#### READING BOROUGH COUNCIL

#### REPORT BY DIRECTOR OF CHILDREN, EDUCATION & EARLY HELP SERVICES

TO: Health and Wellbeing Board

DATE: 27<sup>th</sup> January 2017 AGENDA ITEM: 17

TITLE: Reading Local safeguarding Children Board Annual Report

LEAD CIIr Jan Gavin PORTFOLIO: Children's Services

COUNCILLOR:

SERVICE: Children's Services WARDS: Boroughwide

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Reading LSCB and Children's Trust Partnership

#### PURPOSE OF REPORT AND EXECUTIVE SUMMARY

- 1.1 The Reading Local Safeguarding Children Board is the key statutory mechanism for agreeing how the relevant organisations will co-operate to safeguard and promote the welfare of children in Reading and for ensuring the effectiveness of what they do (Working Together To Safeguard Children 2015).
- 1.2 This Annual Report is being presented to the Health and Wellbeing Board to ensure members are informed about the achievements of the LSCB for the 2015/2016 financial year. The Annual Report has a wide distribution and is sent to key stakeholders and partners so that they can be informed about the work and use the information in planning within their own organisations to keep children and young people safe.

### 2. RECOMMENDED ACTION

2.1 That the Health and Wellbeing Board note the attached annual report.

# 3. POLICY CONTEXT

- 3.1 As required by Working Together 2015, the LSCB Chair is required to publish an annual report on the effectiveness of child safeguarding and promoting welfare of children in Reading.
- 3.2 In line with this statutory guidance the report is presented to the Health and Wellbeing Board for information. It has also been presented to the Adult Social Care, Children's Services and Education Committee and the Children's Trust Board.

#### 4. THE PROPOSAL

- 4.1 Partnership working is a vital ingredient for an effective LSCB and this report contains information on some of the activities and achievements which have taken place that demonstrate this. Board members both champion and lead the safeguarding agenda within their agency and bring to the LSCB issues regarding safeguarding that relate primarily to their own agency, but which have implications for the co-operation between agencies and the monitoring role of the Board.
- 4.2 This report focusses on the achievements and ongoing challenges for the LSCB and partners specifically against our priorities. The priorities for the 2015/16 year were:

Priority 1. Domestic Abuse

Priority 2. Strengthening the Child's Journey and Voice

Priority 3. Child Sexual Exploitation (CSE) and other Particularly Vulnerable Groups

Priority 4. Neglect

Priority 5. Effectiveness and Impact of Reading LSCB

- 4.3 Evidencing the impact of safeguarding work is key to understanding what works and how we can improve. Throughout this report the impact of work is highlighted, alongside what has been delivered.
- 4.4 The annual report in previous years has focused on work being carried out individually by LSCB partners, however it is positive that this year the content reflects more widely the work undertaken in partnership.
- In summary, key LSCB achievements for 2015/16 are listed below under the priority headings. Also listed are the ongoing concerns which the LSCB will continue to challenge in 2016/17, all of which are included within the LSCB Improvement and Development Plan for 2017.

#### 4.5 **Priority - Domestic Abuse**

Achievements:

- LSCB input and endorsement of the Domestic Abuse Strategy 2015-18, managed through the Domestic Abuse Strategy Group (sub group of the Community Safety Partnership).
- Continued support for the Family Choices Programme for families affected by domestic abuse.
- Support, through Public Health, for the IRIS project to support and training GP practices in how to identify domestic abuse and make referrals.
- Domestic Abuse Challenge session identified key areas of progress required in 2016/17.

#### Ongoing Challenges:

- A consistent and comprehensive approach to deliver information and support to schools needs to be further developed.
- Establish a system which allows schools to receive domestic abuse notifications.

# 4.6 Priority - Strengthening the Child's Journey and Voice *Achievements:*

- The Youth Cabinet carried out a domestic abuse survey which was presented to the Board and recommendations discussed and agreed.
- Emotional Health and Wellbeing was identified as a key issue by children and young people and is a key priority for 2016/17.
- LSCB has continued to fund the MoMo app which provides young people an easy way to get in touch with Children's Social Care. Up to April 2016 46 submissions had been made.

#### Ongoing Challenges:

- To better include the direct voice of young people at our Board meetings.
- A review of the MoMo app is required to ensure it is value for money and effective.

# 4.7 Priority - CSE and other Particularly Vulnerable Groups *Achievements:*

- A clear multi-agency LSCB CSE strategy is in place with a live action plan.
- The CSE toolkit and screening tool was rolled out in June 2015 attended by 100 practitioners and managers from across the partnership.
- The LSCB funded productions of Chelsea's Choice in all Reading secondary schools reaching approximately 2000 pupils.
- CSE training continues to be offered to LSCB partners at universal, targeted and specialist levels, with attendees reporting that their knowledge has either significantly or very significantly improved.
- 7,000 CSE Safeguarding Business Cards, produced and funded through the LSCB have been distributed across the partnership.
- There has been increased referrals to SEMRAC (Sexual Exploitation and Missing Risk Assessment Conference) as professional knowledge of CSE indicators increases.
- Improved notification and recording of missing children information and the creation of a dedicated Missing Children Coordinator since January 2016 has enabled better reporting and understanding of the issues and better interagency sharing of information.
- The number of successful missing children interviews has been steadily increasing, and issues identified through these meetings have been reported to Children's Social Care. However the timeliness of these interviews needs to increase.
- An LSCB task and finish group was established to gain a better understanding of the risk of Female Genital Mutilation in Reading, establish the processes already in place and what improvements are required. An action plan and strategy were written, which led to reviewing and improving training opportunities for front line practitioners, production of a clear risk assessment tool with identified pathways for all front line staff to follow.

#### Ongoing Challenges:

- Further training on CSE is required for schools and the voluntary sector to improve knowledge of indicators and pathways.
- A revised CSE risk assessment tool needs to be rolled out and embedded.
- The timeliness of missing children interviews needs to improve to ensure vital information can be captured as soon as possible after the child/young person returns home.
- The FGM guidance and tool kit needs to be embedded in front line practice, with available training opportunities.

#### 4.8 Priority - Neglect

#### Achievements:

- The LSCB produced a Neglect Protocol with clear recommendations for all partners.
- Information from the LSCB regarding neglect was produced and disseminated, this included:
  - the production of a booklet that identified signs, symptoms and effects of neglect
  - o introduction of a 'neglect' page on the LSCB website

- training template written to help practitioners understand, identify and respond to neglect
- neglect briefing session delivered to school designated safeguarding leads.
- The Thresholds document was significantly reviewed and revised in late 2015, with new posters and guidance booklets distributed to all partners. Over 350 front line staff attended launch workshops, and threshold information is now a key part of universal safeguarding training.

#### Ongoing Challenges:

- The LSCB recognised that there had been a lack of progress in this priority area and as a result task and finish group has been set up for 2016/17 to push this work forward. This group has written a strategy and action plan.
- The regular review of thresholds needs to target key areas of the partnership where inappropriate or no referrals are being made.

# 4.9 Priority - Effectiveness and Impact of Reading LSCB *Achievements:*

- A risk and concern log has been established and embedded which is reviewed at each Board meeting to ensure any concerns are kept live until resolved.
- Boards meetings reflect greater challenge and Board members feel more confident in expressing views and holding partner agencies to account.
- LSCB Sub Groups have been restructured to ensure a local focus on quality assurance and performance. Performance data and auditing outcomes are expected and presented at every Board meeting.
- The LSCB training offer has been discussed at Board level to ensure all Board members had oversight of this vital element of the LSCB.
- Reading LSCB has funded Reading Children and Voluntary Youth Services (RCVYS) to provide a range of safeguarding training courses directly to the voluntary sector. In 2015/16 64 different organisations attended training courses which includes universal safeguarding training, managing safeguarding within your organisation, trustee's awareness training and train the trainer training for voluntary sector early years providers.
- LSCB communications has improved with:
  - o a revised website with dedicated pages to key safeguarding priorities
  - 'Safeguarding is Everyone's Business' video created and disseminated to partners
  - CSE Safeguarding business cards and threshold documentation disseminated to front line practitioners
  - o regular newsletters and weekly information bulletins are produced and sent out for dissemination via the Board.

# Ongoing Challenges:

- Further strengthen the governance of the LSCB and its sub groups to ensure better communication with the Board and members.
- Continue to strengthen the auditing and performance review function to ensure the Board can hear and discuss the learning/issues raised.
- Ensure the LSCB Training offer within Reading has a more specific focus on the needs of the Reading workforce.
- Further communication and awareness raising is targeted, such as thresholds information to those practitioner groups that currently make inappropriate or no referrals.
- Learning from audits and reviews are better disseminated to front line practitioners to support improvements in practice.

- 4.10 The Annual Report relates specifically to the 2015/16 year, however there have been a number of developments since March. These include:
  - FGM resource pack (including guidance, risk assessment tool and pathways) was successfully launched to 100 staff from across the partnership.
  - A range of factsheets on topics such as FGM, thresholds, Prevent and Private Fostering have been produced and can be found on the website.
  - School Designated Safeguarding Leads have been running through out 2016 and are routinely attended by up to 40 school colleagues. These focus on specific topics identified by attendees but also provide an opportunity to disseminate safeguarding information direct to schools.
  - The Thresholds document has been reviewed by partners and updated in line with current key priority areas such as CSE, FGM and neglect. Updated guidance, posters have been produced and disseminated, along with a new 'top tips for making safeguarding decisions' sheet and thresholds business cards.
  - A Safer Recruitment e-learning package has been created in Reading and shared with partners across the west of Berkshire. An FGM e-learning package to support practitioners in understanding the pathways and completing the risk assessment tool is currently being produced.
  - New induction packs have been created and distributed to all Board members, plus to sub-groups, to support new members of the LSCB understand their roles and responsibilities. Board members have also signed the revised member compact and agreed a revised Learning and Improvement Framework.
  - CSE Training has been revised to include practical application of CSE tools. CSE short courses have been developed and CSE champions trained to deliver these in schools and to the VCS.
  - Processes and forms in relation to missing children have been revised to enable the collection of better information in a more timely way.
  - Neglect strategy and action plan written and progress is being made, for example guidance on completing chronologies is being produced and training options are being explored.
  - A range of training opportunities are being progressed to compliment the traditional LSCB safeguarding programme, such as LSCB Forums which will be short two hour sessions.
  - A twitter account was launched in April, currently with 226 followers.
- 4.11 Ofsted Inspection May/June 2016 Ofsted agreed that progress had been made within the 2015/16 year citing 'positive change' and that 'the challenge and concern log facilitates active challenge, and has led to practice improvements'. Ofsted graded the LSCB as 'Requires Improvement' and made five recommendations which have been clearly included within the highlighted ongoing challenges for the Board. All challenges are included as part of the LSCB Improvement and Development Plan for 2017.

# 5. CONTRIBUTION TO STRATEGIC AIMS

- 5.1 The work of the LSCB aligns with the Council strategic aim of Narrowing the Gap and two of its service priorities:
  - Safeguarding and protecting those that are most vulnerable and:
  - Providing the best life through education, early help and healthy living.

#### 6. COMMUNITY ENGAGEMENT AND INFORMATION

6.1 This report has been written with contributions from all LSCB partners and circulated to the Board. It will be disseminated to all partners, the Health and Wellbeing Board and Children's Trust Board.

# 7. EQUALITY IMPACT ASSESSMENT

7.1 An Equality Impact Assessment (EIA) has not been carried out for this report however, equality and diversity continues to be a key theme for the LSCB.

### 8. LEGAL IMPLICATIONS

8.1 There are no legal implications with this report. Working Together to Safeguard Children 2015 requires that the LSCB to produce an annual report and that it be submitted to the Chair of the Health and Wellbeing Board.

# 9. FINANCIAL IMPLICATIONS

9.1 None

#### 10. BACKGROUND PAPERS

Reading LSCB Annual Report 2015/16

# Reading Local Safeguarding Children Board

Annual Report 2015-2016





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### **Forward**

Welcome to the 2015/16 Annual Report for Reading Local Safeguarding Children Board. I am very pleased to present the achievements of the Board over the past year in relation to its key statutory duties and the Board's priority themes, agreed in consultation with children and young people and with agency partners on the basis of learning from outcome data, multi-agency audits and from reviews of children's cases. The report also sets out the remaining challenges we face and work we need to do together to deliver fully on our agreed priorities. I am committed to working with partners to further increase the pace of change and deliver better outcomes for children, young people and their families, over the next year.



I hope you will agree that the report shows that the Safeguarding Board is in a very different place than it was this time last year. Strong progress has been made to get basic systems, processes and governance arrangements in place including more robust quality and performance information to enable partners to more effectively challenge and support each other in the collective interest of safeguarding Reading children. I am pleased also at the progress that has been made to involve children and young people in the work of the Board and to contribute their thinking on priorities. Examples include the children and young people's annual report and the consultations undertaken by the Youth Cabinet, in particular their targeted work on children's mental health services and promotion of emotional health and well-being. I would also highlight the much stronger engagement now with schools in the work of the Board and the contribution they are now making to keep children safe and to support those pupils who are vulnerable or have more complex needs.

The Ofsted Inspection of Reading in June 2016 confirmed the Board's own assessment of 'Requiring Improvement' but making progress toward meeting the requirements of a Good Rating. This report shows evidence of some strong improvements in agency practice and some improved outcomes for children and young people. These include the notable increase in referrals to Early Help services and the further development of early support services. This has resulted in a higher proportion of children and families receiving a support service with some good outcomes for those families reported. This is reflected in the relatively low proportion being referred back into Children's Social Care. We will work across the partnership to extend the reach of these services further during 2016/17, resolving problems at an earlier stage and reducing the need for more formal interventions involving safeguarding and looked after children's services.

I would like to say a big thank you to all the agency partners represented on the Board, for their hard work and joint ownership of the challenges and opportunities we face. Also to the LSCB Sub-Group Chairs, Esther Blake and Donna Gray in the Reading LSCB team who, with Gary Campbell and other senior managers, have given their all to support and drive the Board's improvement.

Fran Gosling-Thomas

Tones Galy-Trans

Independent Chair, Reading Local Safeguarding Children Board



# Local context

# **Our Town**

Reading is a vibrant multi-cultural town: the second most ethnically diverse in the South East outside London. Reading is home to approximately 35,850 children and young people under the age of 18 years. This is 22% of the total population in the area. (ONS Mid-Year Population Estimates 2014).

What are the needs? (Figures as at 31<sup>st</sup> March 2016)

Approx. 24%children in Reading live in poverty

184 children and young people are living with their families in B&B

253 children and young people subject to Child Protection Plan (March 2016)

220 Looked After Children

616 children and young people identified as 'Children in Need' by Children's Services

589 identified Young Carers

52% of school population belongs to an ethnic group other than White British (29% in England overall)

259 families were receiving a Health Visiting Service at Universal Partnership Plus Level (Q3)

100 Young Offenders

27 Looked After Children and Young People have a disability (March 16)

Of the 43 children reported missing in March 2016, 40 received a Return Interview, 24 within 72 hours of CSC being notified

12 young people identified at risk of Child Sexual Exploitation (figure for

26.7% of Police Domestic Violence notifications sent to MASH lead to a referral (March 2016)

> 60% of Looked after Children are in stable

66 Teenage Conceptions (2014). (rate per 1000 15-17 year olds = 26.9, England average in 2013 = 24.5)

124 Number of identified vulnerable mothers worked with by midwifery (Dec 2015 annual figure)

34 Looked after Children from other LA areas living in Reading (Jan 2016)

During 2015 there were 97 children referred to Tier 3 mental health services. 10 Looked after Children and 29 Young People Subject to a protection plan were accessing CAMHS (Q3)

Proportion of children entitled to free school

meals: Primary 15.3% (National average

15.6%)

67% of families subject to a CP, CAF or CIN Plan are using Children's Centre services

The proportion of children and young people with English as an additional language:

Primary 35% (National average 19.4%) Secondary 26% (National average 15.0%)

32 (19%) of cases referred to the Multi-Agency Risk Assessment Conference (MARAC) are repeat cases

placements

177 referrals to Children's Social Care from the Royal Berkshire Hospital

3 known Privately Fostered Children

534 missing episodes were reported to Children's Social Care for 394 individual young people in 2015/16

Emergency Department, 131 of them

being for self harm (Q4, West of Berks)

49% of Looked after Children are placed more than 20 miles away from their home address

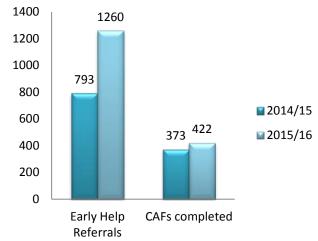
55.3% of 253 children and young people have a child protection plan for neglect

# Journey through Children's Services

### Early Help:

There is a well-established Early Help Service which includes 13 Children's Centres delivering services to families across Reading. These children's centres have good attendance rates across the clusters, particularly from targeted groups. 11165 children have used the Children's Centres which is 90% of 0-5 population.

Early Help Referrals and the number of Common Assessments (CAF) completed have increased in 2015/16 compared to the previous year. Schools, Children's Centres, Early Help and Children's Social Care continue to be the main sources of requests for help. All CAFs continue to be quality assured at point of submission to ensure that the importance of the Voice of Child, multi-agency contributions and clear analysis leading to a plan of support is in place.



Cases are 'stepped up' to children's social work services where required, with all 'step up' referrals

submitted through the Multi Agency Safeguarding Hub (MASH) to ensure a greater consistency of thresholds. 339 cases have been 'stepped down' to the Children's Action Teams (year to date March 2016) from the MASH, A&A or Area teams. Joint home visits or handover TACs (Team around the Child) are well established so that families do not experience any loss of support when cases are transferred and/or stepped down.

A revised Early Help pathway was implemented in early 2016 meaning that referrals for all early help services come through 'one front door', using a web based contact form. Once submitted to the Early Help Hub decisions are made as to what support is to be offered, building upon the already established multi-agency meeting.

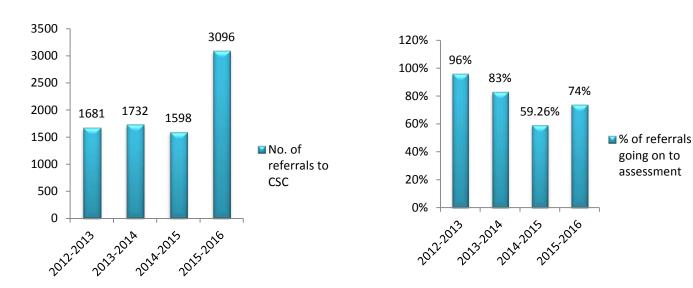
The Children's Action Teams (CATs) are multi-professional teams that link into existing local resources to provide holistic family support, early intervention and prevention services for children 0 to 19 year old and their families. Alongside the CATs, the Specialist Youth Services provides more targeted support to the most vulnerable young people, such as those at risk of teenage pregnancy or sexual exploitation, young people with drug and alcohol misuse issues, young parents, young carers and LGBT young people. For more vulnerable families where children are close to social care involvement, services and interventions such as the Edge of Care team and Multi Systemic Therapy Team work with families and provide more intensive, high-level support alongside other agencies.

83% of referrals to Early Help access a service or intervention depending on the presenting need. As at March 2016, only 7% of closed CAT cases were referred back to social care within 3 months of closure.

#### Children's Social Care:

The MASH team provides the 'front door' or entry point to Children's Social Care. Between 1st April 2015 and 31st March 2016 there was an increasing number of both contacts and referrals - 3096 referrals were accepted and of these 74.2% went onto a single assessment that required a qualified social worker to be allocated to undertake this piece of work to be statutorily compliant. This is almost a two-fold increase requiring a qualified social work intervention.

This was an average of 258 referrals a month. This has grown steadily during the year peaking in March 2016 at 422 referrals for that month. This volume of referral resulted in a rate per 10,000 of 885.9 for Reading with Statistical neighbours at 704.5 and England at 548.3 for 2014/15.

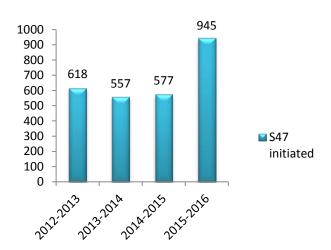


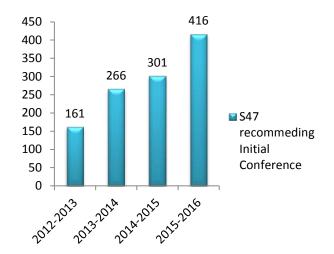
The majority of referrals originated from the Police 33.4% (1035 during 2015-16) with schools being the second highest referrer at 19.22% or 595 for the same period. This also highlights a significant increase in referrals from schools year to date and positively reflects the work undertaken by schools to identify children in need or those who may be at risk of significant harm.

Domestic Abuse has remained the highest reason for referral (629 or 20.3% of referrals). Members of Thames Valley Police are now co located with social work staff in the MASH and all domestic abuse contacts are rigorously screened. Referrals concerning physical abuse (13.57%) and Neglect (9.46%) also remain highly represented.

Section 47 enquiries (undertaken where there is reasonable cause to suspect that a child is suffering, or likely to suffer, significant harm) have increased with 945 enquiries in 2015-16 (rate 272.3 per 10,000 population), an increase from 579 (rate of 161.5 per 10,000) in 2014-15. The statistical neighbour average rate for 2014-15 was 153.4 per 10,000 (the comparative data for 2015/6 is not yet available).

The increase in S47 Enquiries is reflected in a similar increase in the number of Initial Child Protection Case Conferences (ICPC) held with the plan 416 children and young people were considered at ICPC in 2015-16





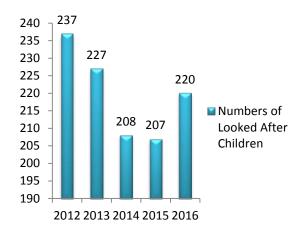
The total number of child protection plans and current breakdown of plans as of 31st March 2016 are:

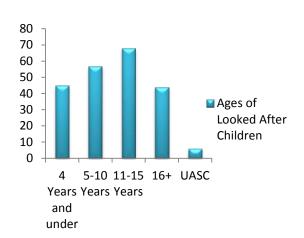
Catergory	0-4 Years Old	5-19 years Old	Total
<b>Emotional Abuse</b>	38	56	94
Neglect	52	95	147
Physical Abuse	2	4	6
Sexual Abuse	1	10	11
Total	93	165	258

As at March 2016, there were 616 children categorised as In Need (rate per 10,000 child population including CP and LAC is 177.5; Statistical Neighbours is 343.8 for 2014/15). At the end of March 2016 58% of our children had CIN plans, but the figure is increasing.

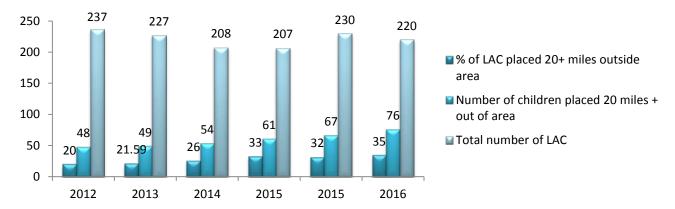
At 31st March 2015-16, there were 220 children and young people Looked After, an increase of 13 compared to last year. This number represents 64 children per 10,000 population, lower than the statistical neighbour average rate of 66.6 per 10,000.

Of our Looked after Children, as at 31st Mar 2016, 116 are male and 104 being female. 114 of these children are noted to have special educational needs.





The lack of local placements in the Reading Borough Council area means that 34.5% of our Looked after Children are placed more than 20 miles away from their home address. While this may be for a positive reason (such as children in adoptive placements or in specialist residential settings) this overall percentage figure must be reduced to retain stability in education provision, receive local health services and remain in contact with their family and community when safe to do so.



Since April 2015 there have been 25 adoptions, 23 children became subject of special guardianship orders, 8 children became subject to Child Arrangements Orders and 133 children ceased to be looked after.

At the end of March 2016 there were 103 young people entitled to services under the Children Leaving Care Act 2000 aged 17-21. 80% had a Pathway Plan which is a significant increase on 27% in April 2015. 39.8% were not in suitable employment, education or training which is slightly higher than the latest Statistical Neighbour benchmark of 39.0%.

Of the 103, 10 young people are in Higher Education and are supported via a bursary from the Local Authority. (87.3%) were in suitable accommodation, this compares to the Statistical Neighbour average of 80.74%.

All care leavers have a Personal Advisor and 85% of care pathway plans are up to date. "Staying Put" regulations have been translated into a policy and implemented from June 2015 currently approximately 6 young people are in this type of arrangement.

# Local context

# **Our Board**

Reading's Local Safeguarding Children Board (LSCB) makes sure that key agencies work together to keep local children and young people safe. The role of the Board is to co-ordinate what is done by each agency to safeguard and promote the welfare of children, and ensure the effectiveness of what is done by each agency that works with children.

Section 13 of the Children Act 2004 requires each local authority to establish a Local Safeguarding Children Board (LSCB) for their area and specifies the organisations and individuals (other than the local authority) that should be represented on LSCBs. Our current membership is listed in appendix 4, page 50.

Partners in the Board financially contribute specifically to the LSCB to enable it to operate and undertake work against the priorities. Information relating to financial contributions can be found in appendix 5, page 52. Some further work is needed to increase both the overall level of funding to the Board and agency contributions to enable the Board to make progress against its priorities.

Reading LSCB meets up to six times per year for standard Board meetings, where evidence on the delivery of work streams against priorities by the sub-groups is considered; performance and audit information is reviewed and emerging issues discussed. The Board also convenes at least once a year for business planning sessions.

# **Business Planning:**

Business planning sessions allow us to review our impact; recent performance data and audit evidence, to decide if our priorities remain relevant and set new priorities accordingly. In October 2014 board members agreed the priorities for the 2015/16 year which are reported on in this annual report. The business plan written for the year to reflect the agreed priorities has been reviewed regularly and in March 2016 the action plan was finalised. Of the 55 actions identified, 46 were completed and rated as green, with any outstanding actions transferred into the plan for the following year. Some of the completed actions include:

- Domestic Abuse Strategy launched
- CSE Strategy toolkit and training pathway developed
- Review of thresholds new guidance has been distributed
- Introduction of Early Help Hub
- Education task and finish group the reinstated Designated School Safeguarding Leads meetings, has enabled better information dissemination from the Board to schools on key safeguarding messages.

In November 2015 the Board agreed the following priorities for the 2016/17 year. The revised Improvement and Development Plan sets out the actions identified to make progress against these priorities, a copy of which can be found on the Reading LSCB website (<a href="www.readinglscb.org.uk">www.readinglscb.org.uk</a>):

Priority 1. Children's Emotional Health and Wellbeing

Priority 2. Strengthening the Child's Journey and Voice

Priority 3. Child Sexual Exploitation (CSE)

Priority 4. Neglect

Priority 5. Improving Cultural Confidence and Competence in our Workforce to Meet Children's Needs

# Joint working:

Reading is one of six Unitary Authorities in Berkshire and the Board endeavours to work collaboratively with our neighbours to ensure a more joined up approach to safeguarding. This is particularly important where a number of agencies deliver services across a number of LSCB areas and in agreeing a common approach and response to specific safeguarding and child protection issues such as child sexual exploitation and female genital mutilation.

The six Berkshire LSCBs work closely together and many partners are represented on all six Boards. There are three sub-groups of the Board which operate across the whole of the county, and two which focus on the west of Berkshire. Sub groups for quality assurance and performance, and child sexual exploitation are Reading specific to maintain a local focus on current issues. Our LSCB Structure chart can be found in appendix 3, page 49.

LSCB Business Managers and Chairs from across Berkshire meet regularly to share and discuss specific issues; protocols and developments, along with examples of good practice.

Reading LSCB also works closely with a number of partnership boards in the area including the Health and Wellbeing Board, Reading Children's Trust and the Berkshire West Adult Safeguarding Board. A new joint protocol initiated by LSCB has been written to provide greater connectivity across the work of the Boards and clarification of lead and support roles and leadership for new areas. The protocol requires a minimum of one meeting a year of all partnership board chairs and this is facilitated by Reading Borough Council Managing Director.



# **Our Performance**

# **Our Priorities for 2015/2016**

# **Priority 1: Domestic Abuse**

Using the national definition the number of Domestic Abuse related recorded and non-recorded crime in Reading remains comparatively high, 7.74 and 7.12 per 1,000 population respectively in 2015/16. This is higher than the average across the Thames Valley (4.77 and 5.94 per 1,000 population). Domestic abuse within a family can result in children being subject to a Child Protection Plan due to the physical and emotional impact as well as neglect. The Board has a key role in scrutinising the effectiveness of partner agencies responses to domestic abuse and advising on improvements that can be made in the co-ordination of or development of services to improve safeguarding of children and young people. Domestic Abuse is also a key priority for the Community Safety Partnership (CSP) and the partnership response to this issue has been progressed through the Domestic Abuse Strategy Group, a sub group of the CSP.

# **Domestic Abuse Strategy 2015-18**

The new strategy was launched in 2015 following extensive consultation, with input from LSCB partners. It outlines key areas for the Domestic Abuse Strategy group to focus on and incudes a clear action plan.

#### **Key themes relating to children and young people:**

Priority 1 relates to improving information and education to children and young people about what healthy relationships look like and how to keep safe, with a particular focus on continuing to improve the level and quality of PSCHE education in schools.

Priority 2 relates to improving the early identification and interventions of services to domestic abuse by providing the right response the first time, and ensuring clear pathways into services such as Early Help and the Multi-Agency Safeguarding Hub (MASH).

- The Domestic Abuse Training sub-group was developed and set out a revised training programme to ensure effective and consistent training across the workforce.
- Successful re-launch of the Domestic Abuse forum.
- Supported by a MARAC improvement plan, and linked to the effective training programme, there has been a focus on increasing referrals to, and improving the effectiveness of the MARAC.
- Specific training for designated MARAC officers has been provided, supported by a standard operating procedure used across Berkshire.
- Introduction of the DARIM (Domestic Abuse Repeat Incident Meeting) which runs in parallel to the MARAC. The MARAC covers high risk cases, but DARIM supports those that have high levels of repeat incidents which in their own do not meet the MARAC threshold. It provides a multiagency response for medium risk, high volume cases, creating action plans to prevent escalation, reduce risk and reduce impact on numerous services.

 All safeguarding training includes a focus on domestic abuse. This includes the LSCB training and that offered by individual agencies. Partners are made aware that disclosures of domestic abuse involving children should lead to a discussion with Children's Social Care.

#### What is the evidence:

- 112 delegates have attended level 1 & 2 Domestic Abuse training in 2014/15. The programme to train 160 delegates is in place for 2016/17.
- Specific risk assessment (DASH) training has been delivered to 57 new starters in social care teams during early 2016.
- 5 well attended Domestic Abuse forums delivered in 2015/16 creating a network of 191 front line professionals.
- A significant increase in MARAC referrals (28%). In 2015/16 185 referrals were received up from 144 in 14/15. This means the number of cases per 10,000 female population has increased from 22 to 29 and is converging on the national average (33).
- 41% of referrals were from partner agencies in 15/16, increasing from 27% in 2014/15.
- In Reading an individual is referred to DARIM if there are more than 6 reports to the police in the last 3 months. Circa 190 cases were discussed in 2015/16. This, and the DA activity as a whole, has a clear links with the Troubled Families programme in Reading and effective links across work programmes have been made both strategically and operationally.
- Circa 270 individuals have engaged in the 'Breaking the Cycle' course delivered by Berkshire Women's Aid (BWA) in 2015/16.
- 26 perpetrators have engaged with the Family Choices programme to address their abusive behaviour (holistic family support).

#### What has been the impact:

- The increase in referrals to MARAC has resulted in a corresponding increase in children discussed at the MARAC, raising from 188 in 2014/15 to 250 in 2015/16.
- 216 young people have been referred to support services (BWA young people programme) in 2015/16 (up 24% from previous year).
- 44 out of 64 (69%) of adults referred to the Family Choice programme engaged with the programme in 15/16.
- 19 cases of whole family engagement in the Family Choices programme in 2015/16.
- 90% of perpetrators that engage with Family Choices do not generate any subsequent referrals or notifications.

### **Family Choices Programme**

This programme is for families affected by domestic abuse, offering support to the whole family. Support is provided via group work and 1:1 sessions, looking at parallel themes including - different forms of domestic abuse, the impact abusive relationships have on partners and children, and ways to resolve conflict in a non-abusive way.

#### What has been the impact:

Feedback from those attending the programme suggest that families find it helpful in a number of ways. Perpetrators have commented on how the work undertaken has had a positive impact on their behaviour, highlighting increases in respect for their partners, with understanding of how to control anger and alternative non abusive ways of behaving. Victims have found the support particularly

helpful in overcoming isolation through the opportunity to meet others with similar experiences. Learning how to identify signs and traits of Domestic Abuse has led to participants feeling more able to set appropriate boundaries within their relationship with their partner, and a subsequent improvement in relationships with their children.

As noted above, 44 out of 64 (69%) of adults referred to the Family Choice programme engaged with the programme in 15/16 and there were 19 cases of whole family engagement in the Family Choices programme in 2015/16. 90% of perpetrators that engage with Family Choices do not generate any subsequent referrals or notifications

# **IRIS Project**

Public Health currently jointly fund and commission the IRIS Domestic Abuse GP referral programme, provided by Berkshire Women's Aid. GP practice staff are trained in recognising signs of potential domestic abuse and are given the skills to discuss issues with patients coming into the practice. Practice staff can then offer to make a referral to local domestic abuse services. The Clinical Commissioning Groups (CCGs) actively encourage the GPs to engage with this programme, and provide support to GPs and clinicians working with families where domestic abuse is occurring.

# What has been the impact:

Following training, there were 60 referrals from GPs to domestic abuse support services in 2015/16 when previously there had been very few.

### **Learning from audits - MARAC Audit**

Reading LSCB Quality Assurance Sub Group tasked agencies to establish how the Multi Agency Risk Assessment Conference (MARAC) process considers children, and contributes towards the safeguarding of children whose parents/carers have become involved in Domestic Abuse. The lessons learnt from this audit and improvements made were:

- Actions specifically relating to children discussed at MARAC will be recorded formally in the MARAC minutes available for all agencies to view on MODUS.
- Agencies named in carrying out the actions for children must complete their MODUS action plan by the agreed date.
- All agencies will consider risk to children (which may be different to the risk to adult) in the context of the child. This consideration will be recorded in the minutes and agencies will robustly challenge inappropriate risk assessment.

#### **Domestic Abuse Challenge Session**

Reading Local Safeguarding Children Board hosted a Domestic Abuse Challenge and Support Session to seek clarity and assurance around the work currently taking place in each agency to tackle Domestic Abuse. The session was an opportunity for agencies to share good practice and identify any changes required to enable professionals to work confidently with children and young people who experience Domestic Abuse. The key lines of enquiry were informed by the Domestic Abuse Strategy Action Plan, written by the Community Safety Partnership and included discussion on education for young people; effective support and training for the workforce; the referral process; sharing of domestic abuse notifications, and an understanding of the needs of our mixed population.

The session identified a range of areas where progress has been made but also identified a number of actions going forward. The Domestic Abuse Strategy Group have included these actions within their action plan, however there are two areas that require further input from Reading LSCB. These are in relation to schools regularly receiving domestic abuse notifications, and a review and improvement in the PSCHE offer to schools. These have been included in the Reading LSCB Improvement and Development Plan for 2015/2016.

### **Ongoing Challenge/Actions:**

- Not enough progress has been made to ensure a consistent approach to the delivery of information and support to schools. Further work is required to progress this action, and the LSCB Improvement and Development Plan for 2016/17 has been updated to reflect this requirement.
- Domestic Abuse Notifications to schools in neighbouring boroughs the schools regularly receive domestic abuse notifications. A similar notification system will be developed to ensure that Reading schools can also receive this vital information and put in place appropriate support for children and young people.



# Priority 2: Strengthening the Child's Journey and Voice

**Purpose:** To evaluate the effectiveness of different aspects of the child's journey into help and services, the quality of the decisions made by individual agencies and the quality of multi-agency processes.

#### Voice of the child in relation to priorities and work of Reading LSCB

#### What has been delivered:

- The Youth Cabinet have presented their campaigns to the Board.
- The Youth Cabinet have been consulted regarding their engagement with the Board.
- The Quality Assurance and Performance Sub group have included the Childs Journey and Voice priority in their dataset and audit programme. It is also now a core standard in all multi-agency audits.
- Young person's version of the Annual Report 2014/15 was produced.

#### What is the evidence:

- The Youth Cabinet carried out the Domestic Abuse survey and the Member of Youth Parliament reported the survey finding to the LSCB at a Board meeting in 2015. The recommendations were discussed and agreed.
- Evidence from hearing the child's voice has been identified to come through the Quality Assurance and Performance sub group. This is also a standing item on Reading LSCB Board agendas and in multi-agency audits.
- Engagement of children and young people in their CP Conferences and reviews is regularly presented to the Board through performance data and from audits.
- The LSCB Independent Chair and Board Manager have attended Youth Cabinet meetings.
- The Member of Youth Parliament has contributed to the Reading LSCB Annual Report 2014/15.
- The Young Carers produced a young person's version of the Reading LSCB Annual Report 2014/15

   the video can be seen on the LSCB website. The video has been shared with partners,
   Children's Services staff events and the Health and Wellbeing Board.
- The Reading LSCB has funded the MoMo App for a further year (2016) to allow Looked After Children to feed back directly their experiences.
- The Youth Cabinet were consulted on their key priorities which have directly contributed to the priorities chosen by the Reading LSCB for 2016/17.

#### What has been the impact:

- The Board has been more focussed on the needs of children and young people and recognises the need for their direct influence on our work.
- Young people have made presentations to the Board and contributed to discussions.
- Young people have contributed to discussions about the LSCBs priorities and are directly contributing to work on some of these.
- Emotional Health and wellbeing identified as a key issue by children and young people and is now a key priority for the Board in 2016/17.
- In the last 18 months (up until end April 2016) the MoMo app has provided young people and easy way to get in touch with Children's Social Care 46 submissions have been made, 14 of

these have been about changing something, 17 preparing for a meeting, 16 to sort a problem, and 1 about a worker visit. Of these 46, 32 have been made since December 2015.

#### **Reading Youth Cabinet**

#### **Achievements:**

The Reading Youth Cabinet is made up of 18 elected young people – in the December 2015 elections, 3,302 young people across Reading voted. The new group decided to again focus on mental health services for young people as one of their campaigns. A second campaign was on challenging discrimination – this was decided by vote of those attending the Youth Cabinet event in November 2015. The group also decided on a third campaign around self-expression and identity, a focus of which is to increase acceptance of young people coming out as LGBT+ across Reading. The youth cabinet have presented these to both the Health and Wellbeing Board and the Children's Trust Board, and are making positive progress towards their objectives as set out in their manifesto.

Reading's Children-in-Care Council, now rebranded as Your Destiny Your Choice (YDYC) continues to meet once every six weeks. Achievements over the previous year include running an event in December for staff and carers, developing an info sheet for social workers to use when they are meeting new young people in care, and participating in the planning of the Looked After Childrens celebration events.

Young people have also been involved in the recruitment of staff by having their own interview panel; including interviewing for the role of Head of Social Care, Head of Transformation and Governance and for new Children's Social Workers.

The new Young Inspectors/Researchers group has now been established, and are undertaking projects looking at Mental Health Services with the Youth Cabinet, and at Fostering Placements with YDYC. Though this work is not yet complete, it promises to be a successful project with young people being able to feedback how services are delivered to young people in Reading with recommendations about what should be done next.

Young people in care are given the opportunity to complete a feedback sheet after each LAC Review, to comment on the process and how it could be improved. These are collated quarterly by the Participation Co-ordinator, and a report fed back to the IRO team to be able to pick up on any issues or themes.

A range of consultations and surveys are undertaken annually with young people. This includes almost 3,000 young people participating in a survey run in conjunction with the youth cabinet elections and one for young people in care about their experiences of going into fostering placements

# Impact:

In partnership with the Reading Borough Council Public Health team, the Youth Cabinet were involved in distributing a mental health booklet to all young people attending secondary schools in Reading, putting together a promotional video in the process.

The YDYC Group wrote an open letter about why it is so important that young people have good placements, and why they want to be heard and have a voice. This letter was given to all Children's

Services staff at some Whole-Staff conferences, and was also presented to the Corporate Parenting Panel.

The LAC Information Pack which the YDYC helped develop has now been given to all young people in care with Reading, and via the IRO's to those coming into care. This also gives young people the opportunity for young people to have one place to store information they are given by social workers, IROs, advocates or anyone else.

Although early days, the YDYC groups Traffic Light challenges, which they present at Parenting Panels, have already ensured the LAC Health Nurses will agree with young people where they want their assessments to be held, and have raised the issue to changes in social workers and breaks of promises when social workers do change.

The LAC Celebration Events, held at Beale Park for those aged up to 10, and Oakwood Youth Challenge for those aged 11+, were very successful, celebrating the achievements of young people in care and being fun and enjoyable days for all.

Young people involved in recruitment have had a direct say on the staff employed by Reading Borough Council.

#### **Challenges**

Engaging regular changes of staff in the work of YDYC continues to be challenging as messages and initiatives are lost as people change. This has a direct consequence on the limited numbers of young people attending YDYC events – though we have a solid core of young people, we would like to recruit more regular members, and particularly members from the leaving care population and males.

## **Ongoing Challenge:**

- There is the need to better include the direct voice of young people at our Board meetings. We are planning to use video/audio presentations of concerns from young people, and then provide responses from Board members.
- A review of the MoMo App is required to ensure it is value for money and effective.
- Increase the number of regular members to Your Destiny Your Choice and those attending YDYC events.



# **Priority 3: Child Sexual Exploitation (CSE) and other Particularly Vulnerable Groups**

**Purpose:** To ensure that those children and young people who are particularly vulnerable or likely to be exploited can be identified and supported appropriately.

#### Multi-agency approach to CSE

In 2014/15 there was no clear CSE strategy in place and no data or profile of Reading CSE available to map the level of concern and inform the work that was needed. The levels of awareness of CSE, indicators and process needed to be improved across the workforce. There was a lack of coordinated approach to interventions for children who are being/at risk of being sexually exploited, with limited access to specialist services for children and young people.

#### What has been delivered:

- The CSE strategy and risk assessment toolkit were developed and launched in June 2015.
- Multi-agency CSE Training has been imbedded since 2013 with Universal, Targeted and Specialist courses available. 464 multi-agency delegates have attended training since Sept 2013 and 438 individuals have completed the Universal CSE online learning.
- The Chelsea's Choice drama production was delivered in February 2015 and February 2016 in all secondary schools. Approximately 2000 have watched this production each year.
- CSE Intelligence Sharing training was provided in November 2014, January 2015 and January 2016. More sessions are being arranged for 2016/17.
- SEMRAC multi-agency risk assessment CSE meetings now occur on a monthly basis. The first SEMRAC meeting was in April 2014and since then there has been ongoing refinement and development of these meetings resulting in significant improvements in attendance, oversight and coordination of safeguarding interventions and planning for children and young people.
- SEMRAC meeting were further developed to combine with the Missing Children's Panel in September 2014.
- The CSE Champions group was established across agencies there currently 23 Champions from various services & teams.
- Services and pathway have been established to support victims of CSE including Champions;
   Barnardos specialist CSE workers; specialist exploitation service and a therapeutic service for victims of sexual abuse.
- The CSE and Missing Strategic group has been driving forward the CSE strategy action plan. It's governance arrangements changed in January 2015 when it became a sub group of the LSCB.
- CSE Safeguarding Business cards have been produced nearly 7,000 cards have been handed out to the workforce across Reading and beyond. This is a handy sized reminder of signs and indicators of CSE and referral pathways for concerns. In addition to staff who work with children regularly, these have also been handed out to all taxi drivers licenced in Reading.
- A CSE Coordinator was recruited September 2015 to provide a dedicated resource to develop and progress the CSE Action Plan.

# What is the evidence:

 A launch event of the CSE strategy that was attended by 100 practitioners and managers from across the LSCB partnership. Copies of the strategy, toolkit and screening tool were provided to

- delegates and these were also made available on the Reading LSCB website, along with the CSE training programme for access by agencies and practitioners.
- Minutes of SEMRAC meeting evidence the attendance, referral numbers and safety plans for children.
- From SEMRAC and Missing reports a network map was developed linking names of victims, friends and individuals of concern. This lead to two (multi-family) complex strategy meetings held in early 2016.
- A CSE and Missing dataset and dashboard has been developed and populated monthly to enable the LSCB to better understand the local picture.
- The LSCB Learning & Development sub group and RBC Workforce Development team have embedded a process for post course evaluation to begin measuring impact of the various training courses on increasing professional knowledge and confidence in identifying and responding to children and young people vulnerable; at risk of and experiencing sexual exploitation to promote early identification and effective safeguarding.
- There have been increased referrals to SEMRAC as professional knowledge of CSE indicators and the process for notifying and responding to CSE increases.

# What has been the impact:

- Improved data/challenge has enabled the LSCB and partner agencies to focus efforts on identifying and responding to the most vulnerable and at risk children. As at end April 2016 there were 19 open CSE cases to Children's Social Care.
- SEMRAC is running more efficiently and enables professionals to better protect children by sharing intelligence to enable disruption activity and identify the key concerns and risk to the child(ren). 53 children and young people have been discussed at SEMRAC over the period August 14 to November 15
- Reduction in risk to children has been evidenced by SEMRAC data within the LSCB dashboard (risk level reduced, case close, friendships disrupted).
- Professionals are better able to identify and respond to the indicators of CSE.

# Learning from audits - Children and young people at risk of or experiencing sexual exploitation

Carried out in quarter 2 of 2015/16, the focus of the audit was to consider the information held within each agency and in particular note:

- Whether or not the Child Sexual Exploitation Screening Tool was used
- Comment on the quality of its completion
- Assess the effectiveness of communication between agencies
- Whether there was a shared understanding of levels of risk as well as how the management of the assessed risk was addressed.

The audit found that professionals in all the agencies were generally more confident, with increased knowledge and understanding of the issues relating to child sexual exploitation. The launch of the Strategy and the information sharing and training around the use of the Child Sexual Exploitation Indicator tool, was seen as positive. It identified that although there was evidence of positive multi agency working, this was not always explicit in the overarching plans for the young people, and that there was not a consistent approach to the completion of the indicator tool or communicating with other agencies that it had been completed or how it was used to inform interventions.

The learning and recommendations were considered by the Quality Assurance and Performance Sub Group, and the resulting action plan has been progressed and incorporated into the ongoing CSE Strategy Action Plan.

#### **CSE Challenge Session:**

Reading Safeguarding Children Board hosted a CSE Challenge Session in June 2015 to seek clarity and assurance around the work taking place in each agency to tackle CSE. This challenge session was an opportunity for agencies to share good practice and identify any changes required to enable professionals to work confidently with these vulnerable children and young people.

Key lines of enquiry, as identified by Ofsted in their CSE thematic inspections included: effective strategic leadership of the multi-agency response to CSE; identification of prevalence, trends, themes and patterns; how effectively are partners sharing information and working together; how effective all organisations are at identifying those at risk at the earlier opportunity; and whether children and young people who are at risk of, or who have been, sexually exploited are effectively safeguarded, protected and supported.

A number of key partners gave comprehensive presentations and actions were identified. All the relevant actions were incorporated in the CSE Action Plan and have been progressed through the CSE & Missing Sub Group. This session directly informed the CSE Toolkit Launch event at the end of June 2015, and led to the production of the plastic CSE Safeguarding business cards.

### **Missing Children**

- An updated and improved workflow for missing children notifications has been developed, with alerts to allocated social workers or MASH, including 24 hours, 5 days and 3 x missing in 90 days.
- The Missing Children Interviews are now being arranged directly from Police Reports to improve timeliness.
- Recording missing children information on MOSIAC (Electronic Social Care Recording system) has improved to capture and identify risk factors, to aid better decision making.
- Since April 2015 the Return interviews have been completed by a rota of Youth workers. The Youth Workers are highly skilled in speaking to young people and their parents, and as they are not Social Workers or Police Officers, are often more successful in engaging with the young people. The Youth Workers are also able to offer additional Early Help services when appropriate.
- The Missing Children Coordinator has been in post from January 2016 (new role) to continually assess and improve delivery.
- The Mind of My Own 'MoMo' App is available for looked after children (11-17 year olds) who want to share concerns in relation to their placement which is fed back into looked after children reviews at the request of the young person. This aims to reduce the number of looked after children who leave their placement and are then reported as missing.

#### What is the evidence:

- There has been improved interagency information sharing and working for Missing Children, Child Sexual Exploitation and Children Missing Out On Education.
- The accuracy and timeliness of reporting missing children notifications from Thames Valley Police
  has improved, along with the recording and workflow for missing children within Children's Social
  Care most reports are now received within 24 hours (or reported first day after
  Weekends/Bank Holiday).
- During 2015/16, 534 missing episodes were reported to Children's Social Care for 394 individual
  young people. This figure has gradually increased over the past 9 months. Out of these episodes
  495 required a return interview. 116 episodes were refused for interview by either the parent of
  young person
- Throughout 2015/2016 264 return interviews were carried out. 53% of missing children have had return interviews carried out although this figure has been improving with 70% children missing in March 2016 having a successful missing interview from youth service.
- A significant issue is the number of missing interviews being completed within 72 hours. Of the completed interviews in 2015/16 only 76 (29%) were completed within the Statutory 72 hours from when the young person is returned home. This figure needs to significantly improve and was highlighted in the recent Ofsted inspection.

#### What has been the impact:

- Improved safeguarding arrangements for children who go missing from home or care placements.
- Better evaluation of risk factors affecting young people to aid improved decision making.
- Return interviews currently being audited for quality assurance. This will be completed by end of June 2016
- Issues for Young People who go Missing have been identified through the Missing Interview process and reported to Social Care for assessment/signposting to services.

#### **Children Missing out on Education (CMoE)**

Children and young people who are missing education can be more vulnerable and liable to exploitation.

- The CMoE Strategic Group meets regularly to discuss and track cases, and an action and communications plan is now in place.
- Cross border meetings take place to ensure those moving in and out of our boundaries do not get lost. All those assessed to be at level 1 (highest risk) have a level 1 plan in place, monitored by a lead professional.
- Pupils in year 12 who are NEET are now tracked, ensuring responsibility is handed over to an appropriate service, such as Adviza (formerly known as Connexions Thames Valley).
- The Virtual Head for CMoE is a member of SEMRAC (CSE); cross-referencing to ensure that the most vulnerable children have robust lead professional support.
- The Virtual Head now has the details and monitors all pupils who are on reduced timetables in Reading primary, secondary and special schools for return to full time education.

• Cross-matching of Management Information will give us greater intelligence of children at risk – we are working on automated systems for the future.

#### What has been the impact:

- Cross checking the CMoE, CSE and Missing Children lists has improved awareness and information sharing, plus the Virtual Head CMoE links directly with schools ensuring that the children are better safeguarded. This was noted as positively in the recent Ofsted report.
- Through the lead professional, the children are 'case worked' ensuring they do not get lost, and 'stuck' cases can be progressed through multi-agency planning meetings.

# Female Genital Mutilation (FGM)

The population profile of Reading indicates that FGM could be a potential issue for certain groups of children and young people in the town. In 2015 the LSCB Independent Chair challenged the Health and Wellbeing Boards across the West of Berkshire to take a lead on FGM, in recognition that this is not an issue only for girls. The LSCB recognised that a co-ordinated strategic direction is required to progress local developments that will ensure girls living in the West of Berkshire who might be at risk of FGM are identified and protected. Successful models of addressing FGM currently existing within the UK are based upon the recognition that tackling FGM warrants a co-ordinated approach, from statutory and voluntary organisations as well as representatives from community groups of those affected.

- A new LSCB task and finish group was formed with representation from across the West of Berkshire progress this issue.
- A vision and action plan for the area has been written and agreed by all three West of Berkshire LSCBs.
- The action plan recognises actions that have a statutory partner responsibility, such as clarity around identification and reporting requirements. It also has a clear preventative element reflecting the importance of working with the voluntary sector, in the high risk communities to raise awareness.
- FGM awareness training has been made available through the annual LSCB training programme and a focus on FGM has been incorporated in to all Reading Universal Safeguarding Children training courses. The free FGM online training course from the Home Office has been identified and promoted for those unable to attend the face-to-face one day course.
- In March 2016, FGM training specific to schools was provided by Forward UK to 19 representatives from across Reading.
- The task and finish group have identified potential pathways into services for girls and women at risk, suspected to have undergone or who have been subjected to FGM. A risk assessment tool has been written, along with guidance on completion of the tool; pathways and a factsheet on FGM. These are being launched at an event open to practitioners across the West of Berkshire on 30<sup>th</sup> June 2016.
- A dedicated page on the Reading LSCB website has been created with links to the guidance, toolkit, factsheet and training opportunities. This page is being used as the central point for all three West of Berkshire LSCBs.

In the first six months of 2016 the task and finish group have fulfilled much of its initial remit however there are clear ongoing actions to enable support to be provided to women who come forward as survivors.

#### **Ongoing Challenge:**

#### Child Sexual Exploitation

- An ongoing review and analysis of data is required to provide a problem profile for Reading, identify themes and recognise areas for development.
- More CSE Champions need to be recruited from schools and children's social care long term teams.
- We will review and embed updated CSE Risk Assessment toolkit. This will enable the
  workforce to work more comprehensively with children and families where there may be CSE
  concerns.
- We will develop and deliver short courses for schools and voluntary sector to improve knowledge of CSE, indicators and pathways.

#### Missing Children

Significant improvement is required in the timeliness of missing children interviews to ensure
that vital information is not lost and support and advice can be offered. The information
gathered from the interviews must also be routinely included on case files and used to
support assessments and decision making.

#### Female Genital Mutilation

- The guidance, toolkit and risk assessment tool launch must be embedded into frontline practice. This will need to be evidenced during 2016/17.
- Actions within the FGM vision and action plan will be progressed and completed. This is
  particularly important with regards to supporting women and girls who present as having
  been subjected to FGM and require emotional, as well as medical support. The aim is to
  establish a Reading clinic, similar to that available in Oxford, which will provide this wraparound service.
- Ongoing FGM training must reference the local toolkit and pathways.



# **Priority 4: Neglect**

There are more children and young people in Reading on a Child Protection Plan for neglect than any other category and this has remained the case for some time. The number of children with a child protection plan for neglect out of the four categories (neglect; physical; sexual and emotional abuse) has been routinely above 50% for the last three years, which is above the national figure of 43%. Research has shown the negative impact of living with neglect can have on children and young people's emotional and physical development and has lifelong consequences in terms of poor outcomes in educational achievement; mental health; employment etc.

#### What has been delivered:

- A multi-agency audit was completed to establish how well agencies were working together in order to address neglect. Recommendations and learning were shared with the Board on 14.05.15 with a clear action plan for improvements.
- An audit of repeat CP cases with Neglect as the primary reason was undertaken. Learning and actions were reported to the CSIB & LSCB.
- A review of Thresholds was undertaken that included looking closely at the neglect indicators.
   The Threshold booklet was updated and LSCB joint workshops with Early Help and Troubled Families explained about use of thresholds and response expected by professionals.
- A specific Neglect webpage for professionals was developed on the LSCB website.
- A Reading version of a 'Guide to understanding Neglect' was developed and placed on the LSCB website as a downloadable booklet.
- A training template to help teams understand, identify and know what to do when they spot Neglect was written and trailed at a RBC Corporate session. This is also available on the website.
- A Neglect briefing session was delivered to designated safeguarding leads in Schools, which highlighted the resources on the LSCB website.

In 2015 Reading LSCB agreed a protocol for all partner agencies that covered the following points:

- A regular review of the LSCB threshold document is undertaken to ensure the inclusion of new signs and symptoms of neglect from research or Serious Case Reviews.
- That key agencies ensure that their safeguarding policy and protocol adequately addresses the risks related to neglect and the need for timely and proactive intervention.
- That all agencies provide access to training for staff in their organisation to assist with the identification and response to neglect.
- That all agencies ensure that staff are briefed or trained on the importance of listening to the
  voice of the child and mindful of the risks of the child's voice being overshadowed by adult
  opinion or circumstance.
- That all agencies ensure that there is a record of significant events over time in the form of a chronology or log on order to assist with the identification of neglect and its impact on the child.
- That all agencies ensure that staff understand how to escalate concerns and are confident in the escalation process.

In response to the protocol partners contributed to a combined short term action plan, finishing in March 2016. However, it was recognised that there had been a lack of progress and pace in relation to neglect in 2015/16. To ensure progress in 2016/17 the Independent LSCB Chair agreed for a task and finish group to be set up, with its first key action to create a truly multi-agency Neglect strategy and

action plan that builds on a partnership workshop that took place in March 2016. In addition the Learning and Development sub-group reviewed the training programme and has included Neglect as an area for development in 2016.

#### **Evaluation of Thresholds**

The thresholds document was produced by RBC in 2011. It therefore needed to be reviewed and updated to become a multi-agency document.

Through consultation with Reading LSCB partners a review of the thresholds document took place in 2015 and a revised poster size version was re-issued. Changes were made to ensure that current practice and current risks were reflected. There was also agreement on the need for common language in line with that used in the Early Help Hub Pathway and the MASH. A Thresholds Guidance booklet was also introduced which includes the threshold risk factors, as well as the protective factors that can sit alongside them. Clear referral processes were also included to enable practitioners to use the document in their day-to-day work. The new documentation was disseminated through workshops during October and November 2015 with over 350 front line staff from across the partnership attending. Attendees took with them a copy of the new guidance, LSCB pens and CSE awareness cards. Post course evaluation shows over 90% of attendees improved their knowledge of thresholds and how to apply them.

The revised Thresholds document and guidance has been circulated widely across agencies and organisations and is also available on the Reading LSCB website

#### What has been the impact:

Thresholds guidance has enabled practitioners to be clear and confident about applying safeguarding thresholds – ensuring that referrals are made appropriately (right service, to the right child, at the right time and in the right place). Verbal feedback has been very positive, with a number of practitioners commenting that they carry the booklet with them and use the guidance every day. For the period Jan to March 2016, there was an increase in referrals to the Early Help Hub of 52% over the same period last year. However, there is an ongoing challenge to ensure that the understanding and application thresholds remain embedded in practice. Thresholds has been included as part of the Universal Safeguarding training and MASH briefing sessions, but following the annual review of thresholds in July and August 2016, a further programme of dissemination and training will be required.

#### **Learning from audits - Neglect:**

In 2015 we carried out an audit to establish identified themes and areas of learning from a multiagency perspective and identify how well agencies are working together in order to address neglect in Reading. The key learning points were:

- There is a lack of evidence of holistic assessments being undertaken led to gaps or inconsistencies in assessments. Inconsistent use and standards of chronologies had a direct impact on the outcome of assessments.
- There is often a lack of coordination between agencies and failure to escalate concerns at an
  earlier stage which has led to drift and delay in some cases. Where evidenced, early robust
  interventions led to timely and appropriate plans being put in place for children. There is a need

- for all agencies to support targeted interventions and support at an earlier stage in order to reduce drift and problems becoming more entrenched.
- The voice of the adult could often overshadow the voice of the child, and there was also evidence
  of over optimism of parental capacity to change or engage with services as well as disguised
  compliance by parents or carers. Better evidencing is required of the understanding of the Childs
  Journey/Voice of the child.
- Inconsistent communication between agencies particularly prior to cases escalating to the child protection process led to delay. Schools need to develop a clear system of recording child protection concerns across schools to prevent information being lost during transfer between schools.
- The use of Family Group Conferencing does not appear to be embedded into practice. There was
  evidence to suggest that in some of the cases this should have been considered and offered to
  families.

A multi-agency action plan was produced and had been monitored through the Quality Assurance and Performance Sub Group. The actions have been transferred into the action plan for the new Neglect Task and Finish Group to ensure they are completed.

#### **Ongoing Challenge/Actions:**

- There has been a lack of progress in improving and understanding of developing agency interventions to neglect in 2015/16. A task and finish group is required to push this work forward at a pace. The multi-agency LSCB group has met and agreed that the new strategy and action plan needs to address 4 key priorities:
  - o To raise awareness and the ability of our workforce across the partnership to recognise and identify neglect enabling earlier intervention and improved outcomes for children.
  - o Information will be systematically gathered and appropriately shared to enable holistic assessments and shared chronologies to take place.
  - The workforce across the partnership is equipped to have difficult and honest conversations with families and provide robust supervision.
  - There will be a suite of coordinated interventions across thresholds to tackle neglect to enable sustained change within families as well as practical support to address immediate needs.
- It is expected that significant progress will be made during 2016/2017 to support front line staff in the identification of neglect, quality assessments, training opportunities and guidance.
- Clear links required between the Neglect Task and Finish Group and the Learning and Development Sub Group to ensure progress with key actions around learning opportunities and raising staff awareness.
- Review of Thresholds to be undertaken, with clear dissemination and embedding of revised documentation by all LSCB partners. (Ofsted Recommendation – see page 43)

# **Priority 5: Effectiveness and Impact of Reading LSCB**

The Board must have a strong focus on scrutiny and challenge of partner agencies and services and its own effectiveness, to ensure it meets local and national priorities and is able to evidence impact on improving outcomes for children.

# **Governance and Challenge function of the Board**

In 2014/15 it was acknowledged by Board members that meetings had not been challenging of partners/services/Board members, with decisions and responsibility often not held at Board level due to the LSCB structure, making effective challenge difficult. There had also not been a systematic approach to recording risks/concerns and areas requiring further assurance. The work of the sub groups are often not known or considered at the Board meetings.

#### What has been delivered:

- Reading LSCB structure was re-organised at the end of 2014.
- The Independent Chair has encouraged the Board to be more vocal and challenging.
- The LSCB recognised that improvements were necessary in terms of the data, audits and Section 11 returns received and considered by the Board to enable them to scrutinise and understand frontline safeguarding practice. This was addressed in the new LSCB structure.
- The Independent Chair raised a number of challenges including:
  - raising concerns regarding the rapid response procedure at the Royal Berkshire Hospital;
  - o with Chief Constable regarding TVP reporting and attendance at CP conferences;
  - o to partners in relation to LAC Health Assessment timeliness;
  - to partners in relation to budget contributions.
- To enable the Board to effectively monitor the progress of the challenges/concerns raised a Risk/Concern log has been established. This is RAG rated and key issues are followed up at each Board meeting.
- Two specific challenge sessions have been held by the Board and the results have fed into action plans. Details of these are noted within the Domestic Abuse and CSE priority sections of this report.
- The Members Compact and Induction Pack have been revised and reissued to support Board members in their role and responsibilities as a member of Reading LSCB. Induction packs for subgroup members are also being developed.
- A requirement has been established for sub group chairs to provide regular reports to the
  Reading Board, and that identified Reading Board members sit on each sub group to ensure
  Reading is represented in the sub-groups. This will ensure that there is improved communication
  and oversight of the work of the sub-groups to deliver that priorities of the LSCB via the
  Improvement and Development Plan.

#### What is the evidence:

• The Executive meetings were removed in 2015 to ensure decisions and responsibility are firmly held by the main Board

- Recent minutes of meetings reflect the increased challenge that has taken place. Board members feel much more confident in expressing their views and holding agencies to account.
- A revised dataset and dashboard has been produced and is discussed at every Reading LSCB Board meeting.
- In relation to specific challenges:
  - A new rapid response protocol has been written;
  - TVP agreed to employ two case managers with specific responsibility to attend CP conferences following challenge;
  - Timeliness of LAC Health Assessments improved from 72.2% in Q4 14/15 to in 92% for initial and 96% for review assessments completed in time for in area LAC Q3 15/16;
  - o Increased budget contributions have been received.
- The learning from audits is now reported back to every Board meeting.

# What has been the impact:

- Improved data/challenge has enabled the LSCB to focus efforts on the most vulnerable and at risk child and young people
- Clear rapid response protocol which is now in place has ensured that families receive an appropriate and timely response when a child dies unexpectedly.
- CP conferences now run more effectively with regular TVP attendance ensuring an improved multi-agency consideration of risk and safety plan.
- More LAC having health needs assessed and met.

# **High Quality Training**

The Learning and Development (L&D) sub-group consists of representatives from the 3 West Berkshire LSCB's. In 2015 it was recognised that the LSCB L&D Strategy was out of date and there were areas that required strengthening. The sub-group subsequently refreshed the strategy, which has formed the basis for the development of the training programme and activity for 2015/2016.

The training programme was created by a working group of the three Local Authority leads and virtual input from other members of the L&D sub-group. It was created through assessing the information from previous years and the learning needs provided by partner organisations.

Post-course evaluation/audits commenced in late 2015 to measure the impact and improvements in safeguarding practice across the partnership and first tranche of evaluations now becoming available.

However, in Reading, we have recognised that connectivity between the work of the West of Berkshire sub group and Reading LSCB, the business plan and priorities of the Board, need further strengthening. A number of changes to membership and clarifying expectations of sub-group members, coupled with the development of the Reading LSCB learning and development action plan, will be put in place to ensure a closer alignment between the priorities of the Board and the sub-group.

# **Training for the Voluntary and Community Sector (VCS):**

In recognition of the difficulty the voluntary sector can have to be able to access appropriate, affordable and accessible safeguarding training, Reading LSCB have worked in partnership with Thames

Valley Police (Reading) and Reading Children's and Voluntary Youth Services (RCVYS) to design, implement and embed a programme which meets the safeguarding training needs of the local Voluntary Sector. Reading LSCB funds RCVYS to provide additional safeguarding training opportunities to the VCS. The Safeguarding Training Programme 2015 proposed delivered a structured programme of Children's Safeguarding Training over the year and was a trial programme designed for the following purposes:

- To increase the knowledge and awareness of safeguarding children for the Voluntary Sector in Reading.
- To test the concept of having a structured programme, and how this would work alongside the LSCB Training Programme.
- To gauge the level of demand for different safeguarding training courses.
- To establish ways to deliver and evaluate the impact of the training.

This programme was focussed around Universal Safeguarding Children Training and other courses which have a strong demand from the local Voluntary Sector, as well as working in partnership with more specialist groups to deliver introductory and specialist courses.

#### What has been the impact:

The original outcomes for the courses were to deliver the following outcomes:

- Keep children safe by training front line workers in safeguarding awareness. In total, 210 different people from 64 different Voluntary Sector organisations received safeguarding training to help to better keep children safe in Reading.
- Ensure that more Voluntary Sector organisations can refer appropriately into MASH or other departments, if this becomes necessary.
   Representatives from 58 different organisations attended a training course which provided them with the tools and information to refer appropriately.
- Increase Voluntary Sector organisations' ability to manage safeguarding in their organisation. Representatives from 44 different organisations attended a training course which helped to increase their ability to manage safeguarding in their organisation
- Increase trustees' awareness of their safeguarding responsibilities.
   7 people representing 8 different organisations attended, and after the course, all of them reported feeling confident about actively promoting good practice in safeguarding children in their organisations.
- Increase the awareness of the importance of safeguarding for BME/Equalities groups, and other Voluntary Sector groups.
  - The Safeguarding Our Children Awareness Seminar helped to increase the awareness of safeguarding for BME groups.
- More PVI Nurseries and Pre-Schools can deliver their own appropriate Universal Safeguarding Children Training.
  - There are now 20 Voluntary Sector Early Years Trainers (a 42% increase this year) trained to deliver the Universal Safeguarding Children Training in their settings, and now have access to specialist complementary materials to increase the quality of the training they deliver.

Following the success of the first year's training, Reading LSCB have agreed to fund this for the next year and thank RCVYS for their support in providing this valuable programme. For more information pleases see the RCVYS training page: <a href="www.rcvys.org.uk/services/training/safeguarding">www.rcvys.org.uk/services/training/safeguarding</a>.

#### Communication

Reading LSCB recognised that it cannot be effective if front line practitioners are not aware of the work of the LSCB and the messages it is disseminating.

#### What has been delivered:

- The Reading LSCB Communications strategy was revised and agreed by the Board. Communication from the LSCB to partners and practitioners has been improved with the new website, regular newsletters and regular information updates to Board members and designated safeguarding leads in schools. Recent communications to the Board have included the request that members confirm that the information has been disseminated and an email from a GP and a school have been received regarding an article in the newsletter – proving it had been disseminated and read.
- A new stand-alone LSCB website has been produced ad is regularly updated to reflect new guidance and developments. This contains a wealth of information not only about the LSCB and what we do, but also provides guidance, information and useful links for professionals, families and children and young people.
- A 'Safeguarding is Everyone's Business' video was created and disseminated to partners for use in public facing areas. The 'Safeguarding is Everyone's Business' video is being shown in GP surgeries and before every Reading football club home game.
- Plastic CSE safeguarding business cards have been produced and disseminated. Nearly 7000 have been distributed across Reading.
- 'Safeguarding our Children' Awareness Seminar took place in May 2015 to promote Black and BME community engagement in partnership with the voluntary sector.
- Most recently, in March 2016 a Reading LSCB twitter account was created with followers increasing weekly (now over 150).
- Key pieces of work have helped to raise the profile of Reading LSCB such as the thresholds workshops, CSE launch event, learning lessons reviews dissemination events and annual safeguarding conference.

### **Learning from audits – Reading LSCB Effectiveness Survey:**

Effectiveness and impact of the LSCB is a key priority for the Board, and this starts with ensuring basic awareness of the LSCB and its role. In July 2015 the Quality Assurance and Performance Sub Group agreed to run a quick survey across a selected number of staff within LSCB partner agencies to establish how aware they are of the LSCB and its role.

#### Survey response:

A number of agencies indicated a good awareness of the LSCB and its role, including Children's Social Care (CSC), Berkshire Healthcare Foundation Trust (BHFT), and the Royal Berkshire Hospital (RBH) however with GPs and Thames Valley Police (TVP) there were some clear areas for development.

Positively, everyone knew where to go if they have a safeguarding concern and all bar one respondent stated they understood their role in safeguarding children and young people. Overall, 74% of respondents were aware of the LSCB website, although only 35% of respondents had visited it.

Although this was a small scale survey it does provide an insight into professionals general knowledge of the work of the LSCB. For those agencies which do not solely have a child safeguarding focus, the results of the survey highlighted less knowledge of the LSCB and its work and this is perhaps understandable. Of those professionals who confirmed that they were aware of the LSCB many (including in TVP and GPs) stated that the LSCB impacted on their role in a positive way.

Recommendations from the audit included improving communications from the LSCB and dissemination methods. These have been significantly progressed in the last year with the new Communications Strategy and various events have taken place with front line staff, e.g. the thresholds workshops.

# **Ongoing Challenge/Actions:**

# Challenge Function

- Ongoing review of data to ensure continued focus on priority areas.
- A focussed review of LAC and Children in Need data, to ensure those vulnerable groups are being appropriately supported.
- Review and embed strengthened governance of Reading LSCB sub groups to ensure clear lines
  of communication to the Board. Sub group chairs will be expected to report quarterly to the
  Board on work within the sub group and six monthly on progress against work plans. This will
  enable the Board to better scrutinise progress against priorities.

# **Training**

- The provision of training within Reading to be updated to provide courses in line with the Reading LSCB priorities i.e. safer recruitment and neglect. (Ofsted Recommendation – see page 43). The Reading LSCB budget is re-aligned to support the delivery of a programme that reflects the priorities
- A training pathway for professionals be clarified and re-issued across organisations commensurate with roles and responsibilities
- That a programme of post-course evaluations now established be reported on a quarterly basis to evidence impact

#### Communication

• Continued focus on communication to ensure the work of the Board is seen by front line practitioners and in the community.



# **Our Performance**

# **Our Compliance with Statutory Functions**

# **Statutory Legislation**

Section 13 of the Children Act 2004 requires each local authority to establish a Local Safeguarding Children Board (LSCB) for their area and specifies the organisations and individuals (other than the local authority) that should be represented on LSCBs. Our current membership is listed in the appendices.

The core objectives of the LSCB are as set out in section 14(1) of the Children Act 2004 as follows:

- a) to co-ordinate 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,
- b) to ensure the effectiveness of what is done by each such person or body for that purpose.

The role and function of the LSCB is defined by Working Together to Safeguard Children 2015, and key extracts can be found in the appendices.

# Policies and Procedures Sub Group (Pan Berkshire)

The purpose of the Pan-Berkshire Policy and Procedures subgroup is to ensure that:

- The six Berkshire LSCBs develop and maintain high quality safeguarding and child protection policies and procedures.
- Safeguarding and child protection policies and procedures remain in line with key national policy and legislative changes.

# Summary of activity/achievements:

- 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. There was no clear
  process in place to manage the online procedures and the contract with the provider TriX was
  not understood. The current Chair took over in July 2015 and led this review and consequent
  work.
- Trix had recognised that this was an issue for a number of authorities and had remodelled their online system.
- The Pan Berkshire Group renegotiated the contract with Trix and work was completed by the Group to review a whole new 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. http://www.proceduresonline.com/berks/
- 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 Group has met quarterly during the year and multi-agency attendance and participation has been excellent. Some of the gaps identified in membership have been addressed and there is now a good range of multi-agency engagement including Children's Social Care which had been a significant gap.

#### What has been delivered:

- A new online format for practitioners across Berkshire with a set of agreed policies and procedures.
- A Group that is structured and contributes effectively to the ongoing plan to maintain and update the policies and procedures for child protection.

# **Ongoing Challenge/Actions:**

Managing the work of this group is time consuming and requires a lot of coordination. The
Group is using electronic communication to manage a lot of business in-between meetings
and group members have taken responsibility for communicating information to their own
local authority / LSCB areas and also for coordinating any responses to consultation on policy /
procedure changes / reviews.

# Section 11 Panel (Pan Berkshire)

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.

# Pan Berkshire Approach

The six Berkshire LSCBs work together through the Section 11 (S11) Panel. Its purpose is to:

- To oversee the S11 process for all pan Berkshire organisations and to support improvement. This currently involves Berkshire wide statutory and voluntary organisations of which there are 9 of a significant size and scope.
- To set clear expectations with the LSCBs and those organisations about the timeframe and process for submission of a self-assessment section 11 audit, and ongoing development towards compliance.
- Review and evaluate S 11 returns of the full three yearly audit (including a mid-term review) of s11 Children Act 2004 for pan Berkshire organisations, in order to make an assessment of agencies compliance with the duty to safeguard. New round of assessments to commence from May 2015.

# Summary of activity/achievements:

- Since the Annual report, the next round of Audits has commenced utilising the new audit tool and the revised process.
- A 6 month interim report was submitted to the LSCB's independent Chairs in September 2015, to provide process assurance.
- The LSCB Independent Chairs are assured that progress is being made, they have provided positive feedback and are happy with the forward planner. The only challenge is around themes for individual LSCBs.

- Membership is now more comprehensive, but continues to lack attendance from any of the Social Care Children's team which will need addressing. Other organisations have provided representation, on the whole, following a request by the chair.
- The panel now splits into 2 subpanels to review submissions with the organisations who submit the return, this allows for fuller exploration of the submissions and an ability to get answers on the day and agree necessary actions to be added to the action plan.
- At the S11 panel meetings in September and December 2015 and March 2016 there were 11 audits for review:
  - o South Coast Ambulance Service
  - o British Transport Police
  - o Berkshire Healthcare Foundation Trust
  - o Royal Berkshire Foundation Trust.
  - o EDT
  - o Thames Valley Police
  - o Probation
  - o Thames Valley Community Rehabilitation Company
  - o CAFCASS
  - o Thornford Park Secure Hospital
  - o Broadmoor Hospital

# **Ongoing Challenge/Actions:**

- Children's social care re-presentation on the panels there are still no representatives.
- How national organisations can provide meaningful assurance for Berkshire specifically.

## **Local Approach**

Reading LSCB is responsible for the undertaking S11 returns for local organisations not included in the S11 Panel above. In 2015 all academies and maintained schools were asked to complete an annual safeguarding audit and by June 2016 all forms were received. These have all been monitored by the Virtual Head for Children Missing out on Education, who has contacted any schools requiring further information, or where clarification was required with regards to a response. This audit had not been undertaken for a few years, therefore this process was new to a number of the schools and headteachers. In 2016 the process will be strengthened with spot checks on a percentage of returns, forms will be returned if evidence is not provided and independent schools will also be included. An improved form will be developed to allow improved analysis.

Early Years providers, including playgroups, are required to complete an annual safeguarding and welfare requirement audit as part of the EYFS requirements. A worker in the early years team reviews these audits to ensure all safeguarding requirements are met.

# **Ongoing Challenge/Actions:**

• Ensure the annual school safeguarding audit process is more robust – include spot checks and the requirement to provide evidence.

# **Child Death Overview Panel (Pan Berkshire)**

In 2008, Child Death Overview Panels (CDOPs) were statutorily established in England under the aegis of Local Safeguarding Children Board (LSCBs) with the 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, (as required by the Local Safeguarding Children Boards Regulations 2006) 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 during April 2015 and March 2016 across Berkshire was 45. Over the past few years, whilst there will be some random fluctuations in numbers of deaths, there is 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.

Expected And Unexpected Deaths - An unexpected death is defined as 'the death of an infant or child which was not anticipated as a significant possibility for example, 24 hours before the death; or where there was an unexpected collapse or incident leading to or precipitating the events which lead to the death.' In the past year 17 unexpected deaths were reviewed, 10 had a rapid response review. During the last 5 years the proportion of unexpected deaths is showing a slight downward trend. Two thirds of deaths now occur within the hospital setting.

# **Summary of key findings**

- In 2015/16 the significant impact of congenital abnormalities on the child death rate is evident again. We not only see significant numbers of deaths in children under 1, we are seeing increasing numbers of children dying as a result of congenital or chromosomal abnormalities in the 1 4 year age group and older as the ability of medicine to support for longer periods children with life limiting conditions improves. This year the impact of Edwards syndrome has been more visible. Edwards syndrome is caused by cells in the affected child having 3 copies of chromosome 18 not 2, which disrupts the baby's normal development. Edward syndrome is now able to be detected as part routine antenatal care: combined blood test and ultra sound. This triple programme began in April 2016 across Berkshire and so in 2016/17 we will be able to assess the impact of this screening programme on our childhood deaths.
- Another reflection in 2015/16 is the increasing mention of socio economic influences on rates of child hood deaths. It is well known that rates of childhood deaths are double in SEC group 5 than in SEC 1, however our database does not currently allow us to map the pattern of child hood

deaths in a timely manner and so we need to develop this ability to support / develop targeted work to minimise the risks of future child deaths

#### Reflections on work of CDOP

- There has been good operational performance against national standards with good cross organisational working that allowed timely and thorough review of cases.
- There was good representation of the panel at the National CDOP panel network and annual general meeting,
- The CDOP panel had supported 4 Ofsted inspections in our local authority children departments and no concerns had been raised with our function.
- Attendance at the meeting was good, with members attending regularly throughout the year.
- It has been noted that the panel is a safe place to have a voice, with members commenting that the group had good open and frank discussions about each case.

# **Ongoing Challenge/Actions:**

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 etc.
- 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.

### Actions identified in the development session:

- New members will be supported by an induction pack, which outlines the main function of the group, how the group works and the role that each member has.
- An annual development session will be initiated to continue improvement.
- A separate neonatal group will be developed to support the panel, the neonatal group will allow proper clinical and professional review of the most complicated cases whilst also allowing the main panel focus on themes.
- We will explore opportunities with neighbouring CDOP groups to look at more specialist areas and share approaches to risk reduction
- Training The group has seen a significant change so a training needs analysis will be undertaken to support each member in delivering their role but also to ensure that we provide assurance about the rigour with which we undertake our function.
- Bereavement support there is some confusion about the support that is available within Berkshire and some cases have been highlighted where support has been variable. We need to understand the support needs that exist and how best to address those.

# **Learning and Development Sub Group (West of Berkshire)**

In order to fulfil its statutory functions under Regulation 5 an LSCB should monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children.

Reading, Wokingham and West Berkshire LSCBs share a Learning and Development sub group whose purpose is to lead the strategic planning and oversee the operational delivery of Learning and Development (L&D). The aim of the group is to coordinate the provision of sufficient high-quality learning and development opportunities that are appropriate to local needs and have a positive impact on safeguarding outcomes; holding partner organisations to account for operational delivery and uptake.

## Summary of activity/achievements:

The sub-group has delivered a significant amount over the past twelve months.

- Membership The sub-group actively engaged with those organisations not represented on the group. A flexible approach was adopted, whereby members could be virtual and conduct their engagement without having to attend meetings.
- Learning & Development Strategy 2015-2018 The LSCB L&D Strategy was out of date and gaps existed within it. This was noted by the sub-group who quickly sought good practice from elsewhere and used this to refresh the document.
- Training Programme 2015-16 The training programme was created by a working group of the three Local Authority leads and virtual input from other members of the sub-group. It was created through assessing the information from previous years and the learning needs provided by partner organisations. The headline figures associated with the programme include;
  - 22 events were run through the LSCB programme which is the same number as the previous year
  - 339 delegates attended the events, which equates to over 15 delegates per event, and was 5% less than the previous year
  - 63% of the places were taken by Local Authority workers (17% higher than the previous year), with 21% from Health (the same as the previous year) and 17% from others (16% lower than the previous year)
  - 55% of people felt the immediate impact of the training was significant or very significant with 41% stating there was some immediate impact which is broadly comparable to the previous year

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

• e-Learning Programme 2014-15 - the e-Learning offer focuses on two main areas, these being CSE (Child Sexual Exploitation) and USC (Universal Safeguarding). Both of these events are provided

through our contract with Kwango, an external provider. The headline figures for the programme include:

- o 2399 delegates completed the USC e-learning which is 132% greater than the previous year
- o 40 delegate completed the CSE e-learning which is 45% less than the previous year As requested, work has been done to review how this headline information can be further broken down to see trends within organisations. As from this year, the CSE e-learning module has been amended to ask for an individual's details before completing the e-learning. This is a pilot and will allow us to have much better management information. If this pilot is successful then the same could potentially be done for the USC e-learning module also.
- Training Programme 2016-17 the training programme was put together having review previous
  years offer and in consultation with the sub-group partners. This is mainly unchanged, but there
  is a priority to review some of the courses being proposed in order to ensure they are fit for
  purpose. Some appear to have consistently low attendance and it may be timely to review how
  these are delivered (e.g. could they be made e-Learning) or even if they remain appropriate.
- Evaluation and Impact the group agreed and identified a programme of quality assurance for all the training included in the LSCB programme. Either members of the L&D sub group or specialists in the workforce will ensure the quality of training remains high. Evaluation sheets will continue to be provided and monitored after training sessions, and Reading will continue to approach delegates for follow up evaluation 3-6 months after the course. An area of development is to ensure that the Reading LSCB Board has sight of the evaluation of training. This information is available but has not been presentment to the Board. In addition, SCR learning continues to be incorporated in to our L&D offer as and when appropriate, helping to disseminate key messages and learning thereby influencing work practices and behaviour and so having a positive impact on the outcomes for children and young people.

## Ongoing Challenge/Actions:

- Being unfunded and with limited resource for support, the sub-group relies on good will
  across partners and this can limit the ability to respond quickly to emerging needs or to
  adequately resource new ideas or work.
- Post course evaluation this process needs to be strengthened and regular reports provided to the sub-group and Board to ensure courses are appropriate for Reading.
- This is a shared sub-group, however clear progress is required to ensure it adequately provides for the needs of each of the LSCBs. In Reading there needs to be greater thought to provision of training in line with the LSCB priorities such as neglect. (Ofsted Recommendation – see page 43).
- A detailed training needs analysis and audit is required to ensure the needs of the whole children's workforce are understood, to inform subsequent training programmes. This work must be reported back to the Board to ensure they are informed of any issues.

# **Case Review Group (West of Berkshire)**

The Case Review Group (CRG) receives and reviews all cases referred to the group where staff from any partner agency of the Safeguarding Children Boards in the West of Berkshire have identified potential learning.

Recommendations will be made to the Chair of the Berkshire West Local Safeguarding Children Boards (LSCBs) when the group agrees that the criteria has been met to undertake a serious case review (SCR) as defined in Working Together to Safeguard Children (2015). Where the group agrees that the criteria for a SCR has not been met it might recommend a partnership review of the case.

Learning from published SCRs will be shared by the group for dissemination across partner agencies of the LSCBs.

# Summary of activity/achievements:

The group met for the first time in February 2015. Since then the CRG has met on seven scheduled occasions up until April 2016. Two additional meetings were held when serious incidents concerning children needed to be reviewed quickly to enable a recommendation to be made to the Chair of the LSCBs about whether or not a serious case review (SCR) should be initiated.

In total the cases of 8 children have been discussed by the CRG (2 Reading, 4 West Berkshire, 3 Wokingham). Of these, one recommendation was made that a SCR should be initiated. However, upon the discovery of additional information and discussion with, the then, Head of Children's Services for Reading, the decision was over ruled by the Chair and a multi-agency partnership review undertaken instead. Both Reading cases resulted in partnership reviews which have been completed. See below for information.

The CRG is well established and arrangements have been made to meet every three months with additional meetings arranged as necessary.

The terms of reference for the group have been reviewed and are currently under consultation with group members before submission to the LSCBs for approval. A checklist to aid LSCB members in their decision to publish partnership reviews in full has been developed. The CRG feel strongly that all learning should be published on LSCB web sites.

There is a strong commitment to the CRG from its members, although particular challenges remain around processes.

# **Ongoing Challenge/Actions:**

- Learning from partnership reviews continues to be shared locally with each LA arranging learning events. Learning needs to be shared across Berkshire West
- There is no representation on the CRG from any school in Berkshire West.
- Individual agencies will need to interpret learning from Partnership reviews and monitor completion of actions. The LSCBs must be assured that actions are progressing to completion.
- A clear and transparent process for referring serious incidents to the CRG is required and agreed by all members. (Ofsted Recommendation – see page 43).

# **Learning from Multi-Agency Partnership Reviews**

In 2015 the West of Berkshire Case Review Group considered two cases from Reading to ascertain whether they met the criteria for a Serious Case Review (SCR).

Case A15: This situation was brought to the attention of Reading Local Safeguarding Children Board after the young person, A15, aged 14 years, self-harmed after alleging she had been raped. A15 had been known to services for some time and in 2013 there were concerns that she may have been the victim of sexual exploitation. This case did not meet the criteria for a SCR, but the group recommended a multi-agency partnership review as it was felt that there was the potential for learning and that further reflection and analysis would be beneficial. A lessons learnt review was initiated.

Case B15: B15, aged 17 years, attacked and stabbed two girls aged 14 (A15) and 15 years. The victims, who were lucky to survive the attack, were left with life-changing injuries. B15 was convicted of 2 counts of attempted murder and 3 counts of sexual assault and jailed for 17 years. This case was initially considered by Bracknell Forest LSCB for a serious case review. It was agreed that it did not meet the criteria for a SCR, however there could be significant learning in reviewing how agencies had worked with the perpetrator, B15, who lived in Reading. The West of Berkshire Case Review Group and Reading LSCB Chair agreed that a review around the circumstances which led up to the incident was required, however, the criteria for a SCR is based on the victim rather than the perpetrator. The National Panel of Experts on SCRs confirmed that the SCR criterion was not met. Reading LSCB, therefore, agreed to initiate a lessons learned review instead.

Both reviews were carried out in the autumn of 2015 by the same independent author, following the Welsh review model. Although they were very different cases and situations, there were a number of similar findings. For example:

#### Assessment:

- Assessments were narrow in focus and lacked assessment of risk.
- In both cases the children were well developed and perhaps treated as older than they actually were.

# Information Sharing and Collation:

- Although recorded, information was not accessible when assessments were made. Information was 'lost' between contacts and a full history was not pulled together or rigorously analysed.
- Information about B15 did not move with him, whether across LA boundaries or between schools.

## **Understanding Risk:**

• The assessments over time for both A15 and B15 failed to adequately identify the risks of their behaviour to themselves and others.

## Key Worker:

 Lack of sustained or consistent intervention by one agency/key worker for A15 and B15 meant instability for the child and no opportunity for a holistic view of the case to be undertaken and understood.

There were 4 dissemination events over 2 days delivered by the independent author. 155 workers attended from across the LSCB partnership. Feedback was positive with 90% confirming they felt it was relevant to their work, and 86% rating the sessions as 'good' or 'excellent'.

Workers felt that identifying barriers, hearing the recommendations, having time to reflect and listening to the child's views were useful as well as listening and hearing how other professionals work. People felt more confident to make challenges.

An action plan is in place to address the recommendations made in the reports, which is being monitored by the Case Review Group, and the Quality Assurance Sub Group.

## **Quality Assurance and Performance Sub Group (Reading)**

Working Together states that in order to fulfil its statutory functions under regulation 5 an LSCB should use data and, as a minimum, should:

- assess the effectiveness of the help being provided to children and families, including early help;
- quality assure practice, including through joint audits of case files involving practitioners and identifying lessons to be learned;

The role of the Reading LSCB Quality Assurance and Performance Subgroup is to ensure there are sound mechanisms for monitoring, evaluating and auditing safeguarding activity in place, particularly in relation to front line services, and ensuring that improvements are made to deliver better outcomes for children. Also, its role is to demonstrate that the LSCB is a 'learning partnership' that has a strong focus on impact and effectiveness, and when necessary, escalate any identified risk in order to provide assurance to the Board to enable them to carry out their statutory responsibilities.

# Summary of activity/achievements:

- The Quality Assurance and Performance subgroup was formed in February 2015 following the
  merger of the two separate sub groups. During the initial stages of the group data was received,
  however there was no real commentary and analysis of the data and/or connection as to how the
  data should be translated into identifying any emerging top issues and linking into the audit
  framework.
- In October 2015 the chair ship of the group changed at which point the group took the opportunity to revise the current data set and dash board. A draft Performance Dash Board and dataset was brought to the LSCB in November 2015 and agreed. Representatives of the Quality Assurance and Performance sub group have worked since October 15 at developing the Performance Dash Board and data set. It is recognised that this will continue to be adapted to meet priorities of the board and emerging top issues across agencies.
- The performance data continues to be a work in progress ensuring data is collected and commentaries are supporting the data. Dates have been reviewed to ensure sub group dates are

in line with quarter end dates to enable through scrutiny and reporting to the board. It has been noted that given the board meets bi-monthly and the data is collated quarterly, the board will not always be updated at each meeting by the most previous end of quarter data.

- The audit programme continues to be linked to the key priorities and the data set where there are issues or themes arising.
- Four multi-agency audits were completed during 2015/16. These have all been included within this annual report, within the relevant priority area. There is recognition that learning from audits and effective monitoring and evaluation of the associated actions plans needs to improve to ensure improvements are made in front line safeguarding practice.

## **Ongoing Challenge/Actions:**

- The data set continues to be improved in its design and presentation to enable it to assist the sub group in its scrutiny of the data. Although progress has been made and moving in the right direction, there remains a challenge in receiving commentary and agreeing the formats that is workable within timescales (quarterly/Yearly) and the structures of each agency.
- Completion of the audit programme for the year within agreed timescales is a challenge for all members of the sub group due to competing demands therefore an audit plan that is structured and achievable is required going forward.
- Learning from audits must be more effectively disseminated and embedded into practice. The action plans must be monitored through to completion. (Ofsted Recommendation see page 43).



# **Our Performance**

# Ofsted Inspection – May/June 2016

In May and June 2016 Ofsted undertook a review of the effectiveness of Reading LSCB as part of the inspection of services for children in need of help and protection, children looked after and care leavers in Reading.

The inspection determined that Reading LSCB requires improvement.

Ofsted made five recommendations in relation to the LSCB:

- Develop an overarching process to ensure that learning from quality assurance activity is properly shared, tracked and reviewed. This should include clear and relevant actions from single and multi-agency case audits.
- Implement a clear and transparent process for referring serious incidents to the case review subgroup for detailed consideration of whether a serious case review is needed.
- Ensure that the work of the learning and development sub-group has a sharper focus on the particular learning and training needs of Reading professionals, including overseeing and, where appropriate, influencing the provision of single agency training.
- Undertake a review of local safeguarding thresholds, including the effectiveness of the early help pathway, and the understanding and application of thresholds at all the key points in a child's journey.
- Secure regular and consistent attendance and engagement at the board and sub-groups by children's social care, to increase the board's ability to contribute to improvements in core social work practice.

All five recommendations were in line with the self-assessment that had been carried out by Board members at a Board meeting in May 2016. These recommendations have been captured in the 'Challenge' sections of this annual report as already identified issues by the relevant sub-groups/Board.

Ofsted also made a number of positive comments which included:

- There has been positive change in the last 18 months.
- There is good representation and commitment from partners.
- Partners and young people have helped to shape the LSCB priorities, which are right for Reading.
- The 2015/16 Business Plan was an effective tool in progressing priorities with most actions completed and the remaining carried over.
- We have a comprehensive dataset which is much improved in the past year.
- The Independent Chair is a strong leader with high expectations and instils a culture of transparency and challenge. The Challenge and Concern log has facilitated active challenge and has led to practice improvement.
- Comprehensive CSE Strategy and LSCB has been instrumental in progress but there needs to be more scrutiny on operational practice and data.
- The Board has developed and published a comprehensive threshold of need document.
- The 2014–15 annual report was comprehensive and well written.

All recommendations have been embedded within the Reading LSCB Improvement and Development Plan for 2016/17.

# **Our Performance**

# **Lay Member Perspective**

The past year has seen the Board working more effectively together under the leadership of the Independent Chair to focus on clearly defined and achievable key priorities, with the goal to ensure we deliver on better outcomes for safeguarding children and young people in Reading.

Delivering on our key priorities for the past year was achievable against the backdrop of the renewed ability of Board Members to query and challenge each other, themselves and their respective agencies, thus ensuring nothing was left to chance. As lay members, we are particularly pleased to have played our part as independent members of our communities in helping to bring about these achievements over the past year

Amongst the many achievements over the past year, we were pleased to see significant development around areas of:

- CSE, FGM and Neglect implementation of strategies and threshold work;
- Private fostering strategy development and acknowledging more to be done;
- Reviews of the 2 exceptional cases with learning across Reading and other local areas;
- Priorities setting making them meaningful, manageable and achievable;
- Business planning ensuring all board members involved and contributing to final plan;
- Performance and Quality reporting the dashboard is slowly getting there, but still some work to be done around data collection and reporting;
- Governance, Auditing Action Plan, Risk Log improved clarity and visibility on what has be done, what has been achieved and what actions needs to be taken;
- Information dissemination particularly through the newly developed website, newsletter and information cards;
- Improved links and communications with schools;
- Improved links with other local authorities and their LSCBs through the Chair, the sub-groups, some of our Boards partnering agencies;
- Improved links with the local community supported and participated in local seminar,
   "Safeguarding Our Children" hosted by Barbados And Friends Association, Reading for members of the Black community and local professionals working with children.

As lay members, we are also pleased to be meeting and sharing experiences with lay members of other local LSCBs in Berkshire, but we were disappointed we were unable to attend the Southeast Lay Member's conference in Brighton.

As part of the re-organisation of subgroups, I was pleased and honoured to play my part in initially Chairing the Performance and Quality Assurance subgroup earlier in the year— this subgroup is progressing well.

We recognised that amongst the positive achievements of the Board, there are still some challenges particularly in the area of staffing – work is ongoing to help partner agencies reduce dependency on agency/interim staff

As lay members, I believe we have shown a strong commitment to supporting local safeguarding in Reading over the past year. In the coming year, we will continue to ensure that our contribution will be reflected in a Board that is continuing to be effective and positively delivering for the benefit of the community it serves.

Anderson Connell
Reading LSCB Lay Member

# **Appendices**

# 1. Glossary

BHFT	Berkshire Healthcare NHS Foundation Trust			
CAF	Common Assessment Framework			
CAFCASS	Children and Family Court Advisory and Support Service			
CAMHS	Child and Adolescent Mental Health Services			
CAT	Children's Action Team			
CCG	Clinical Commissioning Group			
CDOP	Child Death Overview Panel			
CIN	Children in Need			
СМоЕ	Children Missing out on Education			
СР	Child Protection			
CSC	Children's Social Care			
CSE	Child Sexual Exploitation			
DA	Domestic Abuse			
DV	Domestic Violence			
EHC	Education, Health and care Plan			
FGC	Family Group Conference			
FGM	Female Genital Mutilation			
IRO	Independent Reviewing Officer			
JSNA	Joint Strategic Needs Assessment			
LAC	Looked After Child			
LADO	Local Authority Designated Officer			
LSCB	Local Safeguarding Children Board			
MAPPA	Multi-Agency Public Protection Arrangements			
MARAC	Multi-Agency Risk Assessment Conference			
MASH	Multi-Agency Safeguarding Hub			
NEET	Not in Employment, Education or Training			
PSCHE	Personal, Social, Citizenship and Health Education			
RBC	Reading Borough Council			
RBFT	Royal Berkshire NHS Foundation Trust			
RCVYS	Reading Children and Voluntary Youth Services			
SAPB	Safeguarding Adults Partnership Board			
SCR	Serious Case Review			
SEN	Special Educational Needs			
TVP	Thames Valley Police			
YOT	Youth Offending Team			

## 2. Extracts from Working Together 2015

## Chapter 3.1: Statutory objectives and functions of LSCBs

Section 14 of the Children Act 2004 sets out the objectives of LSCBs, which are:

- (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:

- 1 (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.

Regulation 5 (2) which relates to the LSCB Serious Case Reviews function and regulation 6 which relates to the LSCB Child Death functions are covered in chapter 4 of this guidance.

Regulation 5 (3) provides that an LSCB may also engage in any other activity that facilitates, or is conducive to, the achievement of its objectives.

## Chapter 3.4: Statutory Board partners and relevant persons and bodies

Section 13 of the Children Act 2004, as amended, sets out that an LSCB must include at least one representative of the local authority and each of the other Board partners set out below (although two or more Board partners may be represented by the same person). Board partners who must be included in the LSCB are:

- district councils in local government areas which have them;
- the chief officer of police;
- the National Probation Service and Community Rehabilitation Companies;
- the Youth Offending Team;
- NHS England and clinical commissioning groups;

- NHS Trusts and NHS Foundation Trusts all or most of whose hospitals, establishments and facilities are situated in the local authority area;
- Cafcass;
- the governor or director of any secure training centre in the area of the authority; and
- the governor or director of any prison in the area of the authority which ordinarily detains children.

The Apprenticeships, Skills, Children and Learning Act 2009 amended sections 13 and 14 of the Children Act 2004 and provided that the local authority must take reasonable steps to ensure that the LSCB includes two lay members representing the local community.

Section 13(4) of the Children Act 2004, as amended, provides that the local authority must take reasonable steps to ensure the LSCB includes representatives of relevant persons and bodies of such descriptions as may be prescribed. Regulation 3A of the LSCB Regulations prescribes the following persons and bodies:

- the governing body of a maintained school;
- the proprietor of a non-maintained special school;
- the proprietor of a city technology college, a city college for the technology of the arts or an academy; and
- the governing body of a further education institution the main site of which is situated in the authority's area.

## **Chapter 5: Child Death Reviews**

The Regulations relating to child death reviews:

The Local Safeguarding Children Board (LSCB) functions in relation to child deaths are set out in Regulation 6 of the Local Safeguarding Children Boards Regulations 2006, made under section 14(2) of the Children Act 2004. The LSCB is responsible for:

- (a) collecting and analysing information about each death with a view to identifying -
  - (i) any case giving rise to the need for a review mentioned in regulation 5(1)(e);
  - (ii) any matters of concern affecting the safety and welfare of children in the area of the authority;
  - (iii) any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area; and
- (b) putting in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

Working Together 2015 can be viewed via this link: <a href="http://www.workingtogetheronline.co.uk">http://www.workingtogetheronline.co.uk</a>

#### 3. Structure Chart

# **Reading Local Safeguarding Children Board**

Independent Chair: Fran Gosling-Thomas

Related Partnership Groups

**Reading Health and Wellbeing Board** 

**Berkshire West Safeguarding Adults Board** 

Reading Borough Council Adult Children and Education Committee

**Community Safety Partnership** 

**Reading Children's Trust Partnership Board** 

**Corporate Parenting Panel** 

# **Sub Groups**

Quality Assurance and Performance Sub Group

Chair: Reviewing and Quality Assurance Service Manager, RBC

CSE and Children who go Missing Sub Group

Chair: Director of Children, Education & Early Help Services, RBC and Local Area Commander, Thames Valley Police

**Neglect Task & Finish Group** 

Chair: Head of Early Help Services, RBC

**Reading Sub Groups** 

**Case Review Group** 

Chair: Berkshire Designated Doctor for Child Protection, Berkshire Healthcare Foundation Trust

Learning and Development Sub Group
Chair: CSE Coordinator, RBC

Female Genital Mutilation Task & Finish
Group

**Chair: Reading LSCB Independent Chair** 

**West of Berkshire Sub Groups** 

Section 11 Panel

Chair: Director, Windsor and Maidenhead Locality, Berkshire Healthcare Foundation Trust

Policy and Procedures Sub Group Chair: Head of Performance and Quality Assurance, Slough Children's Services Trust

Child Death Overview Panel
Chair: Director, Public Health Berkshire

**Pan Berkshire Sub Groups** 

# 4. Board Membership and Attendance Log (March 2016)

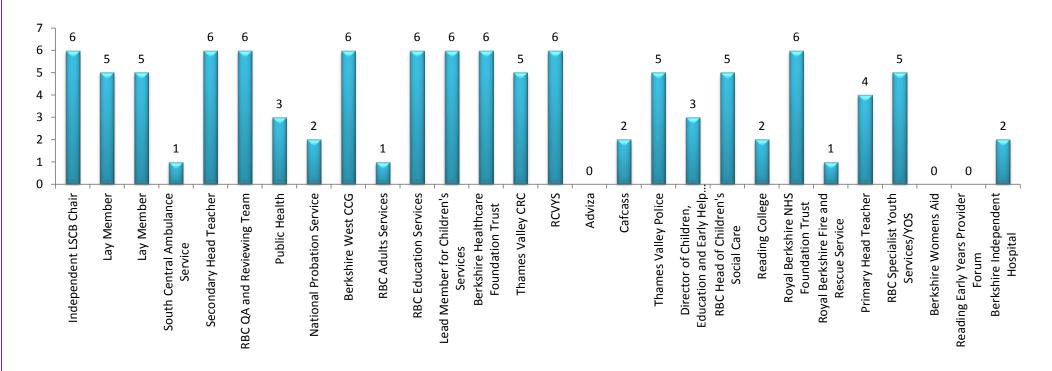
Name	Agency		
Francis Gosling-Thomas	Independent LSCB Chair –Reading, West Berkshire, and Wokingham		
Helen McMullen	Director of Education, Adult and Children's Services - Reading		
	Borough Council (RBC)		
Rachel Dent	Head Teacher, Abbey School (Independent School Rep)		
Catherine Parry	Head of Children's Social Care		
Anderson Connell	Lay Member		
Anne Farley	Lay Member		
Anthony Heselton/Kat Jenkin	South Central Ambulance Service		
Ashley Robson	Ponding School		
Liz Batty	Reading School  Joint Legal, Reading Borough Council		
Ben Sims or Paul Taylor	Activate Learning, Reading College		
Richard Blackmore	Head of Education, RBC		
Chris Lawrence	Early Years Providers Forum		
Christina Kattirzki	Kendrick School CCG		
Debbie Simmons  Debbie Johnson	Probation		
Bindy Shah	Service Manager, Youth Justice, CSE, Specialist Youth Services and Edge of Care Services		
Wendy Fabbro	Director of Adult Care and Health Services		
Cllr Jan Gavin	Lead Member		
Sarah Gee	Housing, Neighbourhoods and Communities, Reading Borough		
Surum Gee	Council		
Gerry Crawford	Berkshire Healthcare Foundation Trust		
Hannah Powell	Probation		
Helen Taylor	RCVYS		
Patricia Pease	Royal Berkshire Hospital Foundation Trust		
Liz Warren	Royal Berkshire Fire and Rescue Services		
Stan Gilmour	Thames Valley Police		
Becky Herron	RSCB Learning and Development and CSE coordinator		
Jan Fowler	NHS England		
Julie Kerry	NHS England		
Kevin Gibbs	Cafcass		
Lise Llewellyn	Public Health		
Ruth Perry	Caversham Primary School		
Julie Skinner	Adviza		

# **Board Meeting Attendance**

Reading LSCB members have a responsibility to attend all meetings and disseminate relevant information within their agency. Attendance at meetings is monitored to ensure attendance is regular and at an appropriate level. These records are presented to members on an annual basis as part of the LSCB's quality assurance process.

Attendance in Reading is generally good and, if a member is unable to attend, they are asked to send a deputy to ensure all messages are disseminated to each agency. Any lack of agency attendance is addressed directly by the Business Manager or escalated to the Chair. In addition, the Designated Doctor and a representative from Adviza attend meetings once a year by arrangement.

Attendance figures by agency, based on six meetings held from April 2015 to March 2016, are shown below.

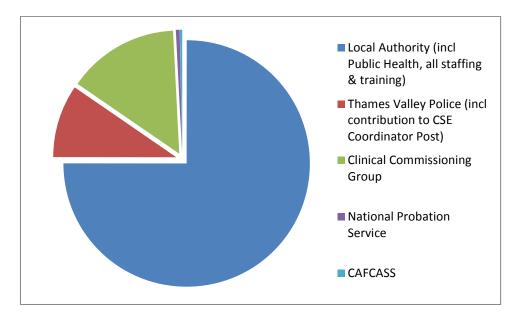


# 5. Financial Contributions

The budget is monitored by the Business Manager with the majority of the budget spent on staffing to support the work of the Board.

The LSCB budget 2015-2016 is made up of contributions from the Local Authority, Clinical Commissioning Groups, Thames Valley Police, National Probation Service and CAFCASS.

Contributing Agency	Contribution Amount
Local Authority (incl. Public Health, all staffing & training)	£133,500
Thames Valley Police (incl. contribution to CSE Coordinator Post)	£17,000
Clinical Commissioning Group	£20,000
National Probation Service	£895
CAFCASS	£550
Total	£177,945



The budget outturn for 2015-2016:

Description	Figure	Comments
Staffing:	£75,700	
• 0.7 fte LSCB Business Manger		
● 1 fte LSCB Coordinator		
Independent Chair's expenses	£20,500	
Room Hire and Catering	£1,000	Board and Sub-Group meetings, Business
		Planning, Learning Lessons sessions
Printing and Stationary	£6,200	Meeting papers, Thresholds Booklets
Publicity Materials	£6,000	Pens (£1000), LSCB CSE Awareness business
		cards (£1200), Safeguarding awareness video
		(£1600)

Events	£12,350	CSE Launch (£1950), Safeguarding our Children seminar(£2,400), Chelsea's Choice production (£5,000), Learning Lesson results events (£2,000)
Contract fees	£1,400	Annual maintenance contract for LSCB safeguarding procedures, including additional payment to move to new model
Subscriptions	£3,500	NWG network (£500), MoMo app (£3,000)
Consultancy fees	£10,420	Independent reviewer for A15 Children's Social Care Chronology (£420), Independent Auditors (£10,000)
Learning Lessons Reviews (x2)	£10,500	Independent Reviewer costs, including expenses, approx. £5,000 per review
RCVYS Training Programme	£5,500	Amount given to RCVYS to provide the safeguarding training programme for the VCS
LSCB Training	£25,000	Cost of running LSCB training programme and designated officer courses, plus proportion of Training Officer Salary.
Total for LSCB Cost Centre	£178,070	

In 2015 the LSCB Chair raised a clear concern that the current budget is not in line with similar authorities and does not allow the LSCB to address its key priorities. A discussion was held at Board and comparative review of the budget undertaken.

As a result, for the 2016/17 year additional contributions were received from Thames Valley Police, increasing to £8,000 per annum from £2,000. In recognition of the improvements required by the LSCB, Reading Borough Council has also offered an additional one off £60,000 for the 2016/17 year as a development fund. Other agencies felt unable to increase contribution for 2016/17 year. Conversations will continue for the 2017/18 year.

# **Ongoing Challenge/Actions:**

• Budget contributions will be reviewed again during 2016 to establish whether additional resources are required and/or available.

# 6. Reading LSCB Board Information

Independent Chair: Fran Gosling-Thomas <u>LSCBChair@reading.gov.uk</u>

Reading LSCB Business Manager: Esther Blake <a href="mailto:esther.blake@reading.gov.uk">esther.blake@reading.gov.uk</a>

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Reading LSCB Coordinator: Donna Gray <u>LSCB@reading.gov.uk</u>

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Civic Offices, Bridge Street

Reading, Berkshire, RG1 2LU

Website: <a href="http://berks.proceduresonline.com/index.htm">www.readinglscb.org.uk</a>

Berkshire Local Safeguarding Children Boards

Child Protection Procedures available on line:

<a href="http://berks.proceduresonline.com/index.htm">http://berks.proceduresonline.com/index.htm</a>

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Date published: xxxxx

If you have any queries about the report please contact Esther Blake at the contact details above. If you require this information in an alternative format or translation, please contact Esther Blake.