Slough Local Safeguarding Children's Board

Annual Report 2016-17

Foreword

This is my first LSCB Annual Report since being appointed as the independent chair of the board in September 2016.

I have been well received by all the partners on the LSCB and in the period covered by this annual report there has been progress in improving the effectiveness of the LSCB and in delivery of the 2016-17 business plan that has informed so much of the work of the LSCB.

There has been progress and this is illustrated in the detail within this report and I am appreciative of the effort and application that has been shown in achieving the improvement up to April 2017. However, the reality is that there is a lot more to do. I am pleased to see that this is picking up pace and it is my ambition, as it is of the LSCB in general, to ensure that our improvement continues into the future.

I am proud to have been given the opportunity to contribute to this improvement as independent chair of the LSCB as well as carrying this same responsibility in the Adult Safeguarding Board. There are numerous overlaps and opportunities for shared learning and practice that will improve safeguarding in Slough. We can see this in individual cases, families and in the circumstances faced by children at risk of abuse in the borough. It is heartening that the value of this approach is endorsed by all the partners working together in Slough.

Our task for the future is to build on the foundation we have developed in the period covered by this annual report, and it is my firm intention that such progress will be evident in the 2017-18 LSCB annual report.

Nick Georgiou

Independent Chair

Slough Local Safeguarding Children's Board

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1. Introduction

What is safeguarding?

Safeguarding is about keeping children and young people safe and protecting them from harm, while making sure they grow up in a safe environment. The Slough LSCB coordinates the safeguarding work of individual agencies on the partnership board and monitors and challenges agencies' progress on improving child protection in Slough.

Slough Local Safeguarding Children Board

Local Safeguarding Children Boards are required under the Children Act 2004. An LSCB must be established for every local authority area. The LSCB has a range of roles and statutory functions including developing local safeguarding policy and procedures and scrutinising local arrangements. The statutory objectives and functions of the LSCB are described in the extraction from Working Together to Safeguard Children:

(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.

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out that the functions of the LSCB, in relation to the above objectives under section 14 of the Children Act 2004, are as follows:

(a) Developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority, including policies and procedures in relation to:

- (i) The action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention;
- (ii) Training of persons who work with children or in services affecting the safety and welfare of children;
- (iii) Recruitment and supervision of persons who work with children;
- (iv) Investigation of allegations concerning persons who work with children;
- (v) Safety and welfare of children who are privately fostered;
- (vi) Cooperation with neighbouring children's services authorities and their Board partners;

(b) Communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so;

(c) Monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve;

(d) Participating in the planning of services for children in the area of the authority; and

(e) Undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

The Children and Social Work Act 2017 sets out a new framework for improving delivery of multi-agency arrangements to protect and safeguard children. In Slough, partners have agreed to maintain the existing LSCB arrangements to ensure a continuation of a strong local focus on partnership work to improve deficiencies identified in the Ofsted inspection in November 2015 and strengthen child protection in Slough.

The LSCB has a new independent chair who provides an independent perspective, challenge and support. The Board consists of senior representatives of all the key organisations working together to safeguard children and young people, including: Slough Borough Council, Slough Children's Services Trust, schools, Clinical Commissioning Group, Thames Valley Police, Berkshire Healthcare NHS Foundation Trust, Royal Berkshire Fire and Rescue Service, South Central Ambulance NHS Foundation Trust, Slough Council for Voluntary Services, HealthWatch, Frimley Health NHS Foundation Trust and the Youth Offending Team.

The LSCB works closely with other partnerships in Slough and with the other LSCBs across Berkshire. It is important to recognise the role of these partnerships in achieving the LSCB's safeguarding priorities and securing effective and sustainable improvements.

During the course of 2016/17 with the appointment of the same independent chair for both the Slough Children's and Adults' Boards, ties between these boards and with the Safer Slough Partnership have been strengthened.

Pan Berkshire LSCB Child Protection Procedures

The Pan Berkshire LSCB Child Protection Procedures set out how agencies and individuals should work together to safeguard and promote the welfare of children and young people: http://www.proceduresonline.com/berks/

Holding partners to account for safeguarding practice

The LSCB evaluates the effectiveness of the safeguarding arrangements of partners. Evidence is drawn from a range of sources including:

- Learning from both internal and external reviews and inspections
- Section 11 of the Children Act audits
- Section 175 of the Educational Act audits
- Learning from child deaths
- Performance management, quality assurance and audit activity
- Engagement with young people

2. Achievements against our priorities in the 2016-17 Business Plan

These themes reflect findings from the Ofsted inspection in November 2015 and the LSCB's actions to tackle these findings.

Theme 1: Revise and implement multi-agency threshold guidance

Purpose of this theme: Working Together 2015 requires LSCBs to publish a threshold document. The 2014 Threshold Document needs to reflect Slough's new operational arrangement together with issues such as FGM, CSE/Missing, and Radicalisation. The changes need to be disseminated to all professionals and consistently applied, resulting in effective response to referrals. Consistency of referrals will enable the LSCB to obtain accurate data regarding levels of risk in the local community. Effective sharing of information and risk will allow more effective safeguarding and decision-making.

What we did:

- The multi-agency threshold guidance was finalised and published in May 2016 and disseminated across partner organisations so that all professionals could use it in their daily practice.
- Slough Children's Services Trust (SCST) Early Help team launched and delivered a training session with early help partners and the Business Manager presented the guidance to a multi-agency early help champions meeting. The threshold guidance is incorporated within LSCB and SCST training.
- A multi-agency audit was undertaken examining referrals and initial response to test whether thresholds are consistently and appropriately applied at the first point of contact and result in effective responses to cases.
- In September 2016, the Multi Agency Safeguarding Hub (MASH) was launched, with Police, Children's Social Care and health professionals co-located at Slough Police Station. Regular evaluation reports into the effectiveness of MASH arrangements enabled the LSCB to monitor progress and performance and identify actions for improvement.

What difference did this make?

Understanding the threshold document and applying it consistently has enabled effective responses to referrals. The November 2016 Ofsted monitoring visit identified: *"Since the inspection, a comprehensive multi-agency threshold document has been published and we saw evidence that it is being effectively applied at the front door."*

In the 10 months since going live, the MASH has seen greater confidence from professionals and the public in making referrals and the MASH has been positively commented on by Ofsted as improving the ability to identify risk and make informed safeguarding decisions for children: *"The recently established MASH provides a timely, considered and proportionate response to children. Consent is well considered."*

What we need to do better:

These developments are being further progressed during the current year including an education presence in the MASH and the intention to relocate the MASH at St Martin's Place.

Theme 2: Establish a programme of effective monitoring and quality assurance of multi-agency safeguarding practice

Purpose of this theme: LSCBs have a statutory function to assess how effectively partners are fulfilling their statutory obligation to safeguard and promote the welfare of children. Through analysis of performance information, Section 11 audits, multi- and single-agency audits, the LSCB has oversight of safeguarding practice and performance which informs decision-making by the Board and identification of risks. The LSCB must ensure that the voice of the child is heard and used to positively influence the improvement of service delivery and outcomes for children.

What we did:

- The LSCB Quality Assurance subgroup completed three successful multi-agency audits: Domestic Violence; Safeguarding Children - Adult Mental Ill Health; and Safeguarding Children - Serious Violent Assault and Aggravated use of Weapon. The learning, themes and recommendations from the audits were considered by the LSCB.
- The LSCB specifies that all auditing and evaluation reports include an analysis of the contribution that the child's voice is making to service delivery and outcomes for children. The new template for key questions for individual multi-agency audits has a standard question to confirm whether the voice of the child has been captured.

- The Quality Assurance subgroup has an audit schedule that reflects the LSCB Business Plan and is flexible to accommodate emerging issues within Slough. Slough Borough Council completed its statutory Section 11 audit and a summary of its findings was submitted to the LSCB Executive Board and presented to the Education and Scrutiny panel in May 2016.
- There is now consistent Slough representation on the Berkshire Section 11 subgroup

What difference did this make?

The Board receives regular performance information from all partners. Risks are identified and consistent learning is shared to effect quality safeguarding practice. Organisations are informed about 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. There is evidence of the child's voice leading to improved outcomes.

The November 2016 Ofsted Monitoring visit identified:
"Quality Assurance, including case auditing by managers, has improved. Themed case audits, such as the recent child sexual exploitation audit, routinely identify good and inadequate practice. Overall, inspectors agreed with the findings of the case audits undertaken by the Trust during the monitoring visit."

"Single assessments are increasingly analytical, with the perspective of children considered well in most cases…. We saw examples of sensitive conversations with children who have been sexually abused, and creative direct work with young children. The views of children are evident in most records, supported by observation."

What we need to do better:

Ofsted found examples of good practice in the involvement of children and evidence of the child's voice leading to improved outcomes, but further focus is still needed to ensure that this is consistent across all cases.

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.

Purpose of this theme: Partner agencies need to be aware of their responsibilities to identify and protect children at risk of Child Sexual Exploitation (CSE). The LSCB needs to understand the full extent of ongoing initiatives and requires clear data to inform the strategic coordination of multi-agency response to the concern and risks and ensure there is effective CSE practice across all agencies.

What we did:

- A revised Child Sexual Exploitation (CSE) and Missing Children strategy and action plan were agreed by the LSCB in March 2016 with a revised CSE and Missing pathway agreed in November 2016, supported by cue cards for practitioner to ensure a consistent approach is taken by frontline workers. The CSE risk indicator tool has been updated and adopted across all Berkshire Local Authorities giving a consistent approach, monitored by the LSCBs.
- Slough Safer Partnership initiated and commissioned an independent overview of the scale of CSE in Slough by LIME, a specialist agency with experience of designing behaviour-change interventions to help young people at risk. The aim was to understand the dominant model of CSE so that resources could be targeted where they are most needed, and to work with those most affected by CSE locally to co-design and co-create interventions. This initiative led to the development of the Healthy Relationship programme to support children to be able to make

safe decisions in their relationships and prevent escalation into domestic abuse, sexual exploitation, Prevent and gang activity.

- The findings of a CSE audit was submitted and considered by the LSCB in November 2016.
- The CSE Pan Berkshire subgroup is now well established and has committed membership from Slough.
- Three tier training model has been developed and implemented as part of the annual LSCB multi-agency training offer, with good take up and positive feedback.
- A joint project with the Safeguarding Adults Board initiated *Safeguarding Your Passenger* training for every taxi driver licensed in Slough on recognising and responding to concerns about adults at risk and child sexual exploitation. This was the first program of its kind in Berkshire and was given an achievement award for outstanding work by the Berkshire Environmental Health Managers Group in February 2017. The long term outcomes will be evaluated by University College London in September 2017.
- Child sexual exploitation parent and child leaflets have been finalised, published on the website and shared with all partners to use.
- Improved partnership working and awareness raising in schools and for CCTV officers, who pass on concerns when they suspect someone is being groomed - an important part of monitoring and disrupting locations of interest.
- Engage carried out regular joint work with Turning Point to manage children's drug and alcohol use. Engage provide a dedicated service to young people at risk of sexual exploitation and have successfully supported young people through police investigations and court processes.
- Multi-agency SEMRAC meetings were well attended by a wide range of core partners.
- The LSCB Female Genital Mutilation (FGM) subgroup developed and launched a FGM strategy and organised and delivered a successful community awareness event.
- The Serious Case Review (SCR) subgroup has considered a local case involving gang related behaviour and has considered learning from national SCRs involving gang related behaviour.
- The Quality Assurance subgroup initiated a multi-agency audit to evaluate outcomes and learning from Serious Violent Assault.
- Honour Based Violence is a themed LSCB training session available to all partner agencies.

What difference did this make:

The November 2016 Ofsted Monitoring visit identified:
"In the cases we considered, risk assessments for children at risk of sexual exploitation were thorough and analytical."

"The contributions of professionals who attend SEMRAC are reflective and child focused. Attendees share ideas and solutions as well as information."

"Overall, concerns about children who are at risk of sexual exploitation are steadily reducing.

"In-house and commissioned services to undertake interviews with children who go missing from home or care are now in place. The records we reviewed of these interviews included detailed and helpful conversations."

Collaborative training and presentations by the CSE and Trafficking Coordinator and police intelligence officers has led to increased confidence amongst partners with information sharing pathways and the creation of a new Thames Valley Police multi-agency intelligence submission form. The outcome has been increased reports from multiple sources, for example, only 7.5 % of

intelligence reports received from Slough partner agencies were CSE related in 2015 compared to 42% in 2016.

Increased information sharing by hotels with TVP has led to CCTV footage being gained to support future investigations and arrests, disrupt activity and safeguard vulnerable people.

Through the work of Engage, levels of risk in cases have been de-escalated, in conjunction with recorded outcomes such as improved self esteem, resilience, sexual health awareness and improved school attendance.

What we need to do better:

Ensure SEMRAC process are strengthened and focus on people and places of interest as well as victims. SEMRAC guidance issued in March 2017 sets out a required agenda but the minutes of conferences need to be improved to ensure that they include relevant information, multi-agency risk analysis and agreed actions.

There is a lack of knowledge around the activity of missing children; this is being addressed but more robust care planning is needed for repeat missing children. All children who go missing must receive a return home interview within 72 hours of their return.

Multi-agency response and coordinated working with the Safeguarding Adults Board to agree processes to support young people who have been sexually exploited but do not meet criteria for Adult Social Care services when they reach 18. Without effective, coordinated support, these young people will continue to be vulnerable, exploited, moving into more chaotic lifestyles with multiple and complex needs.

Further training and awareness raising for frontline workers so there is consistent knowledge about CSE, appropriate identification of risk, better awareness of links between CSE and other modern slavery categories, and increased use of the National Referral Mechanism (NRM) system for exploited and trafficked children.

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

Purpose of this theme: To develop a more creative and consistent method of partner contributions, financial and other, to ensure the Board's work progresses without delay. Closer working with other Boards and forums supports shared learning and enables a coordinated response to safeguarding issues.

What we did:

- Partners agreed to maintain their financial contributions to the Board for 2016 -17 and have provided venues, removing this cost for the LSCB. Partners have agreed to share costs if a Serious Case Review is initiated. A system to receive payment from partners attending LSCB training is now in place.
- SBC assured the LSCB that support is available to enable the LSCB website to be updated.
- SCST assured the LSCB that the training officer and business support is funded in order to enable the delivery of the LSCB training schedule.
- Partners provided staff with specific expertise to take part in critical case reviews and community events. Thames Valley Police volunteered their time to ensure multi-agency learning from case reviews was delivered on behalf of the LSCB at no additional cost.
- The LSCB Independent Chair and Business Manager worked closely with other Boards within Slough to ensure work on overlapping safeguarding themes is not duplicated.

- *Slough Safeguarding People Protocol* was agreed and outlines the relationship between Slough Wellbeing Board, Slough Local Safeguarding Children's Board, Slough Adult Safeguarding Board, Safer Slough Partnership, Preventing Violent Extremism Group and Slough Joint Corporate Parenting Panel.

What difference did this make?

The Board has reassurance of its required funding and remained within budget at the end of the financial year. Increased funding from some partners enabled the Independent Chair to work additional days to ensure the work of the LSCB is progressed. The work of the LSCB benefits from the expertise of a wide range of partners. Joint working with other multi-agency boards within Slough and across Berkshire encourages efficient and cost effective working and reduces duplication of efforts.

What we need to do better:

As the Slough Safeguarding Business Unit is developed in this current year (2017/18) it is essential that we firm up all financial, administrative and communication processes to ensure maximum effectiveness and clarity in our strategic cohesion and service delivery.

Theme 5: Undertake a training needs analysis and regularly evaluate the quality and impact of training (including e-learning).

Purpose of this theme: The LSCB training programme will be determined by a current Training Needs Analysis from all partner organisations. Evaluation of training will evidence improvements in practice and service delivery. Partner organisations will ensure that learning outcomes are incorporated into practice.

What we did:

- The LSCB Training Officer devised and published a training calendar for 2016-17.
- The event evaluation feedback form and follow up feedback form were redesigned, beginning the process to measure the impact of training.
- The chair of the Learning and Improvement subgroup was agreed, with the first meeting held in February 2017.

What difference did this make: Activities under this theme did not progress as effectively as intended in the period covered by this annual report, but have progressed since the Learning and Improvement subgroup was established in February. Further information is provided under the Learning and Improvement subgroup section below.

What we need to do better:

Outstanding actions have been incorporated into the Business Plan for 2017-18 under Objective 4: the LSCB will share learning and improve front line practice through an evidence informed learning and development programme. Specific actions will focus on an annual multi-agency training needs analysis, a multi-agency training programme, and evaluation of the quality and impact of training. There will be a facility to book training through the new LSCB website, which will include links to other relevant training and safeguarding ELearning.

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.

Purpose of this theme: The Children Act 2004 requires the LSCB to include two lay members representing the local community, helping to make links between the LSCB and community groups

and supporting an improved public understanding of the LSCB's child protection work. 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. Slough LSCB needs to ensure that information is accessible to all members of the community.

What we did:

- The Business Manager attended the FGM community event.
- The Independent Chair and Head of Service for Performance and Quality Assurance, met with a local resident to share progress of safeguarding initiatives within Slough.

What difference did this make?

The LSCB has not made sufficient progress in this aspect of its work. We are in discussion with two possible lay members and will be attending a Slough Youth Parliament in the autumn, but we still have a lot to do to make a significant improvement in achieving wider understanding and engagement. Progressing this is a priority for the incoming Safeguarding Business Manager.

What we need to do better:

Creating opportunities to engage with community groups is a priority for the LSCB. A LSCB leaflet and newsletter is planned, as well as community awareness events to increase awareness of child protection issues.

A new safeguarding website is under development, due to be launched in the autumn 2017, which will be easy to use and compatible with mobile devices. A social media platform will be instrumental in supporting the Board's priority to engage with a wider audience and will be integrated within the website. The website will have links to access the Safeguarding Board's Twitter account and Facebook Page.

3. Achievements by LSCB Subgroups

The work of the Board is delivered by multi-agency subgroups, some of which are Pan Berkshire in order to ensure a joined up approach to keeping children and young people safe across the county. A structure chart is included as Appendix B.

Serious Case Review

A key function of the LSCB is to undertake reviews of serious cases and advise the local authority and their partners on lessons to be learned. Serious Case Reviews are undertaken in the event of the death or serious injury of a child where abuse or neglect is known or suspected, the aim being to identify where agencies could have worked together more effectively.

The SCR Sub Group has met on a regular basis throughout the year. The chairing arrangements of the group have changed in this reporting period as the new independent chair for the LSCB came into post in September 2016.

Key activity and outcomes:

Serious Case Review

This was initiated in 2014 following the death of a child on the railway lines with their mother. The SCR concluded in 2015; however, alongside this a Mental Health Domestic Homicide Review was undertaken. Learning from the review was implemented and a further learning event in 2017 is planned which incorporates some of the themes identified in the SCR. The SCR will be published during 2017-18 in conjunction with the Mental Health Homicide Review which was carried out by NHS England.

Critical Case Review 1

A case review was completed following a serious injury to a child. A different methodology was tested whereby partner agencies were asked to complete a chronology and a single meeting convened to review the chronologies and identify key issues and areas for development. Outcomes include:

- Additional information on the Health Visitor Manual: health practitioners will record on the system that they have reviewed previous records and any significant information / risks.
- Where a family has moved around and information is not readily available from the previous area, assessments must highlight this as a potential risk.
- Continued awareness of cultural issues and how they might impact on the way in which risks are managed within a family.

Critical Case Review 2

This case review was held in response to a serious incident where an attempted abduction of a child in foster care took place.

Agencies completed comprehensive reports for the case discussion which took place at the SCR meeting. An action plan was completed at the conclusion of this review and outcomes included:

- Multi-agency escalation policy reviewed and updated in the Pan Berkshire LSCB Child Protection Procedures.
- Children's Social Care implementing a Signs of Safety framework to inform assessment and risk analysis.
- Multi-agency Safeguarding Cue Card provides all practitioners across the children's workforce with clear information about what to do if they are worried about a child.

Gangs and Youth Violence

A shooting incident that had taken place was reviewed by the SCR subgroup in the context of rising concerns about gang and youth violence. This led to a wider discussion and high quality information sharing at an LSCB meeting and an agreed action to carry out a multi-agency audit where young people were known to be associated with gangs or impacted by gangs and youth violence. The audit findings, alongside some wider research, led to the agreement to develop a more focused multi-agency approach to gangs and youth violence. This work will take place during 2017/18.

Learning

A learning event was held in July 2016 which focused on learning from national and local SCR and Critical Case Review activity, led by the Detective Chief Inspector of the Child Abuse Investigation Unit and the LSCB Business Manager. It was attended by 38 delegates from a variety of agencies and was given positive feedback with delegates saying that it was: *clear; useful; informative; revealing; valuable; thought-provoking; stimulating; realistic; interactive; fantastic content; valued multi-agency presence; the event brought professionals together.*

The SCR subgroup has continued to review publications of Serious Case Reviews and also completed a gap analysis using the SCIE – NSPCC Overview of Collation of Serious Case Reviews as a framework. This enabled the LSCB to seek assurance of agency compliance with safeguarding issues and a continued focus on areas for improvement.

Quality Assurance

The Quality Assurance subgroup undertook multi-agency audits on domestic abuse, adult mental health, and gangs and youth violence. Each audit highlighted issues and areas for development for individual agencies as well as wider strategic issues, and relevant learning and recommendations have been incorporated into the LSCB training programme.

The audit findings identified the need for a more comprehensive overview of the issues and challenges of violence and gangs and greater awareness of the impact of this emerging issue for Slough. A multi-agency strategy on gangs and youth violence has been developed, to conclude in 2017. Guidance on gangs and youth violence has been recirculated to LSCB members for wider dissemination and training has been delivered to increase staff awareness of these issues for young people in Slough.

An updated Information Sharing policy has been agreed as part of the Pan Berkshire LSCB Child Protection Procedures which has led to improved information sharing in multi-agency forums, in particular through the MASH and SEMRAC Panels.

The Quality Assurance subgroup had a change of chairing arrangements towards the end of 2016. Membership of the group and attendance has been variable and it will be necessary to refocus on this in 2017/18 to ensure all relevant partner agencies are able to contribute to the multi-agency audit process.

Learning and Improvement

Slough was a partner in the East Berkshire Training subgroup until it was disbanded in January 2016; for the major period of time covered by this annual report we did not have a functioning Training subgroup until the Learning and Improvement subgroup was established in February 2017. There was however an active schedule of training and learning and development opportunities during this period provided by the SCST Training Officer. All training has been updated in line with changes in guidance and legislation. With the absence of a subgroup for much of the reporting year, a formal training needs analysis was begun but not completed. Instead, training was based on the previous year's training needs and in response to bespoke training requests to meet the needs of the workforce, for example, apprenticeship scheme, early years, acute service and foster carers. An honour based violence and female genital mutilation update to the step up to social work students was delivered in response to a request for greater awareness in these areas.

59 sessions have been delivered, offering 752 learning opportunities for the workforce in a range of safeguarding areas through the LSCB offer. Single agency training at targeted level is also delivered. Multi-agency targeted training was reviewed in line with feedback from delegates and as a result of this, a half-day targeted refresher course is now delivered. The targeted refresher takes into account the new emerging safeguarding themes such as modern day slavery, FGM, CSE and online grooming. An additional session was delivered in response to demand for places.

Multi-agency CSE training was reviewed by the CSE subgroup and three levels have been introduced: basic (ELearning), targeted (delivered in house) and specialist (commissioned externally). CSE training has been promoted to ensure staff are able to recognise CSE and use the risk indicator tool effectively. Training provided for 860 taxi drivers licensed in Slough on recognising and responding to concerns about adults at risk and child sexual exploitation was the first program of its kind in Berkshire.

Education

This group was not established during 2016/17. A programme of school Self Evaluation Safeguarding Reports was initiated under Section 175 of the Education Act. This programme has been reviewed and incorporated into the work of the Education subgroup established in April 2017.

Strategic Child Sexual Exploitation (CSE)

The purpose of the Strategic CSE subgroup is to bring together key partners to ensure an effective response to children and young people at risk of, or subject to, child sexual exploitation, missing and child trafficking. The subgroup meets every 6 weeks. The main activity is to lead the implementation of the CSE Strategic subgroup action plan. Close working with the Learning and Improvement

subgroup ensures that training is not duplicated, is attended by appropriate staff and specialist training content is reviewed to ensure it meets the needs of the workforce and local communities. Achievements by the CSE subgroup are outlined under Theme 3 above.

An area of focus for the coming year is to ensure all partner agencies contribute consistently to the subgroup.

Female Genital Mutilation (FGM)

The FGM subgroup meets monthly and includes representation from Slough Borough Council, Slough Children's Services Trust, schools, Slough Clinical Commissioning Group, Thames Valley Police, Berkshire Healthcare NHS Foundation Trust and Frimley Health NHS Foundation Trust.

In June 2016, the Slough LSCB Strategy to Combat Female Genital Mutilation was published. The strategy sets out the local plan for tackling the illegal practice of female genital mutilation (FGM) in Slough. It recognises the interconnectedness of the FGM agenda with that of other forms of violence against women and girls. The intended outcomes of the strategy are that we have:

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

It is the responsibility of the FGM subgroup to develop and implement an action plan in support of the priorities set out in this strategy. The action plan encompasses violence against women and girls (VAWG), including FGM, child sexual exploitation, honour based violence and domestic abuse. Completed actions in the reporting year include: adoption of the Home Office VAWG strategy by the Safer Slough Partnership; actions to raise awareness of the new policing model and how it will support the identification of perpetrators and public protection; and a letter to all schools to raise awareness of FGM.

Pan Berkshire Subgroups:

Section 11 Panel

This pan Berkshire panel oversees the Section 11 Children Act 2004 process for all Berkshire wide organisations and the six local authorities to support improvement. Through a rolling programme, it reviews and evaluates Section 11 returns of the full three yearly audit in order to assess agencies' compliance with the duty to safeguard and to identify and share learning. The subgroup also reviews and evaluates those organisations' mid-term status of compliance against the three yearly full audits and provides support as needed. A sixth monthly and annual report is provided and members take responsibility for feeding back these updates to their respective LSCBs.

Since March 2016, three S11 meetings were held with two additional meetings to complete the Local Authority Audits which had been submitted late. Membership is now more comprehensive, but continues to lack consistent attendance from Children Social Care managers. The LSCB acknowledged that this is an issue for Slough that requires addressing and has sought to ensure improved attendance.

In the reporting year, the panel reviewed its tool and format, agreeing actions to make processes as robust as possible. Guidance notes have been revised and made more explicit.

Policy and Procedures Subgroup

Slough LSCB uses the *Pan Berkshire Child Protection Procedures* and the development and review of these are the responsibility of a pan Berkshire subgroup which reports to each of the six Berkshire LSCBs. This subgroup meets quarterly to identify areas that require review, ensuring policies and

procedures are kept up to date and communicating changes to the LSCB partners. Significant amendments are presented to the six LSCBs for endorsement. Slough LSCB hosted this subgroup until December 2016 but it has since moved to a shared arrangement between Bracknell and Reading LSCBs. The subgroup routinely considers findings from audits, inspections and reviews in order to identify whether changes to the procedures are required.

Agreed changes to the procedures were uploaded in January 2017 and an update on the changes were included in a Policy and Procedures Newsletter which was circulated to all six Berkshire LSCBs for onward dissemination to staff. Further changes were agreed in February to the Information Sharing Agreement, Escalation Policy, Strategy Meetings Timescales and Frequency of Child Protection Plan social work visits. These amendments will be included in the next update in July 2017, along with two new chapters on 'Dangerous Dogs' and 'Modern Slavery' and additional changes to the Domestic Abuse chapter.

Chapters on Child Protection conferences, bullying, organised and complex abuse, and neglect will be reviewed early in the coming year.

Child Death Overview Panel (CDOP)

The CDOP has a statutory function for reviewing the deaths of all children (0 to 18 years) in Berkshire. Through a comprehensive and multi-disciplinary review of child deaths, the aim is to understand why a child died and use the findings to take action to prevent other deaths and improve the health and safety of all our children. Learning is shared regionally and nationally so that it has a wider impact.

The Panel met regularly throughout the year, with good partnership representation. There were 46 deaths in 2016-17, which reflects a downward trend since April 2011. The Panel reviewed 53 cases, including some deaths notified in the previous year but not reviewed until this year. In Berkshire 92% of cases were reviewed within 12 months, compared to 76% nationally. 68.8% of actual deaths were of children under 1 year which is broadly consistent with the national figure of 66%.

In response to the high proportion of neonatal deaths among the overall numbers of child deaths reviewed, the Berkshire CDOP established a specialist panel to better consolidate learning. Most deaths are due to congenital anomalies and/or perinatal medical problems, particularly complications of prematurity and low birth weight.

Modifiable factors are defined as 'those, where, if actions could be taken through national or local interventions, the risk of future child deaths could be reduced.' Nationally, the proportion of deaths assessed as having modifiable factors remained unchanged at 27%. Locally, 11% of cases were assessed as having modifiable factors, which included co-sleeping with an infant, alcohol consumption, consanguinity, untreated UTI in mother before delivery and missed opportunity.

During the last six years, the number of unexpected deaths continues to show a downward trend and over 90% of all deaths now occur within a hospital setting. 11 cases of unexpected deaths were reviewed in 2016-17. All have documented rapid response reviews. Learning led to the following procedural changes for health services (particularly hospitals or ambulance services):

- A consultant and anaesthetist should always be called for a second opinion following a sudden deterioration.
- A member of staff should be appointed to take notes e.g. junior nurse, A&E nurse or junior doctor to ensure case documentation is accurate.
- All second presentations at A&E should have a senior review.
- A review of the sepsis triage tool and a collaboration of practice over the county.

- Training for health care professionals should include recognition of shockable heart rhythms and defibrillation.

The full annual report will be published on the CDOP website:
http://www.westberkslscb.org.uk/professionals-volunteers/cdop/

Child Sexual Exploitation Leads (CSE)

Although not strictly a subgroup of the Board, the CSE leads from the six Berkshire local authorities meet regularly to share good practice and initiatives and identify areas for joined up working.

4. Safeguarding Performance in 2016-17

Contacts

From 1 April 2016 to 31 March 2017 there were 9,861 contacts made to Children's Social Care, down from 11,145 in the previous year. There has been a change in the way these figures are recorded, therefore we may continue to see some changes as the new system is embedded.

Referrals

In the same year, there were 2,219 referrals, down from 2,774 in the previous year.

The rate of referrals per 10,000 0-17 year old population was 535.9, which is lower than the previous year's rate (670). Comparator figures are only available up to March 2016: the rate was lower than the statistical neighbour rate (586.2), but higher than the England rate (532.2).

Of the 2,779 referrals received in the year, 96.5% led to an assessment being undertaken; this was similar to the proportion in the previous year (97.6%).

Repeat Referrals

The proportion of referrals that were repeat referrals was 20.4% in the reporting year; this was slightly higher than the proportion in the previous year (18.5%). Our proportion of repeat referrals was similar to statistical neighbours (18.9%) and slightly lower than England (22.3%).

Single Assessments

In the reporting year, 2,134 single assessments were started; this was lower than the number in the previous year (2,686). 2,355 assessments were completed and authorised in the year, compared to 2,601 in the previous year. Of these, 78.8% were completed within 45 working days; this was slightly lower than the proportion in the previous year (81.8%).

Section 47 Investigations

885 Section 47 investigations were completed in 2016-17; this was slightly lower than the previous year (918). Of these, 317 led to an Initial Child Protection Conference (35.8%); again this was slightly lower than 356 in the previous year (38.8%).

Initial Child Protection Conferences in Timescales

A total of 331 ICPCs took place; this was similar to the previous year (345). 272 of these (82.2%) were held within 15 working days; this was similar to the proportion in the previous year (82.9%) and was above the statistical neighbour (75.6%) and England (76.7%) rates.

Children with a Child Protection Plan on 31 March 2016

On 31 March 2017 there were 157 children who were subject to a Child Protection Plan; this was much lower than the previous year (225). This is a rate of 38.7 per 10,000 0-17 year population, which was below the previous year's figure (54.3) as well as the statistical neighbour (47.1) and England (43.1) rates.

Children in Care

On 31 March 2017 there were 197 children who were looked after; this was a slight increase from the figure of 185 at 31 March 2016. This is a rate of 48.6 per 10,000 0-17 year old population, which is slightly above the previous year's rate (44.7) but remains significantly below the statistical neighbour (59.4) and England (62.0) rates. Note that, unlike those above, the statistical neighbour and England rates in respect of children looked after are at 31 March 2017.

Placement Stability (this is determined by the length of time in placement and the number of placement moves)

On 31 March 2017 12.7% of children had experienced three or more placement moves within the year; this represented a decrease compared to the figure of 15.0% at 31 March 2016, but is still above the statistical neighbour (10.7%) and England (10.0%) rates.

On 31 March 2017 66.0% of children in care under the age of 16 had been in a stable placement for at least two years; this represented an increase compared to the figure of 63.0% at 31 March 2016 but is still slightly below the statistical neighbour (68.3%) and England (68.0%) proportions.

Due to changes made by the Department for Education, these statistical neighbour and England figures are as at 31 March 2016, as no later comparator figures are yet available.

Health and Dental Checks for Children in Care

On 31 March 2017 82.1% of children in care were up to date with all of their health checks; this was below the figure at the end of the previous year (92.9%).

Percentage of children in Care Adopted or Granted a Special Guardianship Order

On 31 March 2017 16.4% of children in care had been adopted or granted a Special Guardianship Order (SGO); this figure is based on the number of adoptions and SGOs in the previous 12 months compared to the number of children in care as at 31 March 2017 who had been looked after for at least 6 months. This was a smaller proportion than the previous year (32.1%) but the figure is susceptible to changes in the cohort of children looked after.

Parental Factors

The most common parental factors applying to all open cases, in descending order, are:

- A known history of domestic abuse (victim)
- A known history of domestic abuse (perpetrator)
- Parental mental health
- Substance abuse
- Alcohol abuse.

These are the same factors, in the same order, as at 31 March 2016.

5. Priority areas for 2017-18

Objective 1: The LSCB will have a programme of effective monitoring and quality assurance of multi-agency safeguarding practice. Actions include: a rolling programme of multi-agency thematic audits; a local three yearly cycle of S11 self assessment activity for identified services and agencies; a local programme of S175 self assessment activity to inform safeguarding in schools.

Objective 2: The LSCB will be informed by a robust approach to the analysis of data and information that is qualitative and quantitative and leads to ongoing improvement activity. Actions include: a multi-agency dataset that enables the LSCB to identify and understand safeguarding issues so that it can respond with appropriate challenge and action.

Objective 3: The LSCB will have oversight of the effectiveness of safeguarding across agencies and will hold partners to account where necessary. Actions include: a challenge and escalation log to be used effectively by partners so that there is a clear record of the challenges made through the LSCB and a record of the impact and outcomes of these challenges; results of S11 and S175 audits to be analysed by subgroups and progress reported to the LSCB.

Objective 4: The LSCB will share learning and improve front line practice through an evidence informed learning and development programme. Actions include: an annual, multi-agency training needs analysis to inform the ongoing training programme which can be accessed by all partners, including the voluntary and community sector; a mechanism to evaluate the quality and impact of training; dissemination of learning from serious case reviews across the workforce through a variety of ways.

Objective 5: The LSCB will have clear mechanisms in place to communicate effectively with partners and stakeholders. Actions include: improved communication across the subgroups to reduce duplication and provide opportunities to share practice; promotion of the LSCB's roles and responsibilities by board members to increase awareness within their own agencies; promotion of the LSCB and its work through a new website, social media, public awareness raising events, leaflets and newsletters.

Objective 6: The LSCB will work closely with other partnerships to ensure individual accountability and shared responsibility for safeguarding and promote joint working around mutually agreed safeguarding priorities. Actions include: ensure stronger connectivity and coordinate service delivery between the SAB and the LSCB through the development of a Joint Business Unit; ensure strong and effective links with other multi-agency boards so that learning is shared and a coordinated response is made where safeguarding issues cut across agendas; ensure Board membership is representative of the partner agencies in Slough, including lay members and the voluntary and community sector; ensure partner members contribute to Pan Berkshire subgroups as necessary to ensure there is a coordinated and consistent approach across Berkshire.

6. Achievements by partner agencies

Berkshire Healthcare Foundation Trust

BHFT have continued to work closely with other organisations and partners agencies. This includes multi–agency audits, provision of targeted level three training, membership of forums and provision of advice to partner agencies on the services within the Trust. The Trust is represented at all relevant LSCB subgroups by the Safeguarding Children Team, with senior management representation on the LSCB.

Named professionals work closely with their safeguarding colleagues across Berkshire, participating in serious case reviews and meeting regularly to share information, influence policy change and discuss relevant cases to influence continued improvement and increased knowledge in safeguarding.

Achieving training compliance has been a priority for BHFT this year and the Trust have achieved compliance above 90% to all levels of safeguarding children training during 2016/17. The safeguarding children and adults teams amalgamated during 2016/17 to facilitate a more joined-up 'think family' approach to safeguarding. Specialist child protection supervision has been extended to all staff groups who work directly with children during the year.

Frimley Health NHS Foundation Trust (Wexham Park Hospital)

Frimley Health Trust (HWPH) has experienced recent staff changes within the Safeguarding Children Team. A newly appointed Lead Named Nurse for Safeguarding Children commenced in May 2017 and a Specialist Nurse for Safeguarding Children has recently been appointed. The team is further complimented by a Named Doctor, a Paediatric Liaison Health Visitor and a senior administrator. Specialist staff are based in maternity (Named Midwife), Neonatal Unit and the Emergency Department.

The Trust is represented at the Slough LSCB by senior post holders (namely the Named Doctor for Safeguarding Children or the Lead Named Nurse) and on of a number of subgroups. The relationships developed through the LSCB enable Frimley Health Trust to provide best practice, up to date safeguarding training, supervision and care to children, young people and families. Strong links have been established within Slough LSCB to provide joined up support in areas such as youth gang violence and child sexual exploitation.

During the reporting year, the Named Nurse for Safeguarding Children recognised an increase and potential trend of violence amongst young people living in Slough Borough attending Wexham Park Hospital Emergency Department. The injuries related to stabbings and involved weapons. The children injured ranged between 14-17 years old. Recognition of the trend was shared with partner agencies (Designated Nurse, Police, Slough Children's Trust) leading to further discussion at the LSCB Quality and Assurance Group. Timely sharing of the information was key to providing effective help for young people and helped to raise awareness of the current gang situation in Slough. The Slough Youth Violence Group received a commendation from the Home Office. Gang violence is now included in safeguarding children training.

Healthwatch Slough

During 2016/17 Healthwatch Slough commissioned Slough Refugee Support to undertake some awareness raising workshops to highlight the fact that Female Genital Mutilation (FGM) existed and was practiced not only in countries across the world but also in the UK, including Slough, provide information and advice on concerns raised by either families or their children, and strengthen the voice of women and communities speaking out against FGM.

Healthwatch Slough also developed a fun initiative to engage local children and to gather information about their understanding and experience of health, wellbeing and related local services. The initiative was carried out in partnership with Slough Libraries, Public Health team and two local schools. Healthwatch Slough delivered a talk at two school Food Fight events (no actual food was wasted in this process!) Children who participated in the sessions received a goodie bag containing a quiz card from Healthwatch Slough. The quiz was also available in local libraries and at local community events. 168 children completed and returned the quiz card. Their responses provided valuable insight into their perspectives on staying happy and well, including their awareness of local health services. In response to the questionnaire findings, Healthwatch Slough recommended seven actions to improve children's health and wellbeing in Slough.

During the year, Healthwatch Slough worked with organisations to raise awareness of young carers and the challenges they face.

Healthwatch Slough also held a number of 'talking shops' with statutory and voluntary organisations which have enabled people to find out more about opportunities, projects and initiatives for supporting wellbeing throughout communities, including for children and young people.

Slough Clinical Commissioning Group

A new named safeguarding professional to work with the Deputy Director of Nursing was appointed. The post of Associate Director of Nursing incorporated the Looked After Children designated nurse role. Achievements so far include an East Berkshire multi-agency liaison group, lobbying for health assessments for LAC children placed 20 miles away from Slough and production of health passports.

An audit of GP case conference reports was completed in March 2017. Primary care safeguarding self-assessments were reported to the Section 11 panel, with gaps addressed in the 2017-18 plan and used to inform GP training.

Primary care safeguarding training took place in autumn/winter 2016 with an emphasis on the Care Act, care homes, MCA/DOLs and lessons from national and Berkshire serious case reviews. Safeguarding level 3 training was delivered to each CCG based training event in the winter of 2016. A safeguarding training strategy for CCG staff was developed, with the addition of Prevent ELearning as a mandatory requirement. The CCG has been successful in a £15,000 bid to fund a conference across east Berkshire against violence and exploitation, scheduled for November 2017.

The concealed pregnancy guidance and the bruising protocol guidance have been updated and republished in the Berkshire Child Protection Procedures. The CCG safeguarding policy in relation to allegations against staff was updated in January 2017.

Communication has taken place with primary care providers regarding the DoLS interim statement and impending statutory changes, and children who are at risk of sexual exploitation. A safeguarding newsletter was published in the summer of 2016.

Slough Children's Services Trust

Slough Children's Services Trust (SCST) was established as a not-for-profit trust on 1 October 2015 after intervention by the Department for Education to remove children's services from Slough Borough Council, following a series of 'inadequate' ratings.

The Trust in partnership with Slough Borough Council submitted an improvement plan in June 2016 which laid out the key recommendations made by Ofsted and what actions the Trust and partners were taking to address the recommendations. A multi-agency Joint Improvement Board was established to oversee the delivery of the plan and progress areas of concern.

A key task for the Trust in its first year was to develop a model of working that was evidence based and proven to make a difference to children and young people. The 'Safe, Secure, Successful' approach is based on working in Hubs which include Consultant Social Workers, Senior Social Workers, Social Workers, Child and Family workers with a Clinician in place for each Hub to support the systemic approach to social work. This model is now implemented across the Trust and an evaluation of the impact on families called 'Measuring What Matters' has been commissioned through Bedford University, to conclude in 2017/18.

The Trust has established a clear single point of contact for all referrals and the revised threshold document is used to inform decision making. Ofsted reviewed the First Contact service during a monitoring visit in November 2016 (https://reports.ofsted.gov.uk/local-authorities/slough). Ofsted said that they saw evidence of the multi-agency threshold document being used at the front door and that social workers made timely decisions. Ofsted monitoring visits continue into 2017/18 as part of the ongoing programme of improvement and support.

The Multi-Agency Safeguarding Hub was launched fully in September 2016 and this has been an important part of ensuring a multi-agency response to referrals that have been made and is an important part of the pathway for children and families.

The Trust was also successful in securing innovation funding to offer a multi-agency approach to helping families before statutory intervention is required. This team includes a domestic abuse worker, drug and alcohol worker, Family Group Conference Coordinator and Child and Family workers.

The PAUSE project (providing direct support to mothers who have had more than two children taken into care) will also work alongside the new hub to prevent more children coming into care and support women who are vulnerable to this happening.

In reviewing the Private Fostering arrangements in Slough Children's Services Trust the following activity has taken place to ensure that there is compliance with the Private Fostering standards:

- A Private Fostering Statement of Purpose was completed in 2014 by Slough Borough Council; this has been updated in 2017 and is published on the Trust website.
- An information sheet on Private Fostering has been written and has been circulated widely to a range of partners and stakeholders including all schools, Children's Centres, Early Years network and LSCB members for onward dissemination.
- Slough Children's Services Trust website contains information about private fostering which can be accessed at: http://www.scstrust.co.uk/what-we-do/fostering/private-fostering/
- Private fostering is addressed in targeted safeguarding training.
- Cases that were identified as Private Fostering have been reviewed to ensure compliance with the standards.
- Slough Children's Services Trust has a nominated manager with lead responsibility for Private Fostering and will be responsible for future reporting to the LSCB.

Slough Council for Voluntary Services (CVS)

Over the last year, Slough CVS has continued to inform the voluntary sector of the importance of safeguarding children and young people in Slough. A weekly electronic newsletter is emailed to over 400 recipients a week and includes messages from the LSCB. An important impact of the work of the CVS is to develop a workforce equipped to deliver effective, safe and quality provision to children and young people in Slough and the use of a quality assurance toolkit has supported the voluntary sector staff delivering robust and safe practices.

Thames Valley Police

Thames Valley Police (TVP) have delivered the initial Safeguarding Vulnerability and Exploitation (SaVE) training and awareness programme to all front line staff and are currently delivering SaVE 2, SaVE specialist and SaVE for Leaders inputs. The programme is designed to improve staff ability to recognise vulnerability and ensure appropriate steps are taken to manage the associated risk. It involves the use of the ABCDE vulnerability tool to support a consistent approach and response.

TVP's dedicated review team conducted a thematic review of all Serious Case Reviews (SCRs) and Domestic Homicide Reviews (DHRs) for which an Independent Management Review was completed in the last five years and identified five themes which have subsequently gone on to inform the Force's Delivery Plan, Strategic Assessment and the training delivery of the SaVE programme, including the dissemination of organisational learning. HMIC commented that this is the first time they have seen a force complete this piece of work and that they see this as excellent practice.

TVP have changed their performance framework which now involves Force meetings around areas of risk including a number of the vulnerability strands. There are now dedicated meetings for child protection, CSE and missing, honour based abuse, forced marriage, female genital mutilation and domestic abuse, chaired by either the Deputy or Assistant Chief Constable. These are attended by key stakeholders from across the Force and the emphasis is on identifying areas of risk, areas for improvement and recognising and developing best practice. HMIC have commented on this approach being the 'Jewel in TVPs crown'.

TVP have developed its Performance Team into the Service Improvement Unit working to the new framework. This has significantly improved the ability to undertake single and multi-agency audit activity with delivery of a consistent standard of product. Internal audits in the last year include a review of data quality in MASH referrals and a review of decision making by TVP within the MASH.

Youth Offending Team (YOT)

Work with partners, young people and their families, in respect of safeguarding, continues to be evident with attendance from the YOT team at strategy and professionals meetings. All staff are up to date in respect of safeguarding training and CSE training.

This year, Slough YOT continued to see a rise in the number of young people involved in serious youth violence or having gang affiliations. In order to safeguard those individuals involved with gangs, Slough YOT has implemented a robust programme of activities and interventions to address offending behaviour. This resulted in a 'Real World' group programme which targeted the siblings of young people who commit violent offences. At the time of writing, only one out of six young people who completed this group have come to the attention of the courts.

Slough YOT attends and contributes to Slough Violence Multi-Agency Panel, the recently established Organised Crime Group and the Local Police Area Gangs Meetings which seeks to reduce violent activity via problem solving and supporting enforcement activity. Work around gangs and serious youth violence is in line with findings highlighted in the County Lines Gang Violence, Exploitation and Drug Supply 2016 published by the National Crime Agency. The YOT seeks to work with various organisations that aim not only to safeguard but also to protect the public, such as the embryonic working relationship with East Berkshire College.

Appendix A Glossary

BHFT	Berkshire Healthcare Foundation Trust
CCG	Clinical Commissioning Group
CSE	Child Sexual Exploitation
CP	Child Protection
DHR	Domestic Homicide Review
DoLS	Deprivation of Liberty Safeguards
Engage	A project initiated by the Young People's Service and aims to support young people at risk of sexual exploitation through 1:1 and group support sessions
FGM	Female Genital Mutilation
FM	Forced Marriage
HBA	Honour Based Abuse
HMIC	Her Majesty's Inspectorate of Constabulary. HMIC independently assesses police forces and policing.
IMR	Independent Management Review
JTAI	Joint targeted area inspections involving Ofsted, Care Quality Commission, HMI Constabulary and HMI Probation.
LSCB	Local Safeguarding Children's Board
MASH	Multi Agency safeguarding Hub
MCA	Mental Capacity Act
NRM	National Referral Mechanism for exploited and trafficked children
Prevent	One stream of the Government's Counter-Terrorism strategy; the aim is to work with communities in order to avoid violent extremism being supported.
RBFRS	Royal Berkshire Fire and Rescue Service
SAB	Safeguarding Adults Board
SAVE	Safeguarding Vulnerability and Exploitation
SCAS	South Central Ambulance Service
SCST	Slough Children's Services Trust
Section 11	Section 11 of the Children Act 2004 places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children

Section 175	Under Section 175 of the Children Act 2004 the schools safeguarding audit is designed to assist schools in ensuring that they have the evidence to show that their safeguarding procedures are robust and to identify any actions needed to make improvements regarding their safeguarding responsibilities.
SEMRAC	Sexual Exploitation and Missing Risk Assessment Conference
Slough CVS	Slough Council for Voluntary Services
TVP	Thames Valley Police
WRAP	Workshop to Raise Awareness of Prevent

Appendix B Slough LSCB Structure Chart