' document has been revised; local communities are strongly engaged in new initiatives on female genital mutilation; and partners are implementing a Multi-Agency Safeguarding Hub (MASH).

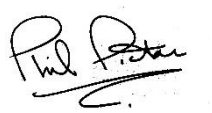
As I write, the Board has agreed new arrangements for partnership working which replace the current structure with a Slough Safeguarding Children's Partnership. This is building on the recommendations of the Government's national review of LSCBs. The new structure should enable a stronger focus on operational safeguarding and give the Chair the opportunity to work much closer with professionals who work with children across Slough. Bearing in mind that in last year's Annual report, I criticised partners for their lack of a 'can-do' culture, Board members' willingness to take on new ways of working gives optimism for the future.

However, there are still significant steps which need to be taken to ensure that the Board's work contributes effectively. These challenges include:

- Ensuring that safeguarding vulnerable children is an explicit priority for all partners, not just in published documents but in all aspects of day to day decision-making. This is particularly important for the Borough Council now that it is commissioning rather than providing Children's Services

- Continuing to develop and review joint working arrangements, such as MASH to ensure that they deliver improving services for children and families
- With constraints on budgets, it is important that partners challenge each other to develop robust arrangements for operational services. Risks to the resilient provision of frontline safeguarding services, such as health visitors, need to be explicitly discussed and assessed before changes are made in the pursuit of efficiencies.

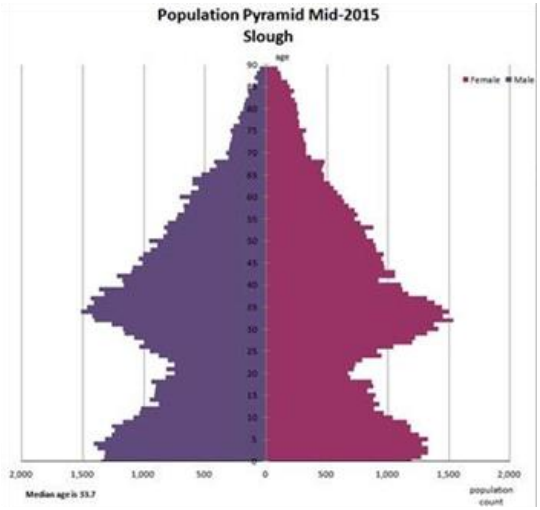
This report is my last in Slough, as I have decided to stand down so that a new Chair giving more time on the ground in Slough can lead the new Slough Safeguarding Children's Partnership. I leave with regret that the Board has not progressed as quickly as I had hoped. However, new approaches are in place both for the Board and key partners and these are showing real progress in delivering services to children. The Board manager and her administrator, in supporting the partners in their work, has assisted the progress of the Board. I am very grateful for their efforts during a particularly challenging year.



Phil Picton,
Independent Chair,
Slough Safeguarding Children Board

What sort of Population lives in Slough?

Estimates for 2015 reveal a total Slough population of **146,000**, of which 28% are under 18 (40,500). Slough shows a distinctively different age pattern to the average in Great Britain - with many more children and young working age adults (aged 25 to 40), and far fewer older people than normal.



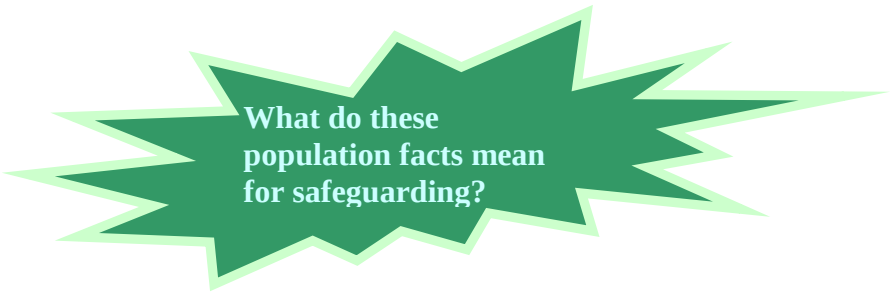
How the population is changing?

Between June 2014 and June 2015:

- Slough experienced a **total resident increase of 0.8%** slightly below the England increase – in the past Slough has grown more quickly than other areas.

- Slough's **birth rate** (177.5 per 10,000) is much higher than England (121.9) and the South East (115.7).

- Slough's **death rate** (56.0 per 10,000) is much lower than England (91.5) and the South East (92.2).
- International migration into Slough was high (58.1 per 10,000) compared with Great Britain (53.0) and South East England (40.0). Slough lost more residents to other parts of the UK than it gained from them (minus 99**.5** per 10,000**)**. The overall impact was a net migration of minus 41.4 per 10,000 residents**.** These changes are important as **the migration flows in and out of Slough are much higher than for Great Britain or region as a whole**.



- With this young, changing population, Slough is a vibrant, diverse community. Whilst this makes it a rewarding place to work with children and families, it also brings challenges for collecting and sharing information about families who are arriving or moving on.

- This is reflected in the words of a primary head teacher – " If you look at who sits on the chairs in a class of thirty 5 year-olds, only three of them will be on their chairs by the time they reach 11 and many of the chairs will have had more than two children using them!"

- All agencies in Slough have to work hard to keep up with such changes.

Further information about population in Slough can be accessed via:

The Slough Story March 2016

Slough Grapevine

Summary of key data on Safeguarding Children in Slough

Performance data is given based on the year 1 April 2015 to 31 March 2016.

Contacts
In the year 1 April 2015 to 31 March 2016 there were 11,146 contacts made to Children's Social Care.

Referrals
In the year 1 April 2015 to 31 March 2016 there were 2,779 referrals, this is 501 more referrals than the previous year (2,278 on 31 March 2015).

The rate of referrals per 10,00 0 – 17 year old population was 697.1 which is higher that the England average (585) and the Statistical Neighbour average (548).

Of the 2,779 referrals received in the year 97.6% led to an assessment being undertaken. This is above both the Statistical Neighbour (92%) and England (86.6%) average.

Repeat Referrals
The % of referrals that were repeat referrals was 18.5% on 31 March 2016, this was lower than the % on 31 March 2015 (20%).

Single Assessments
In the year 1 April 2015 to 31 March 2016 2,686 single assessments were started, and of these 81.8% were completed within 45 working days.

Section 47 Investigations
In the year 1 April 2015 to 31 March 2016; 918 S47 Investigations have been undertaken, of these 356 led to an Initial Child Protection Conference (38.8%). This is in line with Statistical Neighbours (38%) but below the England average (45%).

Initial Child Protection Conferences in Timescales
In the year 1 April 2015 to 31 March 2016 a total of 345 ICPC's took place, 286 of these (82.9%) were held within 15 working days, this is above the Statistical Neighbour (64%) and England (75%) average.

Children with a Child Protection Plan on 31 March 2016
On 31 March 2016 there were 226 children who were subject to a Child Protection Plan. This is a rate of 56.7 per 10,000 0 – 17 year population which is above the Statistical Neighbour (49.5%_ and England (42.9%) average.

Children in Care
On 31 March 2016 there were 185 children who were looked after. This is a rate of 46.4 per 10,000 0 – 17 year old population which is significantly below the Statistical Neighbour (58.7) and England (60.0) rates.

Placement Stability (this is determined by the length of time in placement and the number of placement moves)
On 31 March 2016; 14.1% children had experienced three or more placement moves within the last year, this is above the Statistical Neighbour (11%) and England (10%) average.
On 31 March 2016 63.0% of children in care under the age of 16 had been in a stable placement for two and a half years, this is slightly below the Statistical Neighbour (65%) and the England (67%) average.

Health and Dental Checks for Children in Care
On 31 March 2016 92.95 of children in care were up to date with all their health checks, this is above the Statistical Neighbour (84%) and England (87%) average.

% children in Care Adopted or Granted a Special Guardianship Order
On 31 March 2016 29.4% of children in care had been adopted or granted a Special Guardianship Order, this is an improvement on the previous year (23.3%).

Parental Factors
The most common parental factors in all cases are:
- A Known history of domestic abuse (victim)
- Known history of domestic abuse (perpetrator)
- Parental mental health
- Substance abuse
- Alcohol abuse.

Private Fostering
Between 1 April 2015 and 31 March 2016 2 children were recorded having private fostering arrangements.

What did the Board learn from significant external inspections in 2015?

a) November 2015 Ofsted Inspection of Children's Services and the LSCB

Ofsted reviewed the effectiveness of the Slough Local Safeguarding Children Board from 24 November 2015 - 17 December 2015. Its findings, which are incorporated in the SBC Children's Services Ofsted report published on 17 February 2016. Ofsted rated the Board as 'Inadequate' summarising its findings as:

"The LSCB has not made sufficient progress against the recommendations from the previous inspection in 2013. The independent chair has brought increased focus and challenge to work of the Board. However, the LSCB has not been sufficiently effective in scrutinising or challenging the significant weaknesses in the delivery of front-line services to children in need of help, protection and care. The poor engagement of some partners has been a barrier to progress. The LSCB has failed to strengthen the review of practice through case audits, has not ensured that thresholds are regularly reviewed and has not developed arrangements to evaluate and report on the experiences of children missing from care, home and education.

The threshold document is no longer compliant with statutory guidance and, significantly, does not reflect the current arrangements in place across the partnership. The Board has not reviewed the quality or effectiveness of threshold decision making.

Although some progress has been made by the LSCB in recent months in developing more effective arrangements to oversee and scrutinise data and audit front-line practice, it is yet to provide rigorous evaluation and analysis of local practice and performance.

The strategic child sexual exploitation subgroup has overseen some proactive work such as awareness raising with local businesses. However, overall, the Board has not been effective in reviewing front-line practice in response to children missing and those at risk of sexual exploitation. As a result, it has not assured itself that these children are effectively safeguarded.

The female genital mutilation task and finish subgroup has made good progress, for example in understanding prevalence, developing a draft strategy and pathways and undertaking an audit of cases.

The Board's training programme has not been formulated based on a needs analysis. Although there is good take-up of training, the Board has not evaluated impact or assured itself that training leads to improvements in practice and service delivery.

There are no lay members on the LSCB currently and therefore it is not duly constituted.

The chair is actively seeking a sufficient multi-agency funding arrangement for the work of the Board, but to date a funding formula has not been agreed. This is required in order to ensure that the Board is able to deliver its core functions. "

Ofsted recognised good work by the Board, particularly in reviewing the deaths of children and its progress on the risks of children being subjected to Female Genital Mutilation (FGM)

The report made six recommendations for improvement which are set out below. In order to prioritise the recommendations in its work,

What does the Ofsted report mean for the Board?

- The Board is using the six Ofsted recommendations as the themes around which the 2016 -17 SLSCB Business Plan is structured.
- All Partners take responsibility and are committed to act on all Ofsted recommendations to the Board is effective in ensuring Children and Young People who live in Slough are protected from harm.

How has the Board actioned its six Ofsted Recommendations?

Ofsted recommendation 1: "Revise and Implement Multi – Agency Threshold Guidance"

In response, Slough LSCB revised its Multi-Agency Threshold Guidance which reflects Slough's new operational arrangement provided by Slough's Children's Services Trust and addresses safeguarding themes; Female Genital Mutilation; Child Sexual Exploitation and Missing Children and Radicalisation.

The revised guidance was agreed by the Board in March 2016; disseminated to all partner organisations and is available to access on the LSCB website. In addition, Early Help delivered training to launch the revised guidance.

During the coming year the impact of the revised threshold document on decision-making by professionals will be assessed through the quality assurance audits discussed by the Board (see below)

Multi – Agency Safeguarding Hub (MASH)

Effective information sharing is an essential and statutory requirement of safeguarding children and enables earlier identification of risk. To improve this information sharing and provide a partnership response to threshold discussions, the partners in Slough have agreed to implement a Multi-Agency Safeguarding Hub (MASH).

This will involve a core group of key agencies i.e. Police; Health; Children's Social Care; Early Help; Primary Mental Health, Drugs and Alcohol services; being co-located in a secure environment within Slough Police station where they will carry out the collation and analysis of information in relation to child safeguarding concerns. Further services have agreed to join the co-located core group twice per week e.g. Youth Support Service and Children's Centers.

The MASH will start operating on 4 July 2016 with a view to being completely in place by the 26 September 2016.

Ofsted recommendation 2: "Establish a programme of effective monitoring and quality assurance of multi-agency safeguarding practice. This should include analysis of performance information, section 11 audits and internal partner agency audits, as well as multi-agency auditing led by the LSCB"

A reconstituted Quality Assurance sub-committee for the Board was established in September 2015.

Single Agency Audits

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 of the Board will receive the results of single agency audits and enable partners to understand the areas for improvement in each other's work. This Group will escalate issues and flag risks to the Board as appropriate.

Multi Agency Audits

At the time of the Ofsted visit, the new Quality Audit Group was carrying out its first multi-agency audit and this progress was recognised in the inspection report. However, as the audit had not been completed and the Board could not show evidence of learning from its findings, Ofsted understandably was left with questions about the Board's multi-agency audit process.

Domestic Abuse – Multi-Agency Audit

During winter 2015, all key partners took part in a multi-agency audit of Domestic Abuse cases involving children.

Weaknesses and Strengths within the System

Actions to address areas of weaknesses and concerns were taken during the audit, invariably by members whilst they conducted the audit from their respective organisations. This means the QA audit meetings often received feedback on actions already taken. Areas of good practice were also identified.

- The outcome of the DA audit would be to ensure a minimum standard and guidelines are available to use in all cases of Domestic Abuse
- The DA audit links closely with the recommendations of a local Domestic Homicide Review and is being used by the local Safer Slough Partnership to improve the partnership approach on this topic.

The approach used for the audit was experimental but effective. This included reviewing case studies, members preparing before each meeting and agencies proactively taking action in between meetings. The commitment to regular meetings enabled the group to maintain a successful momentum. It is likely that this pattern will continue for successive audits.

Following a meeting with the Independent Chair of the Board, an option going forward to improve the speed and efficiency of audits is to first agree some minimum standards/guidelines to which all agencies would be expected to adhere when dealing with a particular issue. These would be agreed prior to each audit and used to evaluate cases.

A new programme of potential multi-agency audits has been identified for 2016/17 which will include an audit of the effectiveness of partner working on Child Sexual Exploitation and also an examination of "The welfare and safety of children living with parent(s) and carers with mental ill health"

External inspections and Audits of Partner Organisations

The Board receives assurance about the response of individual partners to any safeguarding risks identified in their respective external inspections such as CQC, Ofsted and HMI inspections

Ofsted Inspection of Children's Services – November 2015

Alongside the LSCB inspection by Ofsted, the children's services being provided by the Borough Council and the new Children's Trust were inspected in November 2015. These services were found to be inadequate. The Board has been closely involved in the development of action plans to address the weaknesses identified by Ofsted and continues to monitor the improvements of both the Council and the Trust.

PEEL – Police effectiveness 2015 (Vulnerability)
An inspection of Thames Valley Police

As part of its annual inspections into police effectiveness, efficiency and legitimacy (PEEL), HMIC's effectiveness programme assessed how well forces keep people safe and reduces crime. Within this programme, HMIC's vulnerability inspection examined the overall question, 'How effective are forces at protecting from harm those who are vulnerable and supporting victims?' We have considered in depth how forces respond to and support missing and absent children and victims of domestic abuse, and assessed how well prepared forces are to respond to and safeguard children at risk of sexual exploitation.

Summary of findings:

Thames Valley Police provides a good service in identifying vulnerable people and generally responds well to them. The force has made good progress since last year and has improved how it tackles domestic abuse. It is working hard to set up multi-agency safeguarding hubs covering the whole force area to provide more effective joined-up services with partner organisations to better safeguard children and vulnerable adults. We found a strong commitment in Thames Valley to improving its services to protect vulnerable people and police officers and staff understands and share this commitment. The force has invested extra resource in its specialist services that identify and support those who are vulnerable and keep them safe. However we found some lack of capacity in the child abuse investigation team which means that the force may not be able to continue to provide the quality of service it aspires to for this very vulnerable group of victims.
The force has made a good start in ensuring that it is well-prepared to tackle child sexual exploitation and is building on this initial approach with its partners.

To access the full report: https://www.justiceinspectorates.gov.uk/hmic/wp-content/uploads/police-effectiveness-vulnerability-2015-thames-valley.pdf

Short Quality Screening of youth offending work in Slough

The inspection was conducted from 23-25 March 2015 as part of the HMIP's programme of inspection of youth offending work.

Context

The aim of the youth justice system is to prevent offending by children and young people. Good quality assessment and planning at the start of a sentence is critical to increasing the likelihood of positive outcomes. The HMIP examined 14 cases of children and young people who had recently offended and were supervised by Slough Youth Offending Team (YOT). Wherever possible, this was undertaken in conjunction with the allocated case manager, thereby offering a learning opportunity for staff.

Summary

The published reoffending rate for Slough was 37.3%. This was worse than the previous year and worse than the England and Wales average of 36.1%.
Overall, we found that staff engaged well with children and young people and their parents/carers.
Staff worked well to address individual needs to help children and young people to meet the requirements of their sentence. However; the Inspectors were disappointed to find that, following
recommendations from the previous inspection in 2011, there still remained considerable scope for improvement in work to protect the public and safeguard the child or young person. Management oversight needed to be more effective and robust to improve both the quality and consistency of the work.

Key strengths

- Children and young people and their parents/carers were engaged well in the initial assessment and planning processes.
- Initial plans to reduce the likelihood of reoffending had focused objectives which were meaningful to the child or young person, and reflected the factors linked to the risks of reoffending identified in the initial assessment process.
- Good effort was made by case managers to identify and understand diversity factors and barriers to engagement. They also gave attention to health and well-being outcomes for children and young people, insofar as this may act as a barrier to successful outcomes from the sentence.

Areas requiring improvement

- Case managers should review plans to help reduce the likelihood of reoffending in a more thorough and timely manner, so that they remain accurate and up to date.
- Assessments and plans to manage risk of harm posed by the child or young person to the public need to take account of all relevant information, the actual or potential harm to victims, and should anticipate potential changes in risk of harm, so that the public are protected.
- Case managers should ensure that assessments and plans to manage safeguarding and vulnerability take account of all relevant information, including risks to the child or young person through their own offending or behaviour, so that children and young people are protected.
- More account should be taken of the needs of victims in order to ensure that appropriate action can be taken to manage the risk of harm to them.
- Management oversight should be more consistent and more robust, including active management and sign off of relevant assessments and plans, and there should be processes in place to ensure these remain current and are of good quality.

The Youth Justice Board commented favourably on the subsequent action plan presented to the Board in response to the SQS inspection.

Section 11 Audits

The Pan Berkshire Section 11panel supports six Berkshire LSCB's to oversee the Section 11process for all Berkshire organisations. It is led by Berkshire Healthcare NHS Foundation Trust on behalf of Wokingham LSCB.

For the period of 1 April 2015 and 31 March 2016, Section 11 audits were presented to the panel by the following organisations:

September 2015

- South Central Ambulance Service
- British Transport Police
- Berkshire Healthcare Foundation Trust
- Royal Berkshire Foundation Trust

December 2015

- Emergency Duty Team
- Thames Valley Police
- Probation

Mach 2016

- Broadmoor Hospital
- CAFCASS
- Thames Valley CRC

- Thornford Park Hospital

Emerging Themes:

- **The voice of the child:** Evident in some that the voice of the child is gained through requesting young people's views in the form of a survey in order to capture the voice of the child, need to ensure all are gaining.
- **Training.** GP training was identified as an issue. It was acknowledged that most staff have received safeguarding training. It was acknowledged that this is the primary care function of the CCG. There are good relations with GPs. Section 11 tool is a sense check to remind GPs of their requirements. It was highlighted that good visibility is a key strategy between the Local Authority and partners, as it was reported that some GPs say they have limited contact with their Local Authority.
- **Supervision.** A formal supervision policy is not evident in all organisations and it was identified that this should be more structured.
- **Training**. For lay members of the 2 CCG's it was reported that lay members receive safeguarding training but queried how they ensure they follow procedures.

Slough Borough Council's Section 11 Audit

In addition to the work of the cross border Section 11 panel, in the winter of 2015, Slough Borough Council carried out a Section 11 audit examining all of the services, including:

- Chief Executive's Directorate;
- Customer and Community Services;
- Wellbeing Directorate);and
- the Regeneration, Housing and Resources Directorate

An action plan has been developed to address any areas for improvement and this plan has been discussed at the Safeguarding Board. The findings of the report were presented to a public meeting of the Council's Overview and Scrutiny Committee in July 2016.

Slough Schools Section 175/157 audit

During 2015-16 a total of 23 schools submitted safeguarding Reports. A summary of the findings of these reports was discussed at the Safeguarding Board

The report template currently in place is limited and restricted with regards to the information it requests and its format. The outcomes and recommendations will reflect the current style of the reporting template.

Summary of the findings from the reports submitted were:

- Policies and Procedures in place varied across all schools;

- Basic Awareness Training for all staff varied. In particular, Governors including the governor designated safeguarding lead; Volunteers; Caretakers; Technicians were not consistently trained in Basic Safeguarding Awareness;

- Compliance with statutory Guidance "Keeping Children Safe in Education" 2015 where it states Governing Bodies should ensure that **"all staff in schools and colleges read at least part one of this guidance"** needs to be embedded;

- "Guidance for Safer Working Practice for Adults who work with Children and Young People in Education Settings needs to be adopted"

Feedback from Schools

- Schools are concerned they receive very little feedback from Children's Social Care once a referral is made;

- Schools feel a significant amount of time is required to manage attendance at Children in Need meetings; and

- Schools have concerns regarding the level of medical support children receive either within school or as a result of school referrals, particularly in relation to Child and Mental Health Service (CAMHS) and Special Educational Needs (SEN).

SLSCB Actions:

- Prior to any future Section 175/157 School audits, there is a need to significantly revise the current reporting template

- Future audit requests need to expand to incorporate all schools including; Independent and Free Schools

- The process and protocol to request and receive completed audits from schools needs to be clarified and made very clear to all schools

Ofsted Recommendation 3: Take action to strengthen SLSCB's oversight and scrutiny of the effectiveness of the local multi-agency response to children at risk of exploitation including CSE and Missing.

Child Sexual Exploitation (CSE) and Missing Children

The Child Sexual Exploitation & Trafficking SLSCB Sub-Group which meets on a 6 weekly basis has been instrumental in driving much needed change in tackling child sexual exploitation and trafficking in Slough. As a result, the main priorities of the sub-group have significantly shifted to reflect a better understanding of the CSE profile in Slough. The activities of the subgroup now focus on enabling a shared awareness of CSE and an understanding of the CSE Pathway.
These include:

- Reviewing the CSE & Trafficking Strategy and action plan, as well as developing the Missing Strategy and Action Plan. Fundamental to achieving the objectives set in the CSE & Trafficking Strategy is a commitment from Slough LSCB to building a shared understanding of the CSE and trafficking profile in Slough and risk linked to missing from home or care incidences across all agencies as well as sectors of the community to ensure the wellbeing of all children;

- Reviewing the CSE Sub-Group membership across statutory and third sector organisations to enable increased investment in multi-agency working;
- Reviewing the membership of the CSE Operational Group – Sexual Exploitation & Missing Risk Assessment Conference (SEMRAC) to enable effectiveness in mapping the CSE Problem Profile in Slough, as well as sharing of intelligence in order to increase disruption of CSE and reduce number of children who go missing.
- Multi-agency training to increase confidence in identifying CSE in Slough as well as take action to support children at risk of CSE
- Development of a Self-Assessment Toolkit as a supportive tool that enables agencies to reflect on their processes in relation to Child Sexual Exploitation, in order to highlight their strengths and identify any weaknesses. This is a new area which will require immediate implementation and robust monitoring by the CSE & Trafficking sub-group.

The Ofsted inspection noted a number of areas of improvement required, to enable a responsive approach to CSE & Trafficking in Slough. Of particular importance was the need to ensure that all children reported missing are offered a Return Home Interview and risk assessed. The following actions have been taken in response:

Response to Children Missing from Care and Home

A total of 267 children were reported missing from care and home during the 2015/2016 Statutory year. 127 of these children were female and 140 were male. The ages of the children ranged from 7 to 17 years.

From October 2015, all children missing from care and home have been offered an Independent Return Home Interview. Return Home Interviews for children missing from Slough are now completed by Young People's Service Targeted Youth Workers. Information from Return Home Interviews is shared with Police and used to further assess risk as well as provide support and help to reduce missing vulnerabilities. From October 2015 to 31st March 2016, a total of 135 Return Home Interviews have been completed.

Children Looked after and placed out of area now receive independent Return Home Interviews completed by National Youth Advocacy Service. The findings are shared with police forces in the placement areas and used to address vulnerabilities as well as assess suitability of placement. Where a concern is identified, the child is linked with an advocate who can continue supporting them.

Where CSE is identified as a concern, following the missing incident, a CSE Risk Indicator Tool is now being completed.

Children Missing Education

As part of the CSE & Trafficking subgroup, Cambridge education are reviewing and monitoring children missing education, including young people Not in Education, Employment and Training, to ensure they are quickly identified and support is offered. Where CSE is identified as a concern, within this cohort, risk assessments are completed.

Response to CSE Problem in Slough

Slough has taken decisive action to ensure that the extent of CSE is known. This is done through the CSE Operational Group, SEMRAC which meets on a 4 weekly basis. On

average 20 – 25 children are discussed in panel on a monthly basis. 7 out of 25 children are male children whose ages range from 14 to 17. This includes, mapping the vulnerable children's profiles, including children with repeat missing episodes, offender profile as well as a shared knowledge and understanding of CSE places of Interest. Furthermore, the panel also provide information on services that children can access across Slough.

Information on cross border concerns and issues are shared in panel and with other boroughs and local authorities across Pan-Berkshire and other neighbouring local authorities and police forces. Although this is still in its infancy, there is a shared understanding of the emerging CSE Profile which at present follows a range of known CSE models.

Permanency in CSE Staffing

The Safer Slough Partnership have accepted the need to have a permanent CSE Coordinator whose role will mainly focus on driving the CSE activities outlined in the action plan. As a result of this, decisions have been made, with funding identified, for a permanent CSE Coordinator to be appointed and take up post from July 2016. The CSE Coordinator will sit within Safer Slough Partnership alongside domestic abuse. The arrangement for a permanent CSE Coordinator, a role separate from the CSE Manager, will enable all strategic elements of CSE to be progressed in a timely manner, as well as enable the strategy to be embedded. Consistency and sustainability is key in this decision

Intelligence Sharing

The development of a robust CSE profile is inextricably linked with timely intelligence sharing with police. Training has been delivered and continues to be delivered to all agencies across Slough to enable better intelligence sharing in order to effectively tackle CSE, missing vulnerabilities and trafficking. Feedback from Thames Valley Police Force Intelligence indicates an increase in CSE intelligence shared. However, this is not sufficient as importance of intelligence sharing is not fully understood and embedded across all agencies.

CSE Training

Completion of the CSE Risk Indicator Tool by each agency is variable. Confidence in undertaking a CSE Risk Indicator Tool as well as understanding the CSE Pathway has been identified as a major concern which requires action to enable effective tackling of CSE in Slough. The CSE Sub-group has identified training and awareness raising as a key area to tackle in order to enable all agencies to understand the CSE Pathway. The following shows reported training activities in Slough for the 2015/16 financial year:

Slough Children's Services Trust

A total of 65 staff members within the Trust attended mandatory CSE Awareness Training delivered by the CSE Coordinator. There are half day sessions planned to train staff on how to complete the risk indicator tool and how to share intelligence in order to increase disruption chances. 1:1 training on how to complete the Risk Indicator Tool has been delivered to 30 members of staff within the Trust.

Slough Borough Council Licensing Sub-Group

5 staff members from the Licencing Team completed the Safeguarding Children – Refresher Level 1 e learning training. All members in this team have previously completed NWG online CSE Training.

The Licencing Sub-Group have delivered CSE awareness training to 15 main representatives from the Taxi Union, private Hire Drivers Association, Private hire Operators and Taxi trade. The representatives have also received Intelligence sharing training delivered by Thames Valley Police Force Intelligence. There are plans underway to train 900 licence holders.

Thames Valley Police – Slough

CSE / Missing Persons (LDO030) – 2783 people completed this course between June 2013 and March 2015. Training participants included Patrol PCs and Sergeants, Neighbourhood PCs and Sergeants and PCSOs, Specials, Local CID, Custody and some units within Force CID (e.g. DAIU)

PVP SaVE (LDO084) – This package doesn't explicitly look at CSE but looks at vulnerability and exploitation in a wider context. At present 2867 people have either completed the course or are enrolled to attend between January and June 2016. The audience is Patrol PCs and Sergeants

Neighbourhood PCs and Sergeants and PCSOs, Local CID, Roads Policing, Custody, Front Counters and some units within Force CID (e.g. CSI, DAIU)

Public Protection – Missing Daughter (PB3411) – This is the e-learning module that covers CSE. To date 3139 people have completed this module. The audience for this package is CAIU, Custody, DAIU, Investigators, Force CID DCs / DSs, Local CID DCs / DSs, Neighbourhood PCs and PSs, Patrol Team PCs and PSs, PCSOs, Roads Policing, Specials.

National Probation Service (NPS)

There has been no formal training in the last year - all staff completed the Chelsea's Choice presentation during the 2014/2015 statutory year. Within Probation Service, Any case discussions/concerns regarding CSE are routinely discussed with managers and reflective discussions take place regarding concerns and how to manage the risk of the offender and protect the victim.

The National Probation service in Slough routinely share information with the Police re any individuals we are concerns -victim and perpetrator and all staff are fully versed in how to do this. All CSE cases - at report stage and throughout the sentence at regular intervals are discussed with the team within NPS who specialise in working with sexual offenders who provide guidance and advice throughout with regards to the risk management of the case. Any learning from the CSE group, serious case reviews is routinely shared with the team in team meetings to ensure that that they are up to date with any developments and changes in legislation and practice.

Youth Offending Team

All members of the Youth Offending Team undertook training in 2014/2015 Statutory year as well as years before. The Team continue to attend refresher training on a yearly basis.

Health

There appears to be 313 members of staff within BHFT who have completed the CSE online training. The training is a kwango e-learning course which includes the recognition and reporting of CSE. It includes a test at the end of the training. All staff who have direct contact with children are expected to undertake this training. The School Nurses have also received a bespoke NSPCC training course on CSE.

All staff receive training on CSE awareness and are given information either at their induction training or as part of their 'refresher safeguarding children training' on referral processes.

Slough Borough Council: Young People's Service

All staff members from Young People's Services have received NWG's CSE E-learning and Just Whistle target training in 2014/2015 as well as the years before. The CSE Engage Youth Workers have attended specialist training in 2015/16 and attended Operation Bullfinch training in January 2016. Engage have also delivered training regarding intelligence sharing alongside Thames Valley Police to Slough Borough Council staff and attended community event to raise awareness with members of the public.

Engage staff have monthly clinical supervisions and use reflective practice to look at thematic issues related to CSE.

Ofsted Recommendation 4: Develop and implement a funding agreement to ensure the LSCB has sufficient resources to undertake its core business.

Who pays for the costs of the Board's work?

Key members of the Board contribute to pay its costs. In 2015-16 these contributions were

Partner	*Contribution*
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	10,000
Schools Funding	30,000
Total Contributions	**108,400**

The Board managed its expenditure within the £108,400. 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 was used in 2015/16 to fund its current Serious Case Review and Annual Conference.

During the 2014-15 year the Slough Strategic Partnership made a one off contribution to fund a CSE coordinator. The work of the coordinator continued in 2015-16 with the new Slough Children's Trust covering the cost of the role temporarily once the SSP money ran

out. The cost has now been accepted by the Council as part of their responsibility to safeguarding and community safety.

In addition to its financial contribution, the partners also provide resourcing 'in kind' for the Board. In the past the Council have 'hosted' 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.

All LSCBs have to have a Child Death Overview Panel to review child deaths. This is funded through agreement with all six Berkshire Local Authorities and is commissioned by Bracknell Forest on behalf of the Authorities and led by Public Health. The service is hosted in Slough and all six Local Safeguarding Children's Boards have oversight of the work through the LSCB Business Managers. A Child Death Overview Panel Coordinator is funded as part of this agreement.

In Autumn 2014, Thames Valley Police reduced 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 on the Board, the Local Policing Commander agreed to reinstate the £10,000 from local devolved police budgets for 2015-16. For the current year (2016-17) the Police have corporately agreed to leave their contribution at £10,000.

- The Government review of LSCBs has been published. In anticipation of the changes being announced, the Slough Board is reviewing its structure and role and also the local Ofsted inspection report published in February 2016 and this is likely to lead to very significant changes to the way that partnership on safeguarding takes place. Future funding of the new partnership arrangements will be addressed as part of that work. The new model of working should ensure the Board operates at its maximum effectiveness, including
    - Meeting provisions are shared amongst Partners.
    - Partners support delivery of Multi –Agency training and community events.
    - Partners will share costs if a Serious Case Review is initiated.
    - Partners are currently considering how they can increase contributions to support the new partnership model.

Ofsted recommendation 5: Undertake a training needs analysis and regularly evaluate the quality and impact of training; including e learning

SLSCB managed its approach to multi-agency training through the East Berkshire LSCB Training Sub Group until January 2016 following the decision from Bracknell Forest to withdraw from the arrangement. Now Slough LSCB is therefore retaining its own the strategic oversight of training.

In October 2015 the training officer for Children's services transferred from the Council into the new Trust. As an informal arrangement the Council had allowed that member of staff to carry out the role of Training Manager for the Board for 50% of her time and had also provided administration for the SLSCB training programme. The provision to support the SLCB has continued through its original format.
The LSCB discussed training in March 2016 and agreed a new approach including:

- SLSCB will no longer commission and support any basic safeguarding training. This is a single agency responsibility and each organisation has a responsibility to ensure this is in place for their staff.
- The SCR sub group will ensure closer links in with the training function to ensure learning from SCR's is disseminated via training sessions.

- Courses should reflect the new emerging themes such as radicalisatio, CSE and modern day slavery, toxic trio.
- An updated threshold document is being incorporated into the training.

Summary of SLSCB Training Activity 2015-16:

- 38 multi-agency training sessions were delivered, attended by 874 staff

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- A successful Neglect Conference was held in September 2015 targeting 150 staff on the subject of Neglect including key note speakers from NSPCC and Action 4 Children. The conference was well received with comments such as:

"Thought provoking; Good conference; Very energetic; humorous and superb introduction; Well structured and positive messages; Technical difficulty; Gained good knowledge".

- CSE training was targeted as a priority and this is being developed further in 2016-17. For example, a multi agency session from Oxfordshire's Operation Bullfinch targeted 41 staff on their SCR. An internal audit identified social care practitioners lacked CSE knowledge and therefore mandatory staff briefing's, targeted 129 SCST staff followed the Operation Bullfinch session. Three further sessions on the CSE Risk Assessment tool training has been promoted in May 2016 to ensure staff are able to recognise CSE and use the risk indicator tool effectively.

- Multi agency CSE training is currently being reviewed for the LSCB partners via the CSE sub group.

- 13 other specialist courses were jointly commissioned across the East Berkshire area and places were shared.

- The changes to FGM legislation have been incorporated into the refresher training. An e-learning resource is also available from Virtual College on FGM which is shared with the workforce. A one day training event was put on for Slough schools on FGM. 22 schools attended and have access to resources to embed back at school in lesson plans

- A multi-agency briefing event on learning from Serious Case Reviews is planned for July 2016.

Quality Assurance of Multi-Agency Training

A review to improve the monitoring framework for capturing feedback and impact of training will take place during 2016-17. This will include a 3 stage evaluation process using the Kirk Patrick evaluation model; on the day course evaluation, follow up after 6 weeks and 3 months.

E-learning

We are currently using NWG for CSE awareness training and the Virtual School for FGM online training.

Ofsted recommendation 6: Engage the wider community in the work of the LSCB by ensuring that the Board has lay member representation and through engagement with local faith groups

The Board advertised two vacancies for lay members in autumn 2015 and carried out a selection process which was unsuccessful. Following this the Board agreed to second two lay members – one from a faith background and a second from amongst young parents. This secondment process was put on hold as the Government announced a review of LSCBs. This review has led to the development of the new model for Children's partnership in Slough which includes a safeguarding stakeholder forum twice yearly. This forum is envisaged as including a wide range of members of community groups and will include members of faith groups.

Meanwhile, the Board is engaged in a range of community links including the work of the community group addressing FGM (see below). The Boards commitment to working with the Slough community is evidenced in some of the following examples:

Early Intervention is strongly supported within Slough through third sector Voluntary Services. In July 2016 Slough Children's Services Trust is organising an interactive workshop, intended to improve engagement with Slough's Voluntary Sector provided by Youth Engagement Slough (YES).

How has the LSCB achieved other aspects of its statutory role and other high priority areas?

Undertaking reviews of Serious Cases and advising partners on lessons to be learned.

Slough LSCB Serious Case Review Multi – Agency Sub Committee has strong representation from a wide range of key partner agencies and meets bi-monthly.

Slough has undertaken a SCR and is awaiting the finalisation of the inquest.

The Sub Committee considered 6 case referrals in 2015-16 which led to the undertaking of two critical case reviews (CCR). These cases were reviewed by a multi-agency panel using a process and system which ensures its simplicity; effectiveness and increased learning from each case. The Multi- Agency panel together identifies areas of good practice; single and multi-agency recommendations.

An Action Plan is designed to incorporate the recommendations and each agency takes responsibility to ensure each action is implemented into daily practice by all practitioners.

The SCR Sub Committee holds a case register which is managed to monitor actions; outcomes; learning and any relevant referrals to alternative Sub Committees i.e. Quality Assurance, to ensure learning is embedded into practice .

Plans to deliver multi – agency learning from Local CCR and National SCR's is planned for July 2016.

- The SCR Sub Group initiated an SCR learning event focussing on Operation Bullfinch. This event prompted Slough to develop and implement a multi agency model where partners can work effectively in partnership to protect children and young people involved in or at risk of CSE.

The Pan Berkshire Policies and Procedures Group is one of a number of Groups that support six Berkshire LSCB's in the delivery of their business. It is led by Slough Children's Services Trust on behalf of the Board.

A review of the online procedures in the summer of 2015 identified that they had become large and difficult to manage and many of the documents were out of date. The current Chair took over in July 2015 and led this review and consequent work to review the whole set of policies and procedures for the new system.

This was achieved in January 2016 with the new system operational, and all new documents uploaded. It was then recognised that there would need to be a programme of reviewing the policies and procedures over the year and a more robust programme to manage this has been put in place.

The new policies can be accessed at http://www.proceduresonline.com/berks/

Allegations concerning persons who work with children and young people.

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 remains a long term vacant position, covered by an officer on an interim basis. It remains a priority for Slough Children's Services Trust to permanently recruit to this position.

Summary of Allegations for the period 2015 – 2016:

- 60 referrals were made during this period. An increase of 17% 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

There were 32 strategy meetings from the 61 referrals. In the majority of cases strategy discussions were held within 1 or two working days. The process of holding a strategy discussion in the first instance means that the safety of children can be quickly established and the process of information gathering can begin. All of the allegations meetings were face to face and therefore able to consider a wide range of information about the concerns.

The Designated Officer has visited Nurseries; Schools and Youth Service Providers as part of a wider drive on safeguarding compliance. They have also delivered 2 training events to develop the quality of referrals to the Designated Officer.

Female Genital Mutilation (FGM)

SLSCB commissioned the development of a FGM multi-agency strategy as part of its Business Plan for 2015-16 recognising the importance of improving our support for those who have been subjected to, or are at risk of, FGM.

Based on research produced through a task and finish group an FGM Strategy has been developed and agreed by the SLSCB.

The Strategy sets out Slough's ambition to ensure:

- we have instigated measures which prevent and ultimately eliminate the practice of FGM;
- we have the ability to identify when a child may be at risk of being subjected to FGM and respond appropriately to protect the child; and
- we have the ability to identify when a child has been subjected to FGM and respond appropriately to support the child.

The related action plan has been developed around four themes which are key to delivering our ambitions:

- Partnership
- Prevention
- Protection
- Prosecution

The first key piece of work the FGM Sub Group undertook was to coordinate a Women's Health Event at Chalvey Community Centre on Friday 22 April 2016. The event was open to all women, but was organised in consultation with representatives from the Somali women's community. The event was attended by 40+ women from across 5 different Somali community groups.

The Board's FGM Sub Group is looking to develop further initiatives over the coming months including:

- Engagement of schools in the process. The Sub Group initially had a school represented, but this has been difficult to sustain.

- Bring children into the discussion as much of focus on awareness raising has been aimed at young women to date (based on the fact that these women are likely to have daughters of an age where they could be at risk of FGM).
- Approaching Head Teachers to engage them in the discussion and work of the FGM Sub Group
- Hold a men's health event in Chalvey along the same lines as the recent women's one
- Development of Somali community FGM support group

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 Slough area has specific safeguarding arrangements in place to protect those who may be vulnerable to extremism and radicalisation. The Safeguarding Board's role regarding Radicalisation is to receive assurance from the Council and other agencies that these arrangements are effective, continually developing and linked in with the other streams of work of the Board.

Regarding its own specific responsibilities, SLSCB made two significant changes during the year:

a) The SLSCB threshold Document has been updated to incorporate identifying the risks of extremism and radicalisation.

b) Slough Borough Council section 11 audit was updated to include the Council's duties and responsibilities with regards to Extremism and Radicalisation.

In addition the following are examples of specific initiatives which have featured in the assurance which the Board has received:

- Slough Borough Council has employed a Prevent Coordinator to manage all Prevent related matters. The Coordinators key role is to work with Education; Faith Establishments; all communities; partners and voluntary groups with the remit to cover all forms of extremism and terrorism.

- As with all Local Authorities, Slough Borough Council has a Channel Panel, Chaired by Assistant Director, Engage and Partnership and Vice Chair; Head of Adult safeguarding. The Multi – Agency Panel meet regularly and consider all referrals submitted under Prevent for individuals who may be at risk of becoming involved in extremism or terrorist activity. Like all Multi – agency panels, appropriate interventions are offered.

- A workshop was held in July 2015 which focussed on reducing the travel to Syria and other conflict zones. This was an interactive workshop with speakers from Slough Education Sector, Police on the danger of travelling to conflict zones, travel advice, minimising the risk to individuals and families and the support that I available should it be known an individual or group of individuals are travelling or intend to travel to a conflict zone. This workshop was delivered to an audience of faith establishments; key figures within the community; schools including Primary; Secondary and Colleges; Key representatives from Local Authority; voluntary sector and wider partners i.e. Health and Probation.

- WRAP training has been delivered to Primary and Secondary Schools and East Berkshire College to teachers; staff and front line staff with responsibility for safeguarding and welfare at East Berkshire College and Governors at schools and colleges. Prevent awareness has been delivered to students at secondary schools in years 7 – 13.

- Train the Trainer (WRAP) has been delivered to Primary and Secondary School staff to enable them to self deliver as trained facilitators. Within this training it both heightens awareness and identifies its links with other safeguarding themes such as CSE; trafficking; Child Abuse and Neglect.

Child Death Reviews

Local Safeguarding Children Board (LSCBs) have responsibility of reviewing the deaths of all children (0 to<18 years) in their resident population.
Within Berkshire there is a shared child death overview panel that works jointly for the 6 Unitary Authority Local Safeguarding Boards and is made up of a range of representatives from a range of organisations and professional areas of expertise. This process is undertaken locally for all children who are normally resident in Berkshire.
The purpose of the CDOP, is to collect and analyse information about each child death with a view to:

- Identifying any changes that we can make or actions we can take that might help to prevent similar deaths in the future.
- Sharing this learning with colleagues regionally and nationally so that the findings will have a wider impact.

The total number of deaths which occurred across Berkshire during April 2015 and March 2016 was 45. Over the past few years, whilst there will be some random fluctuations in numbers of deaths, there has been a downward trend in the total number of deaths notified.

During 2015-16 there were 49 cases reviewed by the panel, the numbers differ as the cases reviewed include deaths from 2014/15 and is due to the time taken to review the circumstances of each death following notification.

The Panel identified the need for clearer procedures in relation to concealed pregnancy. Inter-agency guidance informed by this learning is now available for all practitioners and is now linked to the CDOP Rapid Response protocol.

During 2015/16 learning from CDOP also informed prevention of deaths through ongoing health promotion activities across the region and saw particular efforts to raise awareness in relation to:

- Water safety
- Rubella case
- The management of asthma
- The importance of recognising symptoms associated with raised intracranial pressure
- Early screening for paediatric sepsis
- The increased risk of suicide associated with online exploitation
- Learning from research relating to Deaths from Self-Asphyxial Behaviours (choking games).

Priorities for 2016/17
Before setting or looking at new priorities it should be recognised that we will continue to build on the lessons and work from previous years - with particular reference to:

- Congenital/genetic abnormality work, working with families and communities to reduce risk;
- Sustained reduction of SUDI e. g. supporting ongoing work to improve uptake of safe sleeping;
- Continuing work on deaths from external causes, particularly accidents;
- Reduction of risk factors for preterm and low birth weight deaths;
- Further develop the pilot work on asthma care and mortality reduction after external enquiry in one area;
- This will hopefully support the continued year on year reduction in total mortality that we have seen over the past five years and in particular in SUDI and accidents. However to maintain this downward trend, and also our response when deaths, occur a number of key priorities for action were identified as part of our development session:
  Panel working
  Further emphasis on themes and trends
  Training
  Bereavement support

How does SLSCB know partner agencies listen to the voice of the child?

"*A child – centred approach; which means for services to be effective they should be based on a clear understanding of the needs and views of children".*

The voice of the child is a priority for SLSCB. Reviewing and developing its guidance and practice should ensure this is incorporated into daily practice. The focus of this priority has been addressed by:

- Revising and disseminating the threshold guidance clearly stating the child should be a the centre and their voices heard;
- Incorporating the voice of the child within our Quality Assurance process;
- Ensuring all children who go missing from home or care are offered timely return home interviews that properly explore and address risk and need;
- Inviting Young People to share their views at community events when safeguarding themes are discussed;
- Ensuring the voice of the child plays a key role in the evaluation process when analysing a Serious Case;
- Ensuring Children and Young People are heard when they raise a concern or allegation regarding a member of staff who works with children and young people;
- Involving Children and young people in "Reach Out" group activities and on-line forms to share what promises they felt should be made in the Pledge to Children in Care;
- Youth Parliament;
- Complaints;
- HMI Probation has published a report based on its 2014/15 findings from its first annual eSurvey of young people, as part of its ongoing Inspection of Youth Offending. The full report can be downloaded here.

Appendix A – Why does Slough have a Safeguarding Children's Board?

All local authorities are currently obliged to have a partnership to carry out the Safeguarding Board responsibilities to:

(a) To coordinate what is done the Board members for safeguarding and promoting the welfare of children; and

(b) To ensure the effectiveness of that safeguarding work.

How does the Board work?

During 2015 -16 Slough Local Safeguarding Children board (SLSCB) was independently chaired by Phil Picton, who is accountable to the Chief Executive of the Council, (Ruth Bagley), for fulfilling this role effectively. Board members meet regularly to discuss progress and issues in safeguarding. In addition, Phil has access to the Directors of all the partner agencies and meets with them on a one to one basis to discuss safeguarding issues and where necessary to challenge them on progress. Phil was also an active participant in the Children and Young People's Partnership Board which takes forward a range of work related to the welfare of children. These partnership arrangements are being changed in 2016-17 to better reflect the needs of Slough.

A protocol with the Slough Wellbeing Board and the Safeguarding Adult Board ensures that the work of these Boards complement what SLSCB does. The Slough Wellbeing Board, Police and Crime Commissioner and the Chief Executive and Leader of the Council all receive a copy of this Annual Report so that they can make sure that their plans take it into account.

The interim **Director of Children's Services** (DCS), Krutika Pau, and the recently appointed councillor who leads on **Children's Services, Sabia Hussain,** both sit on SLSCB. The lead member is also the Chair of the Children and Young Persons Partnership Board.

The work of SLSCB is reviewed at least annually by the Council's Overview and Scrutiny Committee which meets in public. At that meeting, the Chair and key Board members explain the issues and risks to safeguarding children and what has been and will be achieved by the Board. The minutes of those meetings are available through SBC's website.

How is the LSCB structured?

In March 2016, Slough Local Safeguarding Children's Board comprised of the main Board, an Executive Group and four Sub – Committees which focus on;

Case Reviews;
Child Sexual Exploitation and Missing Children;
Quality Assurance; and
Female Genital Mutilation

In addition, it joins 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)

A joint East Berkshire Training and Development sub group had also been in existence since 2014-15, but following the withdrawal of Bracknell LSCB from that arrangement, the Slough Board agreed to review its approach to training as part of its wider reorganisation. New structures will be put in place during 2016-17

In October 2015, the new Slough Children's Services Trust took over responsibility for many of the services for children which had previously been delivered by the Council. This new organisation is a key player in the work of the Board and its Chief Executive sits on the Board and Executive. Along with the Council, it has legal responsibility for the Board being effective.

In 2015/16 the Board met five times and the executive group met six times, to progress work between Boards.

For membership and register of attendance at the Board meetings see Appendix B

Appendix B – Membership and register of attendance at Board meetings

LSCB Executive Board	***% of Attendance***
Organisation:	
SLSCB Independent Chair	100
SLSCB Business Manager	67
Berkshire Healthcare Foundation Trust	83
Slough Clinical Commissioning Group	83
Slough Borough Council, Director of Children's Services	83
Slough Children's Services Trust from 1.10.15. (CEO)	100
Primary Education	33
Secondary Education	83
Thames Valley Police	83
Slough LSCB	
Organisation:	
SLSCB Independent Chair	100
SLSCB Business Manager	100
Adults Safeguarding	20
Berkshire Healthcare Foundation Trust	80
CAFCASS	40
East Berkshire Clinical Commissioning Group	100
East Berkshire College	100
Heatherwood & Wexham Park Hospitals	60
Healthwatch	0
Housing (SBC)	0
Slough Children's Services Trust from 1.10.15. (Head of Safeguarding & QA Service)	83
Slough Children's Services Trust from 1.10.15 (CEO)	60
NHS England	20
Primary Education	20
Probation & Community Rehabilitation Company	83
Secondary Education	100
Slough Borough Council, Director of Children's Services	100
Thames Valley Police	80
Voluntary Sector	40
Youth Offending Team (SBC)	100

Appendix C – What are our plans for the future?

Slough Local Safeguarding Children's Board Business Plan 2016 -17

Slough Local Safeguarding Children's Board (SLSCB) Business Plan 2016 -17 was agreed by Members of the Board on 17 March 2016. Members of the Board are required to provide outcome performance measures on actions for which they hold lead responsibility.
The SLSCB Business Plan 2016-17 has been structured to meet the specific risks identified from the December 2015 Ofsted Inspection. It incorporates the priority areas identified at the SLSCB Board Meeting held on 14 January 2016 and finalised by Members of the SLSCB on 17 March 2016. It is designed to be concise and based on SMART principles. It is work in progress and Executive Board Members will hold responsibility to review; amend and add to it at each meeting.
This Plan will replace the 2015 -16 SLSCB Business Plan and the Board will continue an annual planning cycle.

This Plan will address six themes:

- **Theme 1: Revise and implement multi-agency threshold guidance**
- **Theme 2: Establish a programme of effective monitoring and quality assurance of multi-agency safeguarding practice.**
- **Theme 3: Take action to strengthen the LSCB's oversight and scrutiny of the effectiveness of the local multi-agency response to children at risk of exploitation including CSE and Missing.**
- **Theme 4: Develop and implement a funding agreement to ensure the LSCB has sufficient resources to undertake its core business.**
- **Theme 5: Undertake a training needs analysis and regularly evaluate the quality and impact of training (including e-learning).**
- **Theme 6: Engage the wider community in the work of the LSCB by ensuring that the Board has lay member representation and through engagement with local faith groups.**

Slough Local Safeguarding Children's Board

Business Plan 2016-17

Theme 1: Revise and implement multi-agency threshold guidance and scrutinise the application of thresholds at all levels.					
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**	**Impact Performance Measures**
Working Together 2015 requires LSCB's to publish a threshold document. The 2014 Threshold Document needs to reflect Slough's new operational arrangement (SCST) together with issues such as FGM, CSE/Missing and Radicalisation. The changes need to be disseminated to all professionals.	1. SLSCB will revise its threshold document to reflect the requirements of statutory guidance.	SLSCB	**30 April 2016**	A new Threshold document will be published.	Appropriate document is approved, published and circulated.
	2. SLSCB will proactively disseminate the document so that all professionals can use it in their daily practice.	Lead – Independent Chair - SLSCB SLSCB – Business Manager	**31 May 2016**	All partner organisations will ensure that it is disseminated appropriately.	Extent of dissemination by partners.
SLSCB requires assurance that practitioners and managers within all partner organisations are aware of the document and apply the agreed thresholds on a daily	1. Consider a report(s) on the extent to which the Threshold document is being appropriately applied and respond to any weaknesses identified within the report(s).	Chief Executive - SCST	**30 June 2016**	Report and monitoring.	Thresholds appropriately applied result in effective responses to cases. Consistent appropriate referrals will be submitted to the first point of contact. Consistency of referrals
	2. Carry out a multi-agency audit examining referrals and	Lead – Independent Chair SLSCB	**30 September**	Audit shows compliance with thresholds.	

Theme 1: Revise and implement multi-agency threshold guidance and scrutinise the application of thresholds at all levels.					
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**	**Impact Performance Measures**
basis.	response initial response to them.	Chair - QA Sub Committee	**2016**		will enable SLSCB to obtain accurate data regarding levels of risk in the child population.
Children's Social Care should ensure that information about its actions is given to referring professionals.	SCST will dip sample the level of feedback provided to the referrer.	Chief Executive - SCST	**Every three months during 2016-17**	SLSCB is aware of level of compliance and actions to remedy any failings.	Referrers will be better informed to continue working with families.
MASH: Effective sharing of information and risk should allow more effective safeguarding and decision-making.	SLSCB will consider evaluation reports into the project progress and effectiveness of MASH arrangements.	Chief Executive - SCST	**Every three months**	Progress and performance will have been discussed and actions for improvement identified and monitored.	Less variation in quality of safeguarding.

Theme 2: Establish a programme of effective monitoring and quality assurance of multi-agency safeguarding practice. This should include analysis of performance information, section 11 audits and internal partner agency audits, as well as multi-agency auditing led by the LSCB.					
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**	**Impact Performance Measures**
SLSCB requires assurance the Quality Assurance Sub Committee is effective in implementing the Multi-Agency Audit Schedule and providing outcomes to inform the Board of Multi Agency safeguarding practice.	Consider update reports to inform the Board of the Sub Committee's outcomes.	Chair - QA Sub Committee	**Every 3 months during 2016 -17**	SLSCB is aware of safeguarding practice and performance which informs decision – making and actions by the Board.	The Board receives regular performance information from all partners.
LSCB's have a statutory function to assess LSCB partners are fulfilling their statutory obligation to safeguard and promote the welfare of children.	SLSCB will determine an agreed timescale for Section 11 audits to be submitted to the Board by organisations within Slough.	Executive Board Members/ LSCB Business Manager	**tbc**	SLSCB receives the required Section 11 reports.	Risks are identified; Consistent learning and debriefing takes place to effect quality safeguarding practice.
SLSCB must ensure that	A Slough LSCB representative on the Pan Berkshire Sub	Deputy Director of	**Every 6 months**	The Board is informed of all Section 11	

outcomes and initiatives from Pan Berkshire Section 11 audits are received to determine the work of the Board.	Committee takes responsibility to update the Board.	Nursing CCG/ LSCB Business Manager		outcomes	
Organisations should receive feedback from the Board to aid change and improvement.	SLSCB will ensure it provides feedback and challenge to organisations in response to each Section 11.	SLSCB Business Manager	**Twice per year**	Organisations receive constructive feedback.	Organisations are sufficiently informed and achieve best practice.
SLSCB must ensure the voice of the child is heard and used to positively influence the improvement of service delivery and outcomes for children.	SLSCB specifies that all auditing and evaluation reports include analysis of the contribution that the child's voice is making to service delivery and outcomes for children.	Chair of SLSCB - QA Sub Committee	**31 April 2016**	Organisations are informed regarding the quality of their arrangements to safeguard and promote the welfare of children. Audit reports are used to decide future actions by the Board and agencies.	Evidence of child's voice leading to improved outcomes.

Theme 3: Take action to strengthen SLSCB's oversight and scrutiny of the effectiveness of the local multi-agency response to children at risk of exploitation including CSE and Missing.					
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**	**Impact Performance Measures**
Child Sexual Exploitation (CSE) and Missing SLCSB requires clear data to inform strategic coordination of multi - agency response to the concern and risks.	SLSCB will request relevant data is submitted to the Executive Board.	CE -SCST/ Slough LPA Commander –TVP / Director Cambridge Education	**Each Executive meeting**	The Board is in receipt of current data.	Services are greater informed to meet the needs of the risk.
SLSCB need to understand the full extent of ongoing initiatives to aid the identification of failings within Slough.	CSE and Missing Strategy will be in place.	Chair CSE Strategic Sub Group	**April 2016**	The Board will receive a strategic CSE / Missing profile.	
SLSCB must have oversight of the progress of the CSE Action Plan 2016 - 17.	SLSCB will request the CSE Action Plan is regularly submitted to the Board.	Chair CSE Sub Group	**Every 3 months**	The CSE Action Plan is attached as Appendix A	Children at risk of CSE are identified and protected.
SLSCB requires definitive evaluation of CSE training, delivered within a single and multi –agency arena.	The Board will entrust the LSCB QA Sub Committee to initiate an audit to evaluate the impact of training.	Chair QA Sub Committee	**September 2016**	The Board will have sighting of the impact of learning.	Partner agencies are aware of their responsibilities and there is effective CSE practice across all agencies. Improved practice within frontline services.

SLSCB needs to commit to the recently established Pan Berkshire CSE sub group arrangement.	SLSCB will ensure the appropriate representation at the Pan Berkshire Sub Committee.	Chair CSE Sub Group / CSE Coordinator	**Bi-annually**	The Board will be compliant with Berkshire CSE procedures and protocols.	Children will receive a consistent approach to protection and services across Berkshire.
Female Genital Mutilation (FGM) SLSCB requires a Multi – Agency Strategy and Action Plan for FGM.	FGM strategy will be in place.	Chair FGM Sub Group		A Slough multi-agency strategy will be published.	Children at risk of FGM are identified. Potential criminal activity is identified and referred for criminal investigation.
SLSCB needs to evaluate the impact of the FGM referral pathway.	SLSCB will request a multi-agency audit is completed.	Chair QA Sub Committee	**December 2016**	Audit reports are used to decide future actions by the Board and agencies.	Consistent and correct referrals will be submitted and victims will receive appropriate services.
SLSCB needs to have oversight of developments regarding: ***Gangs related Cases*** ***Honour Based Violence*** ***Forced Marriage***	The Board will request progress reports from LSCB representatives who are members of SSP/ Adult Safeguarding Board / CYPPB.	tbc	**tbc**	The Board receives a progress report.	Any actions or recommendations are assigned to body's managing these issues.
Cyber Technology SLSCB needs to understand initiatives within Slough which focus on the concerns regarding Cyber Technology.	SLSCB will circulate relevant local and national conferences and seminars to all Board members, to facilitate access to	Safer Slough Partnership / LSCB Business Manager /	**On-going throughout 2016 -17**	The Board will have recorded evidence of events circulated and will survey organisational access	Organisations will understand current cyber technology risks and prevention awareness.

	organisational development. SLSCB will nominate a representative as a member of the Recently established E-Safety Group.	Adults Safeguarding Board		or attendance.	Children will receive clear guidance to self protect against on-line abuse.

Theme 4: **Develop and implement a funding agreement to ensure the LSCB has sufficient resources to undertake its core business.**					
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**	**Impact Performance Measures**
SLSCB funding contributions are variable from partner agencies.	Develop a more creative and consistent method of partner contributions: - financial and other.	SLCSB Executive Board Members	**May 2016**	An agreed protocol will be recorded within the Executive Board minutes.	The Board's functions and initiatives will progress, without delay, through agreed partner contributions. The Board will have reassurance of its required funding. The Board will remain within budget at the end of the financial year.
Discussion regarding contributions should continue at Executive level in order to free up the Board members to deliver priorities within the Business Plan.	Investigate opportunities to reduce cost and incur additional income. Identify skill-sets within partner organisations to support the LSCB functions of:- *Data analysis;*	SLSCB Chair	**May 2016**	A clear agreed process is in place. Board members are able to progress core business.	

Theme 4: Develop and implement a funding agreement to ensure the LSCB has sufficient resources to undertake its core business.					
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**	**Impact Performance Measures**
SLSCB funding contributions are variable from partner agencies.	Develop a more creative and consistent method of partner contributions: - financial and other.	SLCSB Executive Board Members	**May 2016**	An agreed protocol will be recorded within the Executive Board minutes.	The Board's functions and initiatives will progress, without delay, through agreed partner contributions. The Board will have
	Website design; *Delivery of training;* *Administration of training events*				

Theme 5: Undertake a training needs analysis and regularly evaluate the quality and impact of training (including e-learning).					
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**	**Impact Performance Measures**
SLSCB training programme needs to be determined by a current Training Needs Analysis (TNA) from all partner organisations.	SLSCB will ensure a suitable TNA format is available. SLSCB will identify a realistic timescale for partner organisations to complete and return their individual TNA.	SLSCB Training Officer	**tbc**	The Board will receive an accurate TNA.	Partner organisations will have completed TNA.
SLSCB will clarify the structure and process to deliver and respond to the Training Needs Analysis.	SLSCB will identify its training and agree the appropriate method for its delivery, including e-learning.	tbc	**tbc**	A training programme will be available to meet requirements of organisations in Slough.	Delivery of relevant training will be available and accessed by all practitioners and managers.
SLSCB must understand the impact of the Single and Multi-Agency training programme to determine: *The* improvement of knowledge on attending the training; *The* impact of training on	SLSCB will ensure the evaluation of training delivery and its impact will take place and is routinely embedded within training practice. SLSCB will request relevant	Chair QA Sub Committee	**tbc**	Evaluation reports; data analysis and outcomes of related audits will be available to inform future development.	Evaluation of training will evidence improvement in practice and service delivery. Partner organisations will ensure that learning outcomes are incorporated into practise.

delivery of services; and *The* impact of training on outcomes for children	Audits to be completed by the Quality Assurance Sub Committee.				
1) SLSCB must ensure learning from Case Reviews is disseminated to a multi – agency audience. 2) The Board needs to be informed of issues regarding the SCR Sub Committee activity or difficulties in progressing Case Reviews.	SLSCB will request an evaluation report from the SCR Sub Committee	Chair – SLSCB SCR Sub Committee	**Quarterly**	Regular multi – agency learning events are held and attended by all partner organisations. Attendance Registers and Feedback Reports will be available to evidence partner participation.	Practitioners will self learn from Critical Cases and repetition of identified incorrect practise will cease.

Theme 6: Engage the wider community in the work of the LSCB by ensuring that the Board has lay member representation and through engagement with local faith groups.					
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**	**Impact Performance Measures**
Sections 13 and 14 Children Act 2004 requires the LSCB to include two lay members representing the local community.	SLSCB will appoint two lay members that fulfil the specifications of this role.	SLSCB Business Manager / SLSCB Independent Chair	**June 2016**	Two lay members will be appointed.	Two lay members will attend and participate within the SLSCB. Lay members will attend and participate on the relevant Sub Committees.
SLSCB need to ensure the work of the Board is available to access by the wider community and facilitates engagement with local faith groups.	Revise SLSCB website to reflect current work and initiatives which are available to access by all members of the community.	SLSCB Business Manager	**June 2016**	Data analysis should identify numbers accessing SLSCB website.	SLSCB links with the community and local faith groups will heighten and improve public understanding of SLSCB's child protection work. Information regarding the work of the LSCB is accessible to the whole community of Slough.
Slough is one of the most ethnically diverse towns in the UK, with 28.7% of Slough residents born outside the UK and the EU, and 20% having been resident in the UK for less than 10 years. SLSCB need to ensure the	SLSCB will explore the possibility for sections of the website to be appropriately translated.	SLSCB Business Manager	**July 2016**		

website is accessible to all members of the community.					