Reading Local Safeguarding Children Board

Annual Report 2016-2017

Reading Local Safeguarding Children Board

Contents

Foreword

Welcome to the Annual Report of Reading Local Safeguarding Children Board (LSCB) which covers the period from April 2016-March 2017. The Independent Chair of the LSCB during the period of this Annual Report, Fran Gosling Thomas resigned from this role in May 2017. I was appointed LSCB Chair and took up the position in September 2017 and I am therefore providing the foreword for the Annual Report. The LSCB Vice Chair, Debbie Simmons has provided leadership to the LSCB in the interim period and the LSCB is grateful for her support and that of the LSCB Team and would also wish to acknowledge the contribution of the previous Independent LSCB Chair over the last three years.

During the period of this Annual Report, Ofsted inspected both the Local Authority and the LSCB under its Single Inspection Framework in May and June 2016. The outcome for the LSCB was that it "Requires Improvement" and the LSCB has responded positively to the five recommendations for improvement. The Local Authority was however judged Inadequate and the Children's Services Improvement Board which is independently chaired and includes multi-agency partners has provided oversight of the responses to the 18 recommendations. In addition the DfE appointed a Commissioner to oversee the improvement journey and Ofsted have carried out two monitoring visits in this timeframe – November 2016 and February 2017.

It has become increasingly clear that there is a need to align some of the areas for improvement identified during the inspection process for both the Local Authority and the LSCB where the LSCB has a clear role in leadership and oversight. This work to join up and ensure synergy is currently underway and includes the recommendations around Early Help and Thresholds, Child Sexual Exploitation and Missing Children and Domestic Abuse. The LSCB will also continue to provide oversight, support and challenge to the Local Authority's Improvement journey and the LSCB Chair is a member of the Children's Improvement Board.

This Annual Report 2016/17 sets out the progress made by the LSCB in 2016/17 which has been significant in a number of priority areas identified in the LSCB Business Plan. Some key examples include:

- All secondary schools have received training in Psychological Perspectives in Education and Primary Care to help staff recognise and understand mental health difficulties in children and young people and offer appropriate support and guidance.
- Development and launch of the Female Genital Mutilation Risk Assessment Toolkit which includes risk factors, guidance and pathways. Plus free online training module to support staff using the tool.
- Development and roll out of free online Safer Recruitment Training.
- Delivering new free two hour 'forum' sessions, open to all staff across the West of Berkshire.
- Review of the LSCB Learning and Improvement Framework and delivery of a range of audits included within this report.

Whilst recording my thanks to members of the Board and those supporting the work of its sub groups, I would like to of course state my gratitude to all those staff and volunteers within the local workforce for their commitment, to safeguarding children and young people in Reading. I am looking forward to the opportunity provided by this role as Independent Chair to support and maximise the collective responsibility we all share to secure improvement for the effective safeguarding of children.

Alex Walters
Independent Chair of Reading LSCB

Local context

Our Board

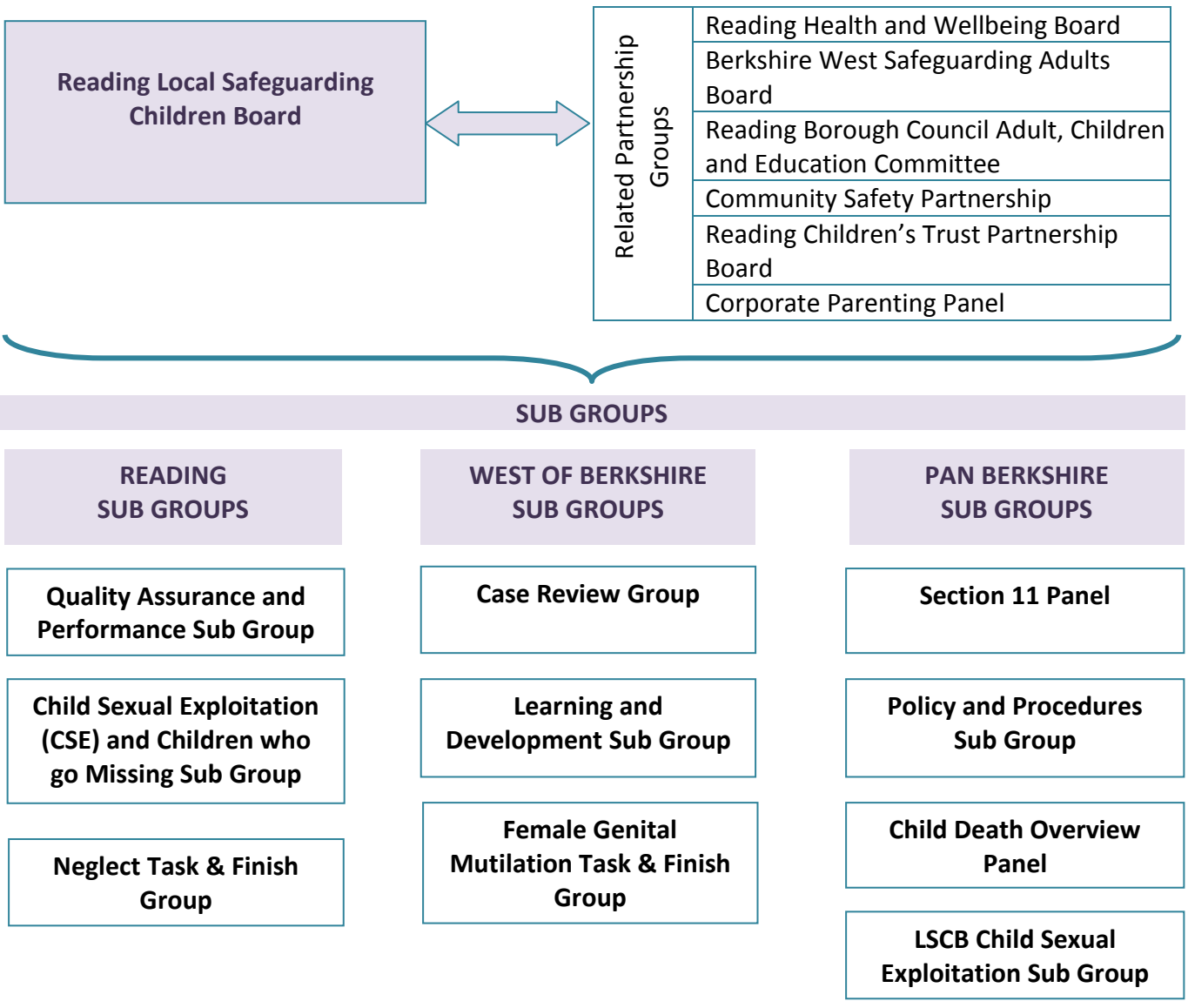
Reading Local Safeguarding Children Board (LSCB) is the key statutory body overseeing multi-agency child safeguarding arrangements across Reading. The work of the Board is governed by statutory guidance Working Together to Safeguard Children 2015.

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

- 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 their area; and
- to ensure the effectiveness of what is done by each such person or body for those purposes.

Reading LSCB has an independent chair and members who are senior representatives from a range of agencies. The Board is collectively responsible for the strategic oversight of local safeguarding arrangements. It does this by leading, co-ordinating, challenging and monitoring the delivery of safeguarding practice by all agencies across Reading. Our current membership is listed in the appendices.

Structure of Reading LSCB in 2016/17



Day to day, the LSCB:

- Undertakes multi-agency audits to review the effectiveness of services and make recommendations. Details of the audits from 2016/17 are given throughout this report.
- Reviews and analyses partnership data to ensure the LSCB understands the needs of the local population.
- Provides a multi-agency safeguarding training programme based on the needs of our local workforce.
- Ensures partners are fulfilling their statutory obligations in relation to safeguarding and promoting the welfare of children within their organisations.
- Undertakes serious case reviews or partnership reviews of cases to ensure that we learn and improve services as a result.

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.

Joint working:

Reading is one of six unitary authorities and LSCBs in Berkshire and the Board works collaboratively with our neighbours to ensure a more joined up approach to safeguarding. This is particularly important where agencies deliver services across, and are represented on, 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.

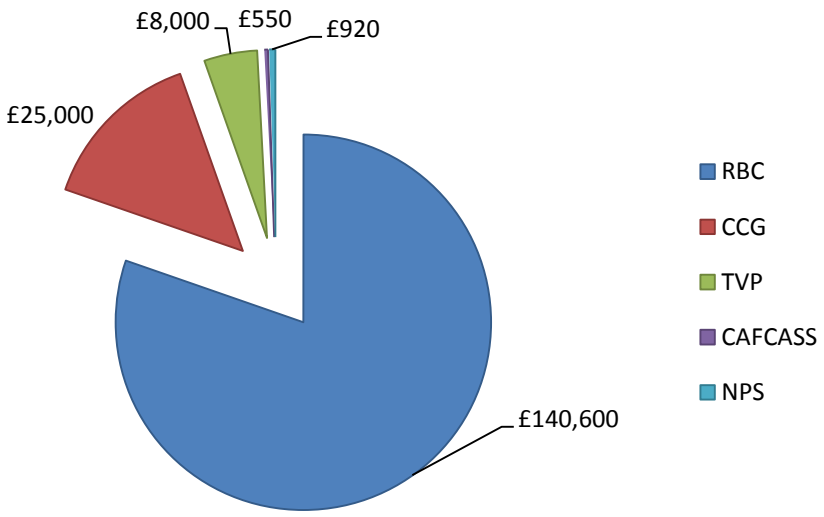
To ensure the best use of resources there are shared sub-groups operating either across the whole of the county or the west of Berkshire. Sub groups for quality assurance and performance, child sexual exploitation and neglect are Reading specific to maintain a local focus on current issues.

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.

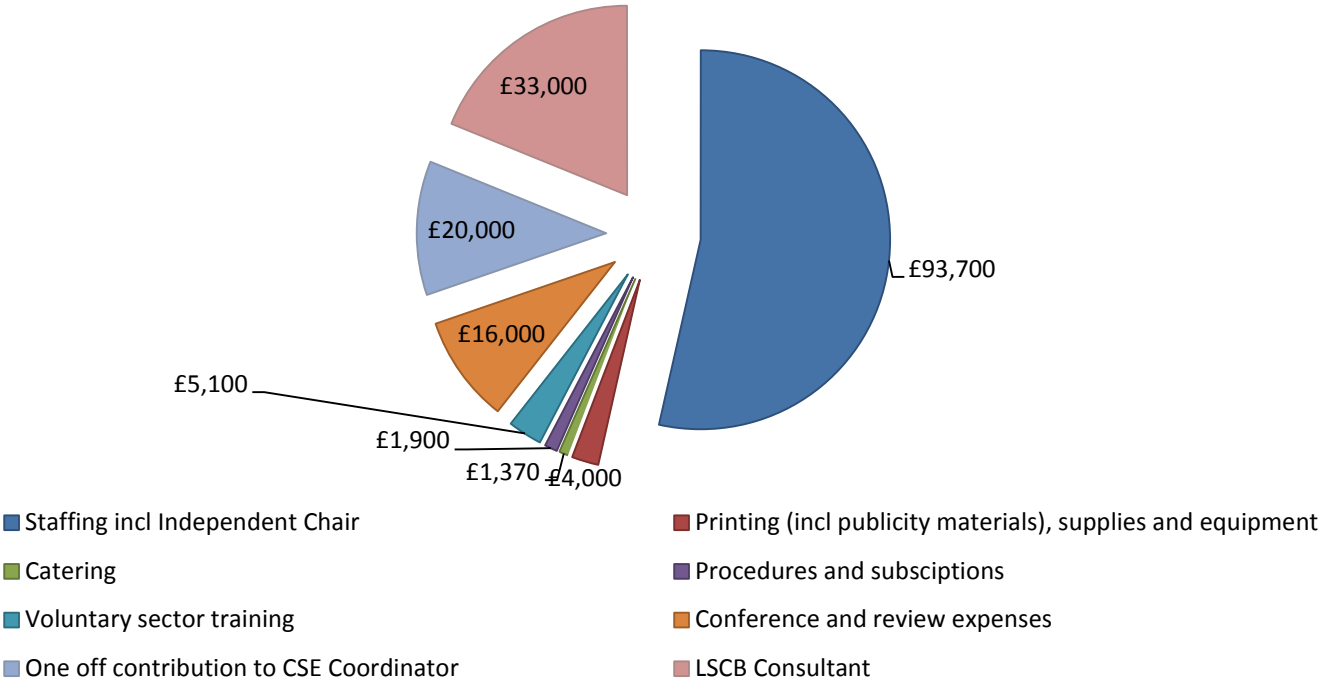
Finance:

Partners in the Board financially contribute specifically to the LSCB to enable it to operate and undertake work against the priorities. The budget for Reading LSCB in 2016/17 was £175,070.

Contribution:



Expenditure:



There were no serious case reviews undertaken in 2016/17, and therefore no costs represented above. The LSCB budget has a separate contingency fund allocated for potential serious case reviews or partnership reviews.

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. As a result, for the 2016/17 year additional contributions were received from Thames Valley Police and Reading Borough Council. This allowed for marketing campaigns and materials, and funding to launch the Female Genital Mutilation risk assessment toolkit. However, the Reading Borough Council contribution has since been reviewed and reduced significantly for 2017/18. This is an ongoing challenge for the LSCB and whether it can meet its statutory duties.

Ongoing Challenge/Actions:

- The agreed budget for 2017/18 is significantly lower than previous years and has been highlighted as a risk.

Local context

Summary of Key Events

Ofsted Inspection in May 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 and made five recommendations which were incorporated into an action plan. More information can be found on page 13.

The Ofsted inspection found that RBC Children's Services were inadequate. 18 recommendations were made which have been incorporated into the Children's Learning and Improvement Plan. An independently Chaired Children's Services Improvement Board, which includes senior members of partner agencies alongside Children's Services management, meets monthly to review and challenge progress against the Improvement Plan.

As a result of the inspection, the Minister of State for Children and Families appointed a Commissioner for Children's Services to oversee the improvement journey. Alongside this, Ofsted have carried out regular monitoring visits (November 2016, February and May 2017), each one focussing on a different area of the child's journey through services. A further visit is scheduled for October 2017.

Children's Single Point of Access

Throughout the 2016/2017 year, evidence through audits and inspections found that the existing referral pathways hindered appropriate referrals into Children's Services. As a result, in June 2017 the new Children's Single Point of Access was launched, with the full support of LSCB partners. Monitoring of this service, appropriateness of referrals and application of thresholds will continue to be scrutinised by the LSCB through data reporting and audits.

Female Genital Mutilation Risk Assessment Tool and Pathways

In 2015 and 2016 LSCB partners audited the prevalence of this issue within Reading, tested existing referral pathways and developed a risk assessment toolkit for practitioners to use, alongside clear pathways for dealing with concerns. In June 2016 the toolkit was launched, shortly after an online training module was developed to support practitioners to identify risk factors and complete the toolkit. Partners have also been able to secure funding to provide a Rose Centre (from September 2017) for any woman who has experienced female genital mutilation and requires support, guidance, or medical help. See page 25 for more information.

Sub Group Process Improvements

Two LSCB sub groups have significantly improved their review processes during the year. The revised cases for consideration process for the West of Berkshire Case Review Group has ensured clear and timely documentation has been presented to the group for review. See page 34 for more information. The Pan Berkshire Policy and Procedures Sub Group have taken a pro-active role in identifying chapters that require review and ensuing updates are agreed and key local issues addressed. See page 27 for more information.

Local context

Lay Member Perspective

One of our Lay Members, Anderson Connell, writes:

'As lay members and full members of the board, we have had an important role to play in the work of the Board in setting and delivering on its key priorities for safeguarding Reading's children and young people over the past year. Our contribution in this work covered a number of dimensions that included, but was not limited to;

- Providing oversight, scrutinising and challenging decisions and policies made by the Board and partnering agencies, ensuring they are having the desired impact on our children and young people
- Providing an alternative professional and community based perspective outside of the local authority or partnering agency's professional position to ensure a community and public view is observed in our decision making.

Although Ofsted's outcome on their review of the Board's effectiveness is, 'requires improvement' around the services for children in need of help and protection, children looked after and care leavers in Reading was disappointing, it was encouraging that our own self-assessment was in-line with this outcome. It was also encouraging to see Ofsted highlighting a number of positive comments on the Board's effectiveness and that all recommendations were embedded in our Improvement and Development Plan for 2016/17.

We are particularly pleased that as lay members, we are developing a stronger and more challenging voice within the Board and able to contribute positively in making improvements in safeguarding of children and young people in Reading.

Over the coming year, we must continue to scrutinise and challenge all our actions and policies, where necessary, keeping at the forefront their impact on children. We must strive to ensure continuing improvement in the process of measuring this impact on children through enhanced data collation and reporting.'

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 31st March 2017)

Approx. 18% of children in Reading lived in low income families

192 children and young people were living with their families in

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

265 Looked After Children

1232 children and young people identified as 'Children in Need' by Children's Services

661 identified Young Carers

6 Cases of Female Genital Mutilation were identified in the Reading locality (Q4 16/17)

182 Victims were referred to Berkshire Women's Aid (Q4 16/17)

56 families were accepted as homeless (Q4 16/17)

23 Looked After Children had a Disability (Q4 16/17)

57 Looked After Children have a Statement of Education, Health and Care Plan (March 2017)

121 children were reported missing in Q4 16/17, 55 received a Return Interview within 72 hours of returning home

Between April 2016 and March 2017, 334 children were in the households discussed at MARAC

32% of Looked after Children were placed 20 miles + from home

15 young people identified as at risk of Child Sexual Exploitation (March 2017)

143 Children were referred to Tier 3 CAMHS Services with 75 of them being referred to the Specialist Team (Q4 16/17)

73 Police Domestic Violence notifications sent to Multi-Agency Safeguarding Hub led to a referral (March 2017)

28 children had been subject to a Child Protection Plan for 18 months or longer (Q4 16/17)

70% of Looked After Children were in stable placements

There were 3 Child on Adult Domestic Abuse Incidents in Q4 16/17

88 referrals to Children's Social Care from the Royal Berkshire Hospital Emergency Department, 43 of them being CAMHS related (Q4 16/17)

3 known Privately Fostered Children

Out of the 746 Children and Young People reported missing (TVP Data 2016/2017) 298 were female, 446were male and 2 were gender unknown

65 (28%) of cases referred to the MARAC were repeat cases

Out of the 23 open CSE & Missing Cases 12 are White British, 5 are Dual Heritage, 2 are Asian/Asian British and 4 are Black or Black/British (March 2017)

16 Looked After Children and 57 Child Protection Cases are involved with the CAMHS Service (Q4 16/17)

Of the 352 children and young people subject to a Child Protection Plan 184 are under the category Neglect

3 CP Cases and 186 CIN Cases had a disability (Q4 16/17)

Journey through Children's Services

Early Help:

There are well-established Early Help Services across Reading which include 5 children's centre hubs delivering services to families across the area. These children's centres have good attendance rates across the clusters, particularly from targeted groups. 9847 children have used the Children's Centres.

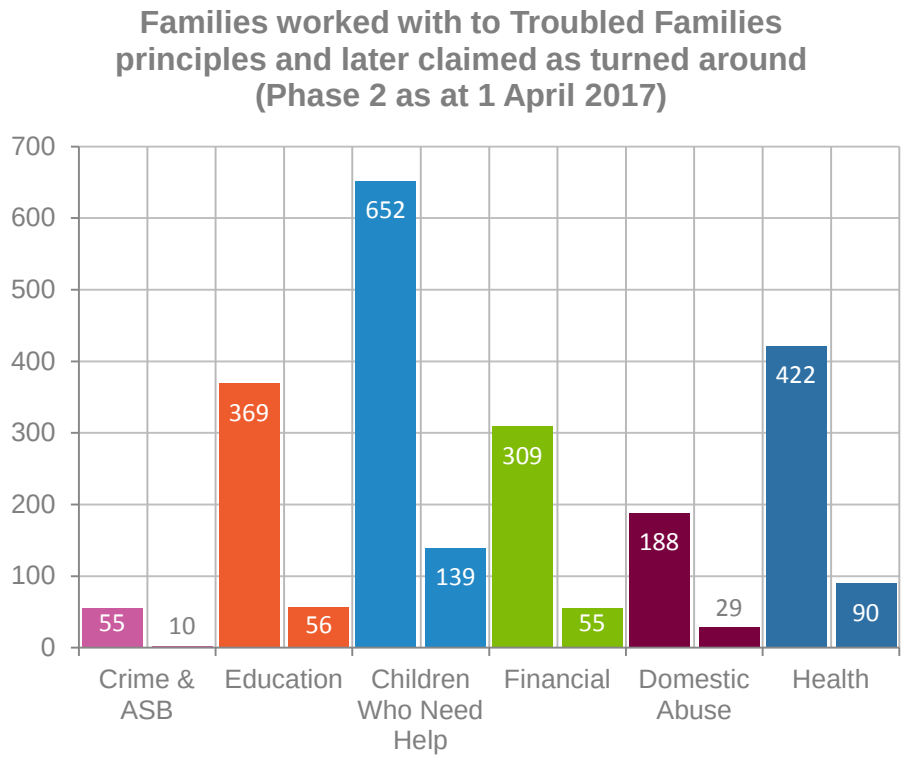
Early Help referrals and the number of Common Assessments (CAF) completed in 2016/17 totalled 637. All CAFs continue to be quality assured at point of submission to ensure that the importance of the Voice of Child, multi-agency contributions and clear analysis leading to a plan of support is in place.

Cases are 'stepped up' to RBC children's social work services where required, with all 'step up' referrals submitted through the Multi Agency Safeguarding Hub (MASH) to ensure a consistency of thresholds and decision making

A revised Early Help pathway was implemented in July 2017 which saw children's services providing the community and partners with a single point of access (CSPOA). Phase two of the CSPOA will be launched on the 29th September, this phase will see greater integration of partners into the CSPOA, supporting the multi – agency safeguarding hub, decision making and clarifying pathways for CSE and Domestic Abuse.

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, Specialist Youth Services provide 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.

Troubled Families

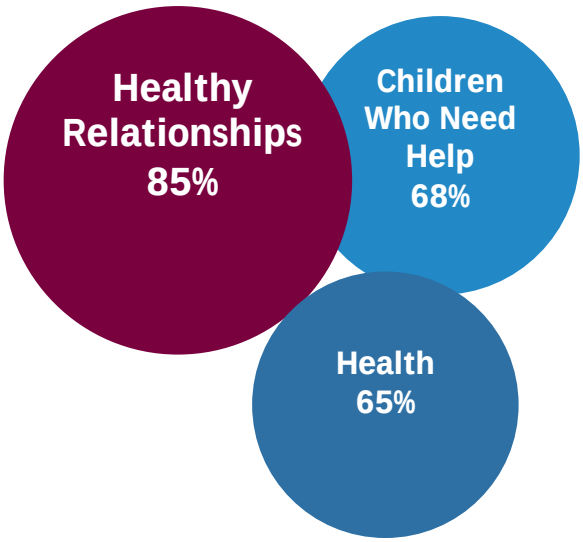


Of 652 families we worked with, 139 have achieved significant progress and sustainable change.

90 families have improved health outcomes and attendance was improved to 90% over three consecutive terms for 56 families.

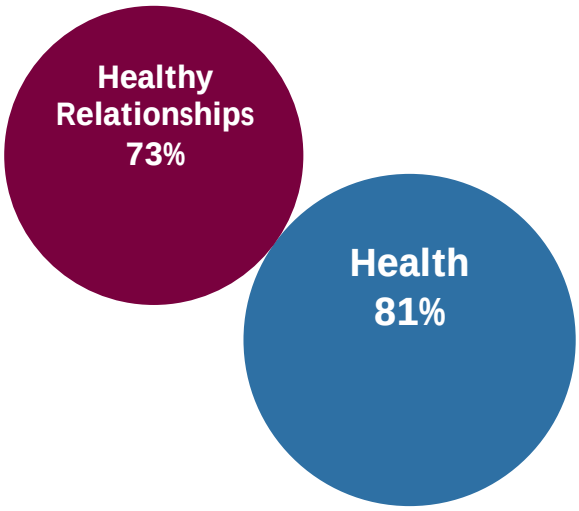
44 families have moved off out-of-work benefits and have sustained work.

Percentage of parents who have made positive changes after attending Triple P Courses
(for families with school age children)



Triple P is a flexible, practical way to help parents develop skills, strategies and gain confidence to handle any parenting situation. The courses have shown many positive effects on families including building on healthy relationships, improving health and overall outcomes for children. The Troubled Families Employment Advisor has adapted similar techniques to engage parents and assist families back to work.

Percentage of parents who have made positive changes after attending Webster Stratton Courses
(for families with children under 5)



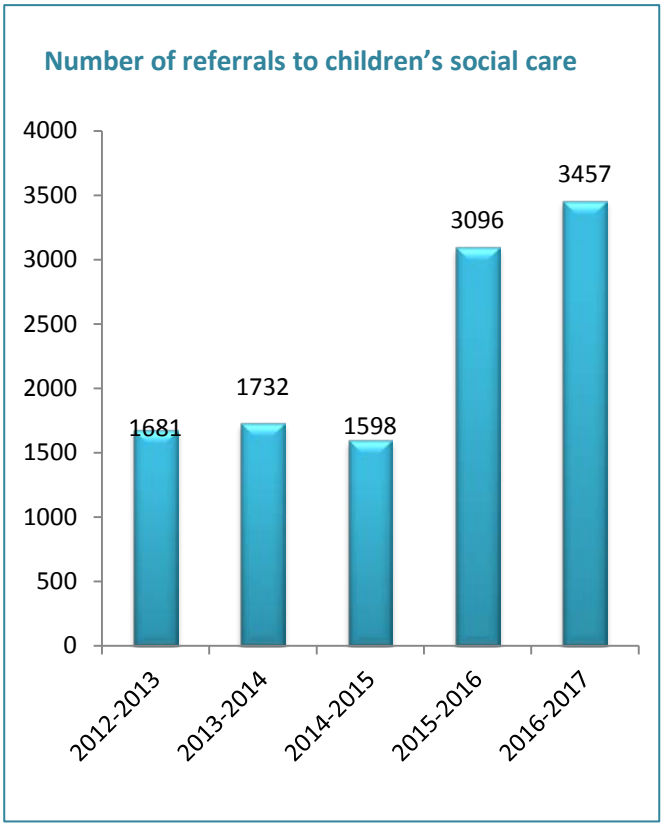
Webster Stratton is a research-based program aimed at reducing children's aggression and behaviour problems and increasing social competence at home and at school. This course for parents with children aged 0-5 has shown positive effects on the family unit including building on healthy relationships and targeting specific health outcomes such as anxiety, stress and depression.

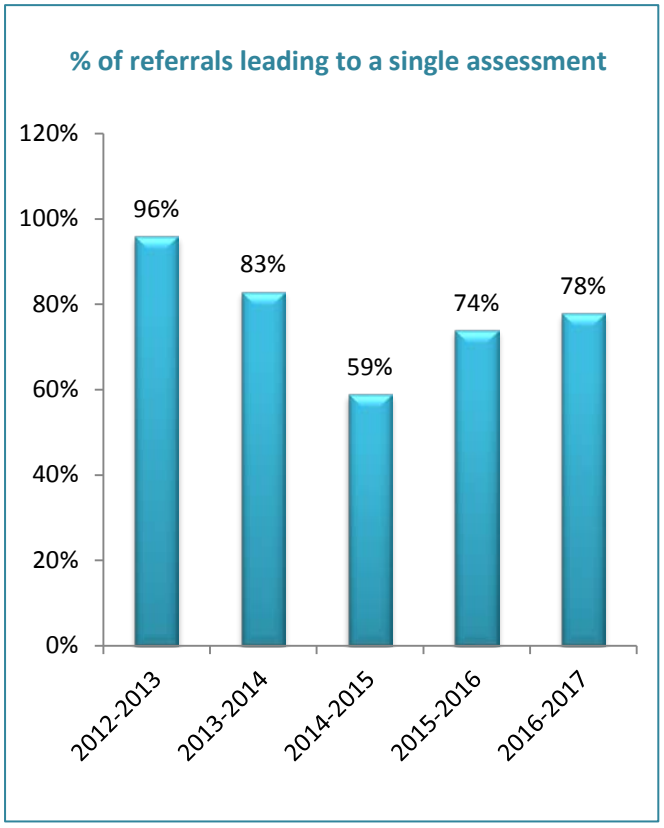
85% of referrals to Early Help access a service or intervention depending on the presenting need. As at March 2017, only 7% of closed CAT cases were referred back to social care within 3 months of closure.

Children's Social Care:

The MASH team provides the entry point to Children's Social Care. Between 1st April 2016 and 31st March 2017 there was 8625 contacts into Children's Social Care of which 3457 led to a referral. 2697 (78%) progressed to a single assessment

There was on average 288 referrals a month, with this figure remaining quite steady during the middle and latter parts of the financial year. There was a peak in referrals in quarter 1 of 2016 with 304, 338 and 325 referrals respectively. The volume of referral resulted in a rate per 10,000 of 844.8 for Reading with our Statistical Neighbours figure being 528.6 and National figure being 532.2 for 2015/16.





35% of referrals originated from the Police (1208 during 2016-2017) with Education being the second highest referrer at 16% (561 during 2016-2017), closely followed by Health Services with 14% (485 during 2016-2017).

Domestic Violence has remained the highest reason for referral with 25.86%, Physical Abuse being the second highest reason with 15.4%, which has increased slightly from 2015-2016. Referrals concerning Neglect (8.3%) have dropped slightly from the 2015-2016 data reported.

The number of strategy discussions held within the period April 2016 to March 2017 was 1374, during this period 1066 section 47 enquiries (undertaken where there is reasonable cause to suspect that a child is suffering, or likely to suffer, significant harm) were initiated. In the same period in 2015/2016 973 Section 47 enquiries were initiated.

The number of Initial Child Protection Case Conferences increased further in 2016-2017 with 472 children and young people considered.

The total number of child protection plans and breakdown of category as of 31st March 2017 are:

Category	Total
Emotional Abuse	148
Neglect	184
Physical Abuse	7
Sexual Abuse	13
Total	352

As at 31st March 2017, there were 1232 children categorised as In Need (rate per 10,000 child population is 513; Statistical Neighbours is 392.7 for 2015/2016). At the end of March 2016 68% of Reading children had CIN plans and 59% received CIN visits on time.

At 31st March 2017, there were 265 children and young people Looked After, an increase of 45 compared to the same point in 2016. This number represents 60 children per 10,000 population, identical to the National Average but lower than our Statistical Neighbour average rate of 65 per 10,000. 62 of Readings Looked After Children have Statements or Education, Health and Care Plans

The shortage of local placements in the Reading Borough Council area means that 32% 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, we are working to reduce this figure to retain further stability in education provision, receive local health services and remain in contact with their family and community when safe to do so. It should be noted that placement stability for these young people remains high.

Since April 2016 there have been 15 adoptions and 7 children became subject of special guardianship orders.

At the end of March 2017 there were 137 young people open to Leaving Care Services. 86% had a Pathway Plan which sees an increase of 6% in from March 2016. 94% were in suitable accommodation which is higher than the National Average at 82% and our Statistical Neighbour average at 81%.

44% were not in suitable employment, education or training which is slightly higher than the National Average of 40% but lower that our Statistical Neighbour average of 51%. All care leavers had a Personal Advisor and 86% of care pathway plans were up to date.

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 sub-group 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. The LSCB Ofsted Improvement Plan was written to ensure actions were identified and tracked and these actions were also captured within the Business Plan for 2016/2017.

As at June 2017, of the 15 specific actions identified, 11 were recorded as complete. Two recorded as red relate to actions which could not be progressed until the Children's Single Point of Access was established and embedded. Two were recorded as amber, one refers to the need for adequate budget to ensure flexible Reading focussed LSCB training is provided. The remaining amber action relates to the requirement for consistent Children's Social Care attendance at LSCB Sub Group Meetings. Changes in staff meant securing attendance had to be re-addressed and as at June 2017 we could not evidence improvement.

It is recognised that further work is required to ensure consistency in the work of the Board, for example with regards to the learning and dissemination of learning from audits and case reviews. The QA&P Sub Group recognise this needs to improve, however a period without a permanent Chair for this group delayed progress in this area.

There remains a key issue for the LSCB in the assertion by Ofsted that 'partner agencies remain uncertain about referral thresholds, and that statutory social work with many children at risk is still not effective in reducing serious concerns about their safety and well-being.' The LSCB has a critical role in supporting and challenging improvements in Children's Services going forward.

Ongoing Challenge:

- The understanding and application of Thresholds continue to be raised as a concern. This issue needs to be understood and LSCB partners work together to resolve the problem.
- RBC have agreed that the Children's Services Quality and Improvement Lead will chair the Quality Assurance sub group to enable this key function of the Board to be effective, provide clear learning and impact positively on practice. This will start from September 2017.
- A re-fresh of the Ofsted Improvement Plan is required to move past the establishment of processes into a phase of robust challenge, where impact and partnership support can be evidenced.

Actions:

- An audit of the Children's Single Point of Access has been identified for September 2017.
- LSCB Ofsted Action Plan will be reviewed with the incoming LSCB Chair alongside the Children's Learning and Improvement Plan.

Priority 1: Children's Emotional Health and Wellbeing

A survey completed by 2,343 young people in Reading in 2015 stated that mental health issues are the 'biggest risk to stopping young people achieving the life they want'. This is within a context of growing concerns about the increasing number of children and young people presenting with emotional health and wellbeing issues, both locally and nationally. The 'Future in Mind' Government paper recommended the establishment of a local Transformation Plan in each area to deliver a local offer in line with the national ambition. The West of Berkshire Future in Mind Group includes key members of Reading LSCB and was the key delivery vehicle for priority 1.

Future in Mind

Future in Mind challenges all partners to focus on improving a number of key areas:

- How quickly and easily service can be accessed when they are needed
- The quality of services
- Better coordination between services and
- Providing services to meet needs regardless of the background of the children/ young person.

What has been delivered:

Offer in Schools

- Reading set up a Schools Link project in 2016/17 that aims to build the knowledge and skills of teachers and associated school staff in identifying and responding to early mental health concerns. As at March 2017 9 participating schools (8 primary, 1 secondary) were trained in the regional PPEPCare approach. Psychological Perspectives in Education and Primary Care (PPEPCare) helps staff in primary care and education to recognise and understand mental health difficulties in children and young people and offer appropriate support and guidance to children, young people and their families using psycho-education and relevant psychological techniques. (By the end of the academic year all secondary schools had received training). In addition there has been a push to provide information into schools.
- Mental Health has been identified as one of the 4 key issues that School Nurses need to spend more time working on. The recommissioned School Nurses service (from Oct 2017 onwards) will enable School Nurses to provide more PHSE (Personal, Health, Social and Economic) sessions with pupils, consult with colleagues in Schools about emerging Mental Health cases, to provide direct work interventions as a Nurse that meets low level mental health needs or escalate/ signpost where necessary.

Offer in tier 2 (prevention and early identification).

- Reading continues to offer a good Primary Mental Health Worker (PMHW) and Education Psychology (EP) service. Reading young people have access to counselling services in the town and the majority of secondary schools offer on-site access to trained counsellors.

- Co-working with the University of Reading, the Local Authority has provided 4 Webster Stratton parenting programmes for parents of 3 – 11 year olds. This has been added to the Triple P parenting offer already in place and the University is researching the impact of this project on children with emerging challenging behaviour.

Offer in tier 3 (Specialist CAMHs offer from BHFT)

- There has been a reduction in waiting times with more children and young people receiving timely, evidence based treatment across all care pathways.
- The Common Point of Entry (CPE) is now open 8am until 8pm Monday to Friday which has positively impacted on waiting times for referrals which are 4 weeks (currently the national average waiting time for a first CAMHs appointment is 9 weeks.)
- The CCGs have commissioned additional short term capacity for the Anxiety and Depression pathway to reduce the number of children waiting for treatment, following receipt of short term funding from NHS England. This low intensity psychological therapy intervention pilot is being delivered on a stepped care basis mirroring adult IAPT services.
- Waiting times on the autism assessment pathway have reduced but remain the most challenging to improve. Currently lower than the national average but longer than we would like locally. Additional funding has been made available to expedite reduction in autism assessment waiting times for children under the age of 5 years by running additional weekend clinics. A multiagency working group has started to map current care pathways in each local area, identify what a good service looks like, identifying gaps and possible areas that need to improve practice.
- The CAMHs Urgent Response Pilot, integrated with Royal Berkshire Hospital, has a full rota in place, providing timely mental health assessments and care. Short term intensive interventions in the community are provided to young people who have experienced a mental health crisis. The service also provides wrap around support when there are delays in sourcing a Tier 4 CAMHS inpatient bed.
- Closer links between partners will enable swifter assessment and discharge of young people requiring social care support and interventions.

Offer in Tier 4

- Berkshire Adolescent Unit is now a 7 day, 24 hour a day service that is now a registered tier 4 provision in Berkshire. The number of beds has also now increased from 7 to 9.

What has been the impact:

Offer in Schools – Following whole school training, the pre and post feedback evaluations have been very positive with significant gains in knowledge and skills reported.
Offer in tier 3 (Specialist CAMHs offer from BHFT):

- The reduction in waiting times enables more children and young people to receive a timely evidence based treatment across all care pathways.
- The current average waiting time for referrals to CPE is 4 weeks, compared to the national average waiting time for a first CAMHs appointment of 9 weeks. More children are being assessed more quickly.
- The CAMHs Urgent Response Pilot has meant the response time to assessment has reduced and length of stay in both A&E and the paediatric wards has reduced with improved facilitation of admission to Tier 4 units.

Learning from audits – THRIVE Audit (February 2017)

West Berkshire, Reading and Wokingham LSCBs agreed with leaders within Berkshire Healthcare Foundation Trust (BHFT) and Berkshire West Clinical Commissioning (CCG) Future in Mind group, to undertake an audit of children and young people with significant emotional health needs, requiring the support of other statutory partner agencies.

The purpose of the audit was to:

1) explore how well we identify emotional wellbeing and mental health difficulties, as individual services and collectively across multiple-agencies
2) evaluate how effectively partner agencies identified need and risk
3) assess the impact and effectiveness of single and multi-agency planning and impact on outcomes for children
4) test the applicability of the THRIVE model in supporting enhanced inter-agency early identification and intervention, assessment and planning; to improve outcomes for children

Learning:

- There were examples of significant inter-agency discussion of need and risk; and evidence of joint contribution to assessment activity across the partnership, to triangulate analysis of need and risk. Where this did not happen, there were significant delays in assessment with potential negative impact on the child.
- There was clear evidence of the impact of parents' wishes influencing and in some cases, overshadowing the voice of the child. The audit group all agreed that in these cases, the parents dominance of risk planning diverted attention from what was in the best interest of the child.
- The THRIVE model could have particular benefit in early help and targeted prevention services, with specific reference to:
    - Improving a shared understanding of levels of emotional health need
    - Improving shared language in the description of emotional health need
    - Improving the effectiveness of identification and planning.

The theme of the 2017 Joint Annual Conference is Mental Health. The first LSCB Forum focussed on Disguised Compliance, including understanding the issue (with Serious Case Review examples) and how to work with the issue. The presentation from the session is available on the LSCB website: www.readinglscb.org.uk/readinglscb-training/

Ongoing Challenge:

- How to improve the collaboration and collective action to prevent the escalation of a small cohort of young people that are often accessing RBH on the back of a mental health episode
- Ensure that more School Nursing time can be protected to deliver more PHSE, consultation and direct delivery in schools around Mental Health.
- The number of referrals into CAMHs Year to date have increased by 4.5% since the 2014/15 baseline. The service is also seeing an increase in complexity of cases.

Actions

The LSCB have agreed that Children's Emotional Health and Wellbeing will no longer be a key priority for the Board, although remains a vital area of work. All actions will continue to be monitored and delivered through the Berkshire West Future in Mind group and reported into the Health and Wellbeing Board. Any issues regarding safeguarding concerns will be fed into and discussed by the LSCB as required.

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.

Young Carers

The Reading LSCB Business Plan identified that Young Carers should be identified quickly and offered support.

To enable partners to identify young carers, understand their needs and its impact on their long term wellbeing, in January 2017 the LSCB produced and disseminated a clear fact sheet. Partners have also received information on the changes in legislation. The fact sheet is available on the Reading LSCB website: www.readinglscb.org.uk/lscb-fact-sheets/

The Young Carers legislative guidance is also now detailed on the pan Berkshire online procedures.

The Youth Service has reported that professionals from a range of backgrounds are completing the tool and more whole family assessments are taking place. Over the year, the number of known young carers increased from 589 in quarter 1 to 661 in quarter 4.

Evaluation of Thresholds

Over the summer 2016 the Thresholds were reviewed in LSCB sub-group meetings including Neglect and Child Sexual Exploitation. Meetings took place with Domestic Abuse and Housing colleagues, plus key Children's services staff with responsibility for the MASH and Early Help front doors. The risk factors were specifically reviewed for priority issues of Female Genital Mutilation, Child Sexual Exploitation, Prevent and Neglect. Partners who were not represented at sub-groups were individually emailed asking for input/ comments.

As a result, updated documentation was presented and agreed by the Board in September 2016. The updated Thresholds poster and Guidance booklet (which includes the threshold risk factors, as well as the protective factors that can sit alongside them) was disseminated and can be found on the LSCB website: www.readinglscb.org.uk/information-professionals/threshold-criteria/.

Following the Thresholds review, two audits were carried out to review effectiveness:

Learning from audits – Multi-Agency Effectiveness of MASH and Early Help Pathways (June 2016)

The purpose of the audit was to explore the effectiveness of the MASH and Early Help Pathways. In particular the effectiveness of the initial point of contact into children's services, the impact of thresholds and the effectiveness of the response to previous referrals.

What we learnt:

- Approximately half of the contacts into MASH were deemed not to require a Children's Social Care assessment and whilst some of those were information requests, it poses the question of whether individuals really understand the threshold document.

- Of those contacts deemed to be inappropriate by the auditors the majority were from the Police and schools.
- The vast majority of referrals had sufficient information in the initial contact for a decision to be made.
- For all cases looked at, the decision made by the MASH Manager in relation to the threshold decision was correct and there were no cases in which it was felt the decision by MASH was inappropriate.
- The number of referrals sent to Early Help from MASH appears low; however there were valid reasons for this relating to the 24hr deadline in MASH and the need for gaining consent which parents are not always willing to give over the phone.

Learning from audits – Inappropriate referrals to MASH (October 2016)

The purpose of the audit was to evidence the concerns in regards to the number of contacts being made into the MASH Service with the expectation that they meet "level 3 or 4" of the Reading Threshold Guidance. However, a significant number of these do not proceed to the referral stage and passed to Access and Assessment; instead they are stepped down to Early Help Services.

What we learnt:
In October 2016, contacts and referrals into MASH were reviewed with the following findings.

- 210 contacts were received by MASH from the Police, 65 contacts were received from Health Services, Schools/Education Services made a total of 137 contacts.
- Of these 412, 257 (62%) were signposted to Universal Services, Early Help or Information Request.
- Of the 257, 158 were signposted following MASH screening;
- Over 60% of contacts received into the MASH Service from the Police, Health Services and Schools/Education do not meet level 3 or 4 of the Reading Threshold Guidance.

Key recommendations from both audits:

- Introduce a single front door for both safeguarding and early help services, so that universal services or members of the public do not need to make the decision whether the concern is for MASH or Early Help.
- Professionals working with children in the community need to be skilled and have a sound understanding of the entry into the MASH Service as well as Universal Services and Early Help.
- Review the messages being given in safeguarding training
- Ensure professionals within the front door have the right skills to support colleagues making referrals.

What has been done:

The recommendations from the audit were taken into consideration and on 30th June 2017 Reading Children's Services moved to the Single Point of Access. This is the front door service for reporting any new concerns in relation to child protection or requests for additional support needs. All Universal Safeguarding Training and other Safeguarding courses as relevant have been updated in line with the new process.

The Thresholds documentation was updated in June 2017 to reflect the process for the Children's Single Point of Access. Communication with partners focussed on the new process and how thresholds can support colleagues with decision making and expected outcomes when making a referral.

Ongoing Challenge:

- Ofsted continues to raise the correct application of thresholds across the partnership as an area of weakness. Partners report that this is not an issue with neighbouring authorities however the LSCB must work alongside the Children's Single Point of Access to understand why this issue has not yet been resolved. (See also 'Our Performance, Ofsted Inspection May/June 2016, page 13).

Actions:

- Phase 2 of the Children's Single Point of Access was implemented in June 2017. Improvements will continue to be made as Phase 2 is progressed.

Private Fostering

Private fostering numbers continue to remain low (3 as at March 2017). In June 2016 a webpage on the Reading LSCB website was created and a Private Fostering factsheet produced and disseminated to all partners with the Reading Borough Council leaflet.

Safeguarding courses trainers have been informed to emphasise private fostering and the leaflet is sent as post course material for all delegates who attend.

In February 2017 the Service Manager with responsibility for fostering wrote to all GPs and schools via the Looked After Children (LAC) Nurse and Virtual Head, to remind them of the regulatory requirements around private fostering. The link to the LSCB website was provided and the RBC guide for professionals included.

In September 2017 the LSCB will receive further reports in relation to Private Fostering to discuss this issue further and to seek guarantees from partners that they have disseminated the information.

Ongoing Challenge:

- Private Fostering numbers remain low. We need to better identify these vulnerable young people and ensure front line staff understand what constitutes a private fostering arrangement, and what to do if they suspect an arrangement is in place.

Action:

- The LSCB to discuss the Private Fostering annual report when received in September 2017 and agree how to better identify these vulnerable children.
- This is recorded as an action in the Children's Learning and Improvement Plan to progress joint working with partners.

Priority 3: Child Sexual Exploitation (CSE)

The sexual exploitation of children is sexual abuse. Reading LSCB seeks to ensure that all children and young people who are vulnerable to exploitation are identified and protected through the co-ordination and provision of effective multi-agency service provision.

Multi-agency approach to CSE

This year the focus has been to improve:

- The comprehensive SEMRAC data dashboard to provide a profile of CSE in Reading and enable us to more effectively target interventions
- Use of CSE Risk Indicator (screening) Tool
- Support and recovery pathway for all victims of CSE
- Structure and process in place for responding appropriately to all CSE cases

What has been delivered:

- The LSCB has continued to fund the Chelsea's Choice drama production in Reading secondary schools, delivered to all 9 secondary schools in March 2017. The production is aimed at Year 8 pupils and was shown to the entire year group in each school. Reading's pupil referral unit, due to the low number of pupils and the vulnerability of these pupils showed the production to the whole school.
- Implementation of SEMRAC (Sexual Exploitation & Missing Risk Assessment Conference) triage, escalation policy and audit process
- The CSE Champions group meet bi-monthly. This group includes members from across partner agencies and voluntary sector and enables key staff to be kept update with the latest information and best practice.
- Development of CSE Strategy action plan for 2016/2017
- The Pan Berkshire CSE Risk Indicator Tool was reviewed, updated, implemented and included on the online pan Berkshire Procedures
- Expansion of the training pathway to include offer to night-time and other economies, including taxi drivers, bus drivers, internet cafes and hotels.

What is the evidence:

- Minutes of SEMRAC meetings evidence attendance, referral numbers and actions/safety planning for children
- The SEMRAC data dashboard is reported to CSE & missing strategic group and the Children's Services Improvement Board
- There has been a consistent number of referrals to SEMRAC as knowledge of indicators and process improves
- Training figures and the offer from all partner agencies are reported to the CSE & Missing strategic group. In 2016-2017 we ran 6 courses and a total of 112 delegates attending.

What has been the impact:

- SEMRAC is running more efficiently enabling professionals to better identify and protect children
- Data produced for SEMRAC is helping with understanding risk and reduction
- Improved quality and quantity of CSE Risk Indicator Tools being completed. We now have 91% of cases presented at SEMRAC with a completed risk indicator tool.

Learning from audits - Missing Children, Return Interview Quality Audit (August 2016)

The purpose of the audit was to assess the quality of the interviews being carried out. The audit was looking for key areas that the interviewer would be asking the young person in order to gather information which can help to assess ongoing risk.

What we learnt:

- A new interview form was needed that asks more direct questions in order to obtain basic information more consistently. Training to support interviewers in the use of the new form was required to ensure consistency.
- Without gaining a holistic assessment of the current situation for each missing episode from a variety of sources, the analysis of risk and need may be insufficient.
- The national guidance states that the interview should be conducted within 72 hours of being returned home. This is not the case for 77% of interviews audited.
- Escalation procedure is required to ensure that workers are aware of the process that will take place if the standard of expectations is not met without reason.

What have we done:

A new interview form and training on how to use this was implemented in September 2016. A new standard of expectations has been written and delivered and since this the timeliness of interviews has improved. Since the audit was completed the timeliness of completion of interviews within 72 hours has increased to 70%. An escalation policy has been written should the standards of service not be met. The Missing Coordinator has met with Long Term Team Managers to discuss how recommendations from interviews can form part of assessment and planning.

Ongoing Challenge:

Child Sexual Exploitation

- Requirement of a robust problem profile for Reading to enable us to better understand the local issues and development of disruption dataset
- Ongoing analysis of data through newly revised dashboard
- Development of direct work resources and good practice guidance for children's social care staff and targeted youth workers for use with all children identified with vulnerabilities and/or identified as level one risk at SEMRAC
- Improve uptake from schools in CSE training and preventative education programme
- Increase intelligence reports submitted to TVP to identify and disrupt perpetrators

Local CSE and Missing Group:
Following business planning discussions the LSCB has revised the priority for 2017/18 to encompass wider issues of exploitation. There is a challenge around whether the existing group can accommodate this wider remit, and whether the membership is still appropriate. Chairing of this group will pass to Thames Valley Police, who will progress this discussion.

Action:

- Develop a Reading problem profile
- Develop a CSE hub within the Children's Single Point of Access, alongside a review of the CSE pathways

Priority 4: Neglect

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.

It was recognised by the Board 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, following a partnership workshop that took place in March 2016.

What has been delivered:
The Neglect strategy was written and agreed by the Board in July 2016. The strategy and action plan have been reviewed at each task and finish group meeting with actions assigned to group members

The focus during the year has been work to raise awareness of neglect. This has included:

- The Thresholds document has been specifically reviewed to ensure neglect signs and symptoms are clear. These updates were part of the revised documentation for 2016/17 and in line with the recommendation made by Ofsted as part of their inspection.
- Consistent chronology guidance has been written and reviewed by members of the task and finish group. The document is available on the LSCB website, and will be used as part of the neglect audit learning events to further raise awareness.
- Neglect leaflet has been updated and available on the website. Partners from the task and finish group have disseminated to their organisations.
- A specific Neglect webpage for professionals was developed on the LSCB website in May 2016.
- A Neglect briefing session has been delivered to designated safeguarding leads in Schools, which highlighted the resources on the LSCB website.
- Neglect is included in all universal safeguarding training.
- The sub group has supported preparation for the roll out of the Graded Care Profile 2. This is an assessment tool that helps professionals measure the quality of care being given to a child and helps them to spot anything that's putting that child at risk of harm. A Graded Care Profile plan is written and this action will continue into the 2017/18 year. This has been captured within the 2017/18 LSCB Business Plan.

Ongoing Challenge:

- 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.
- Implementation of the Graded care Profile in Reading to support key practitioners to identify and work with families where neglect is an issue.
- Enabling staff across the partnership to hold anxiety and feel confident enough to have difficult conversations with families.

Actions:

- Share learning from the joint neglect audit with West Berkshire and Wokingham (reporting in September 2017) to staff across the partnership.
- Learning from the audit to specifically reference the LSCB chronology guidance.
- Review membership of the Neglect Task and Finish Group to ensure representation from Workforce Development.

Learning from audits – Ofsted Recommendation 8 (an audit of all cases where neglect or domestic abuse was a key factor - quarter 3 2016)

The Ofsted inspection of Reading Borough Council's Children's Services published in August 2016 recommended that 'Reading review all cases where children are exposed to domestic abuse and neglect, to ensure that their needs have been thoroughly assessed and that they are safeguarded, where appropriate'.

In response between September and December 2016, RBC commissioned independent consultants to audit 718 cases, ranging from cases in assessment through to those on a child protection plan. The executive summary of the findings stated that there was some good practice, often where social work staff had been consistent and were known to the families. However, there were a range of significant concerns raised about the quality and consistency of social work practice, frequent changes in social workers and team managers, as well as the absence on social work files of challenge and contribution from other agencies.

The LSCB Quality Assurance and Performance Group received these reports in February and April 2017 and raised a number of challenges with RBC. The Director of Children's Services acknowledged the concerns raised and provided assurance that all recommendations have been included within the Children's Learning and Improvement Plan, and that all cases where immediate concerns were raised were swiftly acted upon. In addition, the Chair of the Children's Services Improvement Board has attended an LSCB Board meeting to provide assurances to the LSCB that the Improvement Plan is being robustly monitored and challenged.

Ongoing challenge as identified in the audit recommendations:

- All partners must continue to work together to improve front line practice across the workforce. It is vital that the focus remains on ensuring positive impact on children's lives, rather than the process of improvement itself.
- Partners must support, and challenge, social work practice to enable improved outcomes for children. Partners must actively participate in, report to and attend core groups and child protection conferences.
- Staff at all levels, from Board members to front line practitioners must keep lines of communication between agencies open. Colleagues must have the courage to initiate, and be willing to accept, honest and challenging conversations.

Actions:

- RBC to develop, with LSCB partners, local protocols for assessment to improve the quality and timeliness of Early Help Assessments, statutory Social Work Single Assessments and Education, Health & Care Assessments (from pre-birth to 18 years/25 years for young people with SEND). This activity will ensure that all assessments address referral issues and concerns and include a comprehensive analysis of the child's needs, risks and circumstances, set out the desired outcomes to be achieved and routinely take full account of the: Child's individual characteristics; Family background and relationships; Chronology of significant events; Child's views, wishes and feelings and their day to day lived experience; parenting skills and capacity to change, including consideration of any additional needs; Multi-agency checks and assessment.
- RBC Children's Learning and Improvement Plan includes a range of actions to improve practice and outcomes for children, with the support and challenge from partners.

Priority 5: Improving Cultural Confidence and Competence in our Workforce to meet Children's Needs

Reading is hugely diverse made up of many cultures and ethnicities, it is the second most ethnically diverse in the South East outside London. 49.4% of school population belongs to an ethnic group other than White British.

Female Genital Mutilation (FGM)

The population profile of Reading indicates that female genital mutilation could be an issue for certain groups of girls in the town. The LSCB recognised that a co-ordinated strategic direction was required to progress local developments to ensure girls who might be at risk are identified and protected. A west of Berkshire LSCBs task and finish group was established and a strategy and action plan was developed.

Key areas of progress:

- **Understanding local prevalence –** initially the LSCB had very little information to confirm if female genital mutilation was an issue and if the hospital and Children's Services at Reading Borough Council were responding appropriately to concerns. An audit by Public Health (detailed below) confirmed our understanding and directly influenced the production of local guidance.
- **Guidance –** There was a need to create shared pathways for all staff to be able to follow, plus a risk assessment toolkit to allow staff to make informed safeguarding decisions. This detailed guidance document and associated risk assessment toolkit was completed in June 2016 and launched at an event to 70 managers and practitioners from across the west of Berkshire. Feedback from the event was overwhelmingly positive with all feedback sheets recording the session as 'good' or 'excellent'. This documentation is available on the Reading LSCB website on a new page set up specifically to provide information on this subject. All local FGM training links to this web page: http://www.readinglscb.org.uk/information-professionals/fgm/
- **Policies and procedures -** The Berkshire online policies and procedures were updated to reflect our guidance and new legislation. In addition, it was important that the information sharing framework allowed staff to confidently share concerns and information. The revised Information Sharing Agreement has been signed off by all six LSCBs and will be uploaded to the online procedures in July 2017.
- **Training -** The LSCB training Programme continues to offer half day training sessions on FGM. This has been supplemented with the information from the launch event, access to the Home office online training and most recently we have developed an online package to support practitioners when completing the risk assessment toolkit. In addition we have spoken, and continue to speak regularly on this topic with School Designated Safeguarding Leads.
- **Numbers of referrals -** This continues to be a highly hidden form of abuse, but we are confident that the training and resources are now available and accessible to front line practitioners. This is evidenced in the increased numbers of referrals where FGM has been ticked on the contact. By calendar year, in 2015 in Reading the number was 18 referrals, which increased to 114 in 2016.

Learning from audits - Multi-Agency Female Genital Mutilation Audit (June 2016)

The purpose of the audit was to assess the Royal Berkshire Hospital Safeguarding Service's and Reading Social Care Services teams' adherence to the 2015 LSCB Guidelines on female genital mutilation. To assess the need for additional training, support for staff regarding FGM to ensure the guidelines are being met.

What we learnt:

- The nationality of the women concerned, and the types of female genital mutilation they have been subjected to, are in line with national statistics.

- All cases identified were appropriately referred to the hospital safeguarding team for scrutiny and referrals to Children's Social Care for assessment were made when appropriate.
- All cases of female genital mutilation were self-reported cases apart from one.
- None of the cases involved women who were born in the UK.
- Based on the estimated figures the 24 Reading cases are about half of what would be expected.
- Procedures are being followed.

What have we done:
The findings from this audit informed the Female Genital Mutilation Action Plan and the formulation of the West of Berkshire FGM Pathways and Risk Assessment Toolkit launched in July 2016, this can be found on the LSCB Website: www.readinglscb.org.uk/information-professionals/fgm/ where you can also find an FGM Factsheet. New local online training in relation to female genital mutilation was commissioned and details on how to access this can also be found on the above web page.

Actions:
- The challenge will be to maintain the momentum achieved by the launch in 2016, but we will continue to raise this issue at the School Designated Safeguarding Leads meetings, and will send round emails to school and other LSCB colleagues before main holiday periods.
- The main area of outstanding work is the establishment of the Rose Project that would include a FGM clinic within it. A business plan has been created by the CCG that identifies the full scope and funding requirements for a centre of excellence Rose Project. A working group between statutory partners and ACRE, will meet again in 2017/2018 to continue to review progress together.
- With the majority of work completed on the action plan the LSCB agreed in May 2017 to close the FGM task and finish group. Annual updates for the LSCB will be provided through the governance of the Rose Clinic when established, but if this is not set up then for the 3 LSCBs to meet in January 2018 to review the:
    - use and impact of the training
    - numbers of both adults and children being flagged up for concern due to FGM
    - ensure guidance in the tool kit and training is up to date and agree changes from partners' recommendations.

Prevent

Reading LSCB agreed that we needed to support schools to understand their responsibilities towards the assessment and prevention of radicalisation.

As a result we have:
- Delivered a detailed session to School Designated Safeguarding Leads in July 2016 including tools and risk assessment forms. This session provided clarity on the statutory responsibilities on schools from government Prevent guidance and Keeping Children Safe in Education 2015.
- Created a 'Prevent' page on the LSCB website populated with information from the presentation to Designated Safeguarding Leads.
- Produced a 'Prevent' factsheet which has been disseminated to the Board and through the Designated Safeguarding Leads network.

The School safeguarding audits 2016 reflect that staff have been trained in Prevent and schools are confident in their responsibilities.

A report from the Channel Panel will be presented to the Reading LSCB in September 2017.

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.

Issues:

- The forward work programme and expectations on group members were not always clear.
- The relationship with the procedure provider had not been consistent, leading to difficulties in maintaining a cumbersome set of procedures and the sub group feeling disempowered.

Summary of activity/achievements:

- The new online format for practitioners across Berkshire with a set of agreed core policies and procedures has been received positively.
- A sub group that is structured and contributes effectively to the ongoing plan to maintain and update the policies and procedures for child protection.
- Safeguarding and child protection policies and procedures remain in line with key national policy and legislative changes.
- A consistent relationship with the provider has enabled a more robust process for agreeing recommended changes and understanding of responsibilities.
- A Policy and Procedures Newsletter has been created for circulation following each procedure update, for onward dissemination to staff via all six LSCB Boards.

Specific updates agreed within the 2016/2017 year include:

- Information Sharing Agreement - All six LSCBs signed off a revised Information Sharing Agreement. This will provide a clear framework for information sharing between agencies across Berkshire.
- Escalation Policy – A recent serious case review within Berkshire led to the creation of the pan Berkshire Escalation Policy.

- Wording changes with key chapters such as female genital mutilation, domestic abuse, child protection enquiries and management of allegations.

Ongoing Challenge:

- Ensuring sub group members are able to give the time and resource to review changes to policies and procedures prior to the meetings.
- Although there has been an escalation policy in place in Reading since May 2016 it has not been used.

Action:

- Pan Berkshire Escalation Policy will be recirculated to all Board members.

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 commenced from May 2015.

Summary of activity/achievements:

- There is a strong core membership of experienced individuals who have been in the group for some time so this provides consistency. Other organisations continue to support and continuity of attendance has been good. We have had an additional lay member join with a voluntary sector background. This provides additional experience and challenge.
- The panel have questioned how robust the process is in seeking further evidence and assurances about the information being provided. As a result it has been agreed to test out some of the links embedded in submissions in our preparation and to seek further evidence if it is not sufficient.
- The feedback from presenters from the organisations has been generally positive and the panel members feel that the format and audit tool is robust.
- In an effort to strengthen the tool further, we have revised the guidance notes on the tool to be more explicit and have asked organisations to list at the beginning who has conducted the audit and for LAs we have asked them to indicate which directorates were involved.

The activity and output of the panel is set out below.

At six S11 panel meetings between March 2016 and March 2017 the audits from the following organisations have been reviewed:

South Central Ambulance Service	Calcot Services for Children Residential Provision
British Transport Police	SWAAY – Residential provision
Berkshire Healthcare Foundation Trust	West Berkshire Council
Royal Berkshire Hospital Foundation Trust	Bracknell Forest Council
Berkshire West Clinical Commissioning Groups	Royal Borough of Windsor and Maidenhead Council
Berkshire East Clinical Commissioning Groups	Reading Borough Council
Care UK-Sexual Health Referral Centre	Wokingham Borough Council
Frimley Health Foundation Trust	

Themes:

- The general quality of audit returns has been good and the model of supplementing the written submission with a verbal presentation works well and allows more in depth questioning.
- There is a challenge for large organisations to ensure the audit is completed by all departments and directorates and then collated in advance of being presented to the panel. The strongest submissions have been able to evidence how the audit was completed and which departments contributed. The most comprehensive audit was provided by Reading Borough Council who presented a very honest assessment and the presentation included data about compliance which was a helpful addition.
- In all local authority (LA) submissions, safer recruitment seems to be well embedded with employees but the knowledge about the safer recruitment and training of volunteers within LAs was less assured. This theme will be revisited in the review cycle.
- Some very good practice was noted in relation to evidence of the child's voice being central to processes.
- As this Panel only considers Berkshire wide organisations, we would like some assurance that S11 audits are being done locally and that LSCBs have a process in place for monitoring this.

Ongoing Challenge/Actions:

- Maintaining robust challenge. The panel has received a challenge in relation to one organisation's S11 audit which the panel judged to be good but was later judged not to be compliant in another process. In order to strengthen the scrutiny of the S11 process, the panel will be requesting evidence of compliance in each area of safeguarding and sample checking the evidence provided.
- To start the mid-term review cycle in September 2017.
- To seek and collate more detailed feedback from agencies on their experience when they submit S 11 audits to the panel.

Local Approach

Reading LSCB is responsible for the undertaking S11 returns for local organisations not included in the S11 Panel above. In 2016 all academies and maintained schools were asked to complete an annual safeguarding audit and by July 2017 90% of returns had been received. These have all been monitored by the Virtual Head for Children Missing out on Education and feedback has been given to each school on their audit. Themes were raised via the Designated Safeguarding Leads meeting and findings were considered at the Quality Assurance and Performance sub group in June 2017. In 2017 the audit will be strengthened by ensuring the questions ask 'how do you implement…' rather than 'the schools has a policy for…'

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

Ongoing Challenge/Actions:

- Improve the questions within the school safeguarding audit to provide greater evidence of compliance.

Action:

- Compliance with safeguarding training requirements for school staff to be queried with all schools where this was not clear.

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.

CDOP activity:

The group has met regularly throughout the year with good partnership representation. There were 46 deaths within 2016/17, which reflects a downward trend since April 2011. In 2016/17 CDOP has reviewed 53 cases, including some deaths notified in the previous year but not reviewed until this year. Nationally 76% of cases are reviewed within 12 months; however, locally we have achieved closure on 92% of cases within 12 months.

In 2016-17 68.8% of actual deaths in year were in children under 1 year which is broadly consistent with the national figure (66%).

Neonatal deaths - In response to the high proportion of neonatal deaths among the overall numbers of child deaths reviewed, the Berkshire CDOP established a specialist panel to better enable the CDOP to consolidate the possible learning. Most deaths are due to congenital anomalies and/or perinatal medical problems, particularly complications of prematurity and low birth weight. The findings were fed back to the CDOP panel with the focus on themes and trends rather than individual cases and were well received.

Modifiable factors - defined as ‘those, where, if actions could be taken through national or local interventions, the risk of future child deaths could be reduced’. Nationally the proportion of deaths which were assessed as having modifiable factors has remained unchanged at 27% in the most recent year. Locally in 2016/17 of the cases reviewed there were 7 cases that had modifiable factors (11%).

The modifiable factors included co-sleeping with an infant, alcohol consumption, consanguinity, untreated UTI in mother before delivery and missed opportunity.

Unexpected death - defined as 'the death of an infant or child which was not anticipated as a significant possibility.' In 2016/17, 11 cases where there were unexpected deaths were reviewed. All have documented rapid response reviews. During the last six years the number of unexpected deaths continues to show a downward trend. Over 90% of all deaths now occur within the hospital setting.

Learning

Learning from the other deaths reviewed led to procedural changes for health services (particularly hospitals or ambulance services). These were:

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

Other learning included:

- A recommendation that if a general pathologist carries out a post mortem on an adolescent in circumstances of a medical death they should consider seeking the opinion of a paediatric pathologist.
- Complete agreement with Police advice to never use a mobile phone while driving.

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

Priorities for 2017/18

- The 2ND annual multi-agency CDOP training day will take place on Wednesday 07/03/2018 at Easthampstead Park Conference Centre, Wokingham.
- The CDOP will continue to build on our successful work to date in supporting a reduction in mortality from SUDI and accidents.
- We will look to reduce risk factors for preterm and low birth weight deaths and to continue our work with families and communities to reduce risk of congenital / genetic abnormality.

For 2017/2018 we will be carrying out thematic reviews on the following:

- Sepsis management/effectiveness of paediatric early warning and sepsis tools
- Knife crime (because nationally there is a rise)
- Children with life limiting conditions and deteriorating neurological conditions – now the largest group we review other than neonatal
- Better community understanding of Safe Sleeping
- Home educated children, as they can become invisible.

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:

- **Training Needs -** the annual West of Berkshire LSCB training programme has not always been needs led, offering the same courses for a number of years and likely contributing to low attendance on some courses. In November 2016 a Training Needs Analysis (TNA) form was completed by Local Authorities, Health, Probation, Education and Voluntary sector partners with the results influencing the 2017/18 programme. In addition to some new subjects, the 2017/18 programme will include more short courses and workshops, making it more accessible to members of the workforce that may previously not have utilised the programme on offer.
- **Attendance and Evaluation**
  Figures for 2016/17
    - 20 Courses ran – two were cancelled early in the year due to low numbers
    - 274 Staff attended
    - 1611 staff completed the Universal safeguarding children online course
    - 437 staff completed the Introduction to CSE e-learning – across West of Berkshire.

  Attendees at face-to-face courses are asked to self assess their understanding before and after training to provide us with some immediate impact. 70% reported significant improvement in their understanding, 27% reported some improvement and 3% reported a very significant improvement.

  The L&D group have agreed a standard Impact Evaluation template. This will be emailed out to all delegates 3 months after attending an LSCB course. Questions on the evaluation form aim to identify the difference that attending the course has made to professional practice, whilst also identifying any organisational barriers to implementing learning. From July 2017 (3 months after the launch of the 2017/2018 programme) these impact evaluations will be imbedded in to the L&D process for all LSCB courses.
- **LSCB Forum -** In January 2017 we ran the first LSCB forum. These 2 hour events will take place quarterly and will be hosted by each LA and Royal Berkshire Hospital. The January event theme was Disguised Compliance, as suggested by Business Managers. The Forum was hosted in Reading and facilitated by Reading LSCB Business Manager and Chair of the L&D sub group. 74 staff attended including a number of GP's, who historically have found it impractical to access the LSCB training programme. Feedback has been extremely positive.
- **Training Audit -** In November 2016, partners completed a Training Audit which provided assurance that adequate and appropriate safeguarding training is provided to staff and volunteers across the partnership.
- **Training Pathway –** In January 2017 the L&D sub group agreed a Training Pathway document. This provides clear guidance on what staff should be completing what level of safeguarding training, and also highlights any refresher requirements. By having this in one document it provides a consistent

message across the West of Berkshire and enables the annual training programme to be pitched at the correct level.

- **Safer Recruitment -** Safer Recruitment training was identified as a gap as a result of Section 11 audits in 2015, particularly for non-school settings. Therefore Reading Borough Council developed an online Safer Recruitment course which was reviewed and signed off by members of the L&D group. This online course was launched in October 2016 and to April 2017 has been completed by 66 staff (RBC, Hospital, RBHFT, CCG, PVI, other Local Authorities). The Reading Local Authority Designated Officer will monitor and progress any Reading focussed issues.
- **Sub Group Induction -** an induction pack has been developed to clarify to new (and existing) members of the group how the L&D fits within the LSCB structure and its role and accountability to the Boards.

Ongoing Challenge:

- Post course evaluation – this process needs to be strengthened to provide assurance to the sub group and Board that courses have improved professional practice and are appropriate for Reading.
- It is apparent that there are still professionals across the workforce that are unaware of the Safeguarding training offer provided by the LSCBs. This is evidenced by the results of the recent Training Needs Assessment and reflected in LSCB course delegate numbers.

Actions:

- In 2017/18 information from the new post course evaluations will be scrutinised at each sub group meeting and reports provided to the Board.
- All Board members are to promote the annual LSCB programme across their agencies. This can be via email distribution and should be included in newsletters, bulletins, reference to courses in meetings and uploading the programme on their websites.

Learning from audits - Multi-Agency Safer Recruitment Audit (May 2016)

Audit Purpose:
In 2015 the Pan-Berkshire Section 11 Panel identified via agency audits that safer recruitment training was not easily accessible and nor was it always clear to agencies what constituted safer recruitment or that it was being consistently being taken up. It was agreed to undertake an audit to measure LSCB agencies awareness of and completion of safer recruitment training to ensure compliance with the s11 requirement.

What we learnt:

- Agencies themselves do not seem to have fully understood the requirement for safer recruitment training as part of the recruitment process for those in regular contact with children.
- LSCB members needed to ensure that managers are identified and signposted to the training and ensure their staffs attend.

What we have done:
The West of Berkshire Learning and Development Sub Group ensured that further Allegations Management and Safer Working Practices courses were commissioned in the 2017/2018 LSCB Training Programme. New online training in relation to Safer Recruitment was identified and details on how to access this training can be found on the Reading LSCB website, along with further information and guidance: www.readinglscb.org.uk/safer-recruitment-safer-working-practices/

Action:

- A re-audit of partners will be undertaken in late 2017/2018 to ensure that the additional training opportunities and awareness raising have improved the understanding of safer recruitment.

Training for the Voluntary and Community Sector (VCS):

Reading LSCB have worked in partnership with Reading Children's and Voluntary Youth Services (RCVYS) to 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 programme started as a trial in 2015, but its success has enabled continued funding for 2016 and 2017.

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.

The following courses/workshops were delivered as part of the programme this year:

Universal Safeguarding Children Training - 6x courses	Safeguarding for Trustees - 1x course
Designated Persons Training - 2x courses	Are they Safe? - 1x course
Disclosure & Barring Service Workshop - 3x courses	Safer Recruitment Training - 2x courses

What has been the impact:

- **Keep children safe by training front line workers in safeguarding awareness -** In total, 168 different people from 77 different Voluntary Sector organisations received safeguarding training to help them improve the way they keep children safe in Reading.
- **Ensure that more Voluntary Sector organisations can refer appropriately into MASH or the Early Help Hub, and to the Local Authority Designated Officer (LADO) -** 139 people from 64 different organisations attended a training course which provided them with the tools and information to refer safeguarding concerns appropriately.
- **Increase Voluntary Sector organisations' ability to manage safeguarding in their organisation. -** Representatives from 85 different organisations attended a training course which helped to increase their ability to manage safeguarding in their organisation.
- **Increase Voluntary Sector organisations' ability to recruit their staff and volunteers more safely -** Representatives from 46 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 -** 12 people representing 11 different organisations attended, and after the course, all of them reported feeling confident about actively promoting good practice in safeguarding children in their organisations.

This year reflected an increase in attendance in all RCVYS safeguarding training, and a number of organisations booking courses in advance in 2017. 2017 will be a period where we move towards endeavouring to make the Safeguarding Training Programme as self-sustainable as possible, with an expectation that LSCB funding may be reduced in the near future. We have also decided to provide more 'fixed date' Universal Safeguarding Children Training courses, to reduce the maximum number of attendees. This will hopefully increase the take up of the training over the year, but make the courses a little more manageable for the trainers.

The collecting of the '6 months on' follow up feedback has remained the most challenging element of this programme, and a careful balance has had to be managed between expending time, effort and costs to gather this information. However the overwhelmingly positive feedback and real examples of impact provides invaluable evidence.

For more information please visit the RCVYS website:www.rcvys.org.uk/services/training/safeguarding.

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 are made to the LSCB Chair when the group agrees that the criteria has been met to undertake a serious case review (SCR) as defined in Working Together (2015).

Summary of activity/achievements:
The group has met regularly, with generally good representation. Membership has been regularly reviewed to try to ensure appropriate representation and commitment from all agencies.

The group has continued to review those cases referred in as potentially requiring either formal serious case review or other form of multiagency consideration. In 2016/2017 six cases were submitted, all from Reading. These included two cases of sexual abuse, two cases where a baby had sustained head injuries, one case which was eventually recorded as sudden infant death syndrome and one case of a sexual assault. Of these cases, one has been referred to the Child Death Overview Panel to include in an audit of similar deaths, to establish local learning, and one case was recommended for a serious case review. The SCR was initiated in December 2016 and is ongoing at the time of writing this report.

As can be expected in this challenging area, several of the cases discussed were complex, with differing professional views either about whether the threshold was met for serious case review, or regarding what type of review would be appropriate. The group took external advice from the LSCB chair and legal team where appropriate.

The process for referring cases in for group discussion has been strengthened to ensure that any case causing concern regarding multi-agency working to a partner agency is able to be discussed by the group, with an emphasis on an open approach to enable cases to be discussed in a supportive manner.

The group has taken an oversight on monitoring action plans from previous reviews to ensure that they have been fully implemented.

The group has undertaken regular review of national SCRs to extract learning and action points to incorporate into local training. Opportunities to link work plans with other subgroups should continue to be developed. Following discussions within this sub group, the Learning and Development Sub Group agreed that the first West of Berkshire LSCBs forum should focus on disguised compliance.

Ongoing Challenge:

- Many of the themes in national SCRs, such as the vulnerability of infants, poor mental health in teenagers, impact of neglect and drift in multiagency management of child protection cases continue unchanged, and it is a challenge to all case review groups to try to extract relevant learning points, and disseminate them to the children's workforce in a way which supports professionals to protect and make effective change for children at risk of harm.
- Any cases to be reviewed by independent authors require significant funding and partners should be aware that this request could be made retrospectively. The group is clear that cases must and will be undertaken when SCR criteria are met or significant learning is apparent, but all partners must be aware of the cost implications.

Action:

- The group will focus on identifying themes and concerns in national SCRs that resonate with local issues and challenge partners to provide assurances, or actions to improve local practice.

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. This requires LSCB partners to challenge and scrutinise their peers and where assurances are not robust, to hold those partners to account. This is achieved through a supportive environment and a committed core group of QA partners, however in order to have a wider and stronger impact, there needs to be significant representation from all key players.

The QA group undertakes multi-agency auditing and encourages partners to bring their single agency audits to share with the partnership for learning and assurance.

The key audits undertaken and reviewed by the group have been incorporated throughout this report and learning has been shared with Board members. These audits include:

- Multi-agency effectiveness of MASH and Early Help pathways
- Inappropriate referrals to MASH
- Missing children, return interview quality audit
- Multi-agency Female Genital Mutilation audit
- Multi-agency Safer Recruitment Audit

Recommendations from these audits have directly led to improved support for practitioners such as online training in safer recruitment and female genital mutilation (FGM), the FGM risk assessment toolkit and children's services single point of access. However, the auditing process is not yet robust

enough to evidence positive improvements in front line practice. A process that better enables multi and single agency audit learning as a combined programme, that learns from each other and influences each other, is required to drive improvements in practice.

The group has continued to meet with core membership remaining stable, however representation has not been consistent from key services and this has had a detrimental impact on the effectiveness of the group.

Ongoing Challenge:

- From December 2016 the group was without a permanent chair, hampering progress. However this has since been resolved with the RBC taking on this responsibility.
- Develop a process that better enables multi and single agency audit learning as a combined programme that learns from each other and influences each other, to drive improvements in practice.
- 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. Moving forward, it is essential that multi-agency auditing continues, but with a focus on quality and depth of audit work, as opposed to quantity.
- Learning from audits must be more effectively disseminated and embedded into practice, however this must be completed at no cost and LSCB partners must take joint responsibility for this work. The action plans must be monitored through to completion.
- Audit work needs to focus less on processes themselves and more on their outcomes for children. The voice of the child in audits must be routinely included, better reported and directly influence recommendations and 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 and subsequent presentation to the Board, to achieve a document which has ease of use, which demonstrates trends and encourages partners to scrutinise and challenge the data where necessary. 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.

Action:

- Head of Service for Quality and Improvement will chair the group from September 2017, plus the Quality Assurance lead for Children's Services will regularly attend.
- Audit leads from RBC and partners will contribute to the audit programme to ensure cross-referencing of all auditing, to better focus resources and avoid duplication.
- Learning from each audit will be disseminated to partners to share with staff, or via practitioner forums.

Appendices

Board Membership and Attendance Log (March 2017)

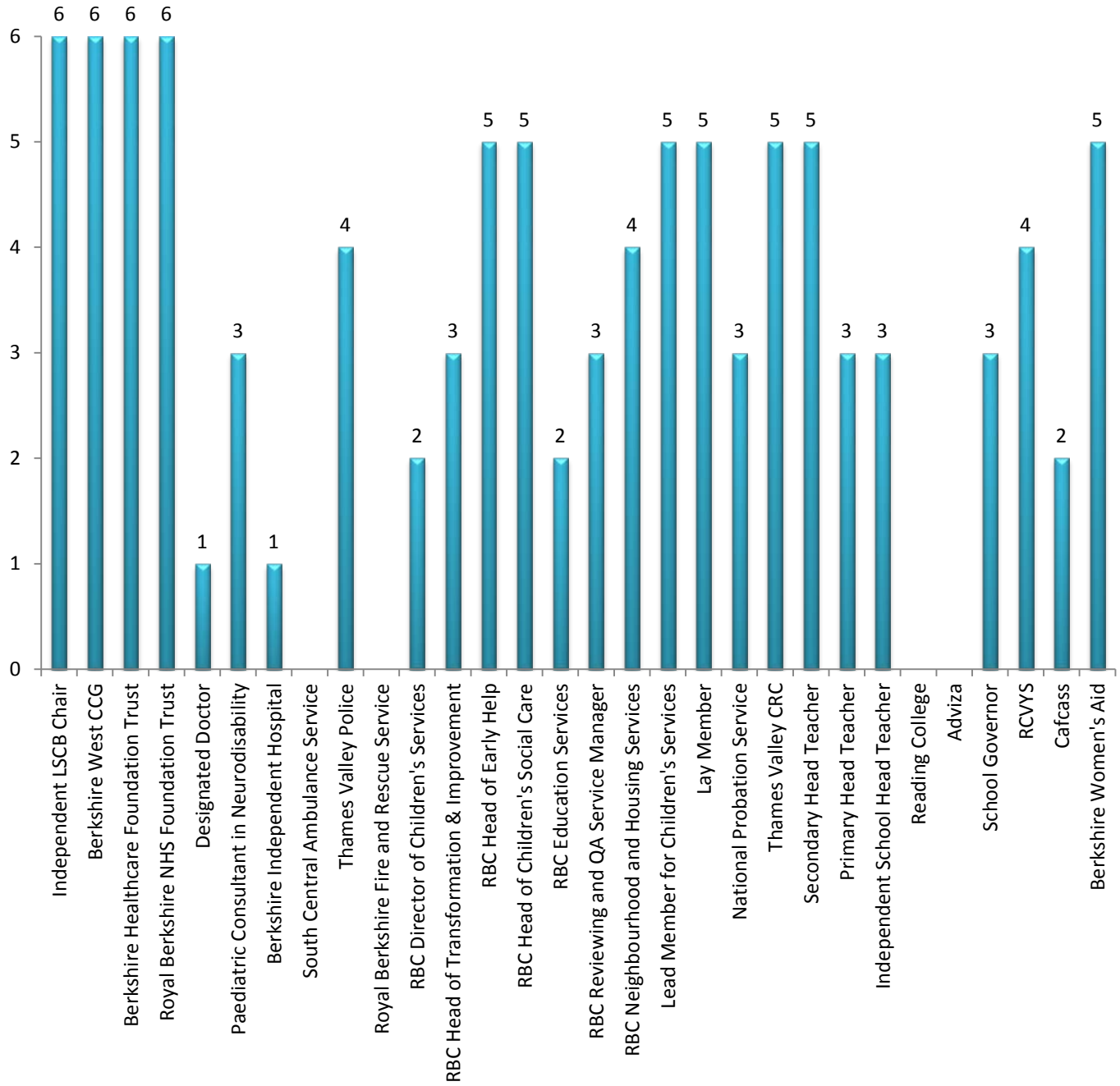
Name	Agency
Francis Gosling-Thomas	Independent LSCB Chair
Ann Marie Dodds	Director of Education, Adult and Children's Services, RBC
Rachel Dent	Head Teacher, Abbey School (Independent School Rep)
Elaine Redding	Consultant for Safeguarding and Improvement, RBC
Anderson Connell	Lay Member
Anne Farley	Lay Member
Anthony Heselton/Kat Jenkin	South Central Ambulance Service
Ashley Robson	Reading School
Liz Batty	Joint Legal, RBC
Katy Nesbitt/Shawn Fox	Activate Learning, Reading College
Christina Kattirzki	Kendrick School
Debbie Simmons	CCG
John Ennis	National Probation Service
Cllr Jan Gavin	Lead Member, Participant Observer
Sarah Tapliss	Housing, Neighbourhoods and Communities, RBC
Gerry Crawford	Berkshire Healthcare Foundation Trust
Hannah Powell	Thames Valley Community Rehabilitation Company
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	LSCB Learning and Development Sub Group Chair
Kevin Gibbs	Cafcass
Kim Wilkins	Public Health, RBC
Ruth Perry	Caversham Primary School
Julie Skinner	Adviza
Emma Kettle	Berkshire Women's Aid
Bob Kenwrick	School Governor
Grace Fagan	Service Manager for Quality Assurance and Reviewing, RBC
Andy Fitton	Head of Service for Early Help, RBC
Sarah Hughes	Paediatric Consultant in Neurodisability, RBHFT

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.

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 2016 to March 2017, are shown below.



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Berkshire Local Safeguarding Children Boards
Child Protection Procedures available on line:
http://berks.proceduresonline.com/index.htm

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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.