Better Together For Children

# Walsall Safeguarding Children Board

## Annual Report

## April 2013 – March 2014

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# INTRODUCTION BY THE INDEPENDENT CHAIR OF THE BOARD

This is the second Annual Report I have presented on behalf of the WSCB.

There can be no greater responsibility than working to ensure the safety and protection of children and young people. As Government guidance says:

*"Safeguarding children - the action we take to promote the welfare of children and protect them from harm - is everyone's responsibility. Everyone who comes into contact with children and families has a role to play."*

*"Safeguarding and promoting the welfare of children is defined as:*

- *protecting children from maltreatment;*
- *preventing impairment of children's health or development;*
- *ensuring that children grow up in circumstances consistent with the provision of safe and effective care; and*
- *taking action to enable all children to have the best outcomes."*[1]

Local Safeguarding Children Boards are established to ensure that all relevant agencies work together to safeguard children and young people, to coordinate and monitor that work and to hold local agencies to account for the effectiveness of their work and of inter-agency, partnership arrangements.

In reporting on the work of Walsall's Local Safeguarding Children Board (WSCB), in the 2013/14 year, it needs to be borne in mind that, throughout the period, Walsall Borough Council's Children's Services remained in special measures, and subject to a Department for Education Improvement Notice (having been considered to be providing inadequate services, by Ofsted Inspectors, in the summer of 2012.) The Children's Improvement Board continued to meet throughout 2013/14 to oversee Walsall's improvement journey: in many respects the Improvement Board covered much of the ground which would normally be the responsibility of a Local Safeguarding Children Board and, therefore, this meant that the WSCB's activities felt to be constrained at times. (Two important things to note: a re-inspection by Ofsted in the summer of 2013 concluded that Walsall's services were improving: they were now considered to be "Adequate". Secondly, in July 2014, The Improvement Notice was formally lifted by the Minister of State.)

Having said that, it was clear that the WSCB still had much to do. The 2012 Ofsted Inspection had rightly levelled some serious criticisms at the Board – and although we had made a start on addressing these matters in the latter part of 2012/13, the Board had further major work to do during 2013/14.

We were aided in our task by the publication, at the end of March 2013, of a new version of Working Together to Safeguard Children[2]. This revised and briefer version

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[1] Working Together to Safeguard Children: DfE, March 2103 (see footnote 2 below).

2. www.gov.uk/government/publications/working-together-to-safeguard-children

of the key Government Guidance gave the Board an opportunity to "get back to basics" and to redesign our structures and ways of working to best effect for the children of Walsall. During 2013/14, the Board had two special development sessions at which we undertook self-evaluation exercises designed to identify specific action points to strengthen effectiveness and impact. We utilised criteria provided by Ofsted to check our progress and to work towards being ready to continue the improvement journey in Walsall at the point where the Improvement Notice might be lifted. (In one very practical change, recognising the sheer scale of the agenda, the Board increased our frequency of meetings from bi-monthly to monthly.)

By December 2013 I was able to report to the Children's Improvement Board that:

- The WSCB has full "buy in" from its constituent member agencies, including lay members and young people from the Safeguarding Inspectors Team.
- The Board is working to a published Business Plan (to be extended/revised, as necessary, to include key elements of the Improvement Board's Strategic Improvement Plan). We have a Learning and Improvement Framework, to be underpinned by a balanced scorecard and aligned with quality assurance arrangements in constituent agencies. We also ensure that we have ways of picking up on lessons learned from Serious Case Reviews, peer reviews and complaints and compliments.
- The Board has formal links to the Children and Young Peoples' Partnership, the wider Health and Well Being Board and the Council's Children's and Young People Scrutiny and Performance Panel.
- The Board now has the capacity and capability to drive forward the improvement journey. Our culture is one of "Better Together for Children in Walsall", of effective and fair challenge, holding each other to account without fear or favour and being open and honest throughout
- The WSCB, with the Committees, is now able to play its part in ensuring that there is effective prioritisation of service improvements for Walsall's children and young people across all constituent agencies, maximising resource capacity and impact.
- The Board has resolved to develop, through the Quality Assurance and Performance Committee, a rolling programme of multi-agency case file auditing, using a common auditing tool, which spans the full range of WSCB partners.
- Over the coming months, we will be giving particular attention to the Early Help/Front Door offer, particularly on an inter-agency basis: we need to ensure that "preventative" measures are positively impacting on the need for statutory intervention.
- Similarly, we are ensuring that clear up-to-date policy and practice guidance for front line staff is in place, to inform and support decision making on thresholds and inter-agency or team transfers.
- We would also be keeping the Children with Disabilities service under review and also undertaking an examination of Private Fostering in the Borough.
- Together with colleagues on the Walsall Adult Safeguarding Board we have commissioned a full review of the inter-agency Domestic Violence work in the Borough. We were also mindful of the "Toxic Trio" of domestic violence,

parental mental ill-health and substance abuse, having held a successful multi-agency conference on this issue earlier this year

- At a time of continuing pressure on public sector finance, the WSCB will need to ensure that all constituent agencies continue to make a fair financial contribution to the Board's operation

I also reported that the West Midlands Police would shortly be announcing a reconfiguration of their Public Protection Units and their safeguarding work overall. I suggested that there would inevitably be major implications for us: for example, we anticipated that the establishment of multi-agency assessment teams (MAST's) will be high on the shared agenda.

In the early part of 2013/14, the Board established a Task and Finish Group to consider how best we could respond in Walsall to growing concerns, nationally as well as locally, about the sexual exploitation of children and young people. This led to the formation of a new Child Exploitation and Missing Board Committee, meaning that the Board now has five standing committees:

1. The Serious Case Review Committee;
2. The Policy, Procedures, Learning and Development Committee;
3. The Quality Assurance and Performance Committee;
4. The Child Sexual Exploitation and Missing Children Committee;
5. The Child Death Overview Panel (jointly with Wolverhampton LSCB).

Each Committee is chaired by a Board member and reports into the Board at regular intervals. Committee membership is drawn from all the agencies represented on the main Board and the Committees meet at approximately monthly intervals. In the body of this report is a summary of each of the Committee's work and activities during 2013/14 (and also a report from the Local Authority Designated Officer – the LADO). I would want to place on record here my appreciation for the time, expertise and commitment shown by Committee members, without whom the Board itself could not perform satisfactorily.

At the very end of 2013/14, the Board published a Serious Case Review[3] – our first such review for some time. The case was given the reference name W3. The report made a total of 43 recommendations, addressed to a range of agencies in the Borough and to the WSCB itself. The recommendations were fully accepted by all parties and action plans have been drawn up accordingly. The action plans are being monitored and kept under review by the Serious Case Review Committee and reported in to the Board. (Further details of the Serious Case Review can be found in the Serious Case Review Committee's report, later in this Annual Report.)
[Note: Subsequent to the Review publication, two inter-agency learning events were held to give an opportunity for professionals to learn together and improve safeguarding practise. Over 200 people attended these sessions.]

The contents of the main body of this Annual Report are as follows:

- A report from each of the Board's Committees;
- A report of the work of the Local Authority Designated Officer (LADO);
- A summary of our financial position;
- Concluding remarks including a look at the issues of particular importance to the Board in 2014/15 and beyond.

3. The full report can be found at http://www.wlscb.org.uk/scr_overview_report_final.pdf

# THE POLICY, PROCEDURES, LEARNING AND DEVELOPMENT COMMITTEE

**Chair: June Morrow. Director of Student Journey, Walsall College**

The Policy, Procedures, Learning and Development (PPLD) Committee supersedes an earlier committee with a remit for the development of training across Walsall. The PPLD Committee has been operational since July 2013 and meets monthly. Membership is drawn from and nominated by Board member agencies and includes representatives from Police, Health, Mental Health, Children's Services, voluntary sector, Probation Committee members are expected to have sufficient seniority within their individual organisations to make decisions and act on change.

The PPLD Committee was supported by the WSCB Training and Development Manager until April 2014, and subsequently by the WSCB Board Manager.

The work plan for the Committee was aligned to WSCB Business plan. The Committee has been keen to understand the landscape which it is looking to influence and support. The 2013-14 focus has been:

- To collate and analyse information from partner organisations to inform the continuous improvement of WSCB policy and training in Walsall in order to improve learning.

- To refine and develop the content and delivery arrangements for WSCB policy and training in Walsall to reflect learning and improve impact and outcomes for children.

This resulted in initial research, conducted over a three month period into the:

- Basic training delivered 'in-house' by non-school partner organisations across Walsall
- Availability and basic content of safeguarding policies.

The research itself was useful as it prompted partners to review their single agency activity and to begin to address any gaps identified e.g. the Council has introduced a safeguarding e-learning programme. In the future through the Quality Assurance and Performance Committee (QAAP) and with the support of data analysts linked to the Learning Improvement Framework data set, it will be possible to have a more structured approach to the review of single agency training. Information related to levels of training within schools was provided as an outcome of the section 11 Audit.

Walsall has a well-developed process for delivering multi agency training which was well accessed by partners. 614 attendances were recorded across the partnership from Children's Services including Children's Centres, Education, Police, Fire Service, Voluntary Sector, Housing, Probation, Residential Education and Health and other partners. It is planned that the mechanism for delivering multi agency

training, its content and ability to respond to emerging themes will be reviewed as part of the implementation of our training and development strategy for 2014/15

The Committee has spent significant time considering ways in which the impact of training, both single and multi agency can be better tracked and evaluated. The outcome of this work was presented to Board in June 2014. Support for this activity was provided by the Assistant Director for Children's Specialist Services (interim) who contributed guidance related to evidence informed practice. The first stage of the agreed process has been applied to all multi agency training, resulting in feedback that evidences increased understanding and awareness. However gaps in staffing have prevented the follow up impact assessment process going beyond the pilot stage, which will be addressed going forward.

Through multi agency work a Learning and Development strategy has been approved. A training programme has been identified which covers both statutory requirements and addresses needs identified specifically for Walsall. Key policies and procedures, including Early Help and Thresholds have been received and through Committee work have led to the development of easy access leaflets on both subjects available across the workforce.

**Multi agency training**
Course attendance data Sept 2013 – Mar 2014

| Name of course | Attendance | Agencies represented | Evaluation |
|---|---|---|---|
| Safeguarding Children with Disabilities x 1 | 6 | Children's Services, Education | Info not available |
| Safeguarding Children & Young People x 6 | 150 | Children's Centres, Children's Services, Education, Religious Organisation, Voluntary Sector, Residential, Probation, Health, Housing | 93% felt knowledge of different forms of abuse had been increased; 87% felt more confident about recognising signs of abuse |
| Advanced CP refresher x 4 | 82 | Children's Centres, Children's Services, Education, Health, Early years, Voluntary Sector, Fire Brigade, Residential, Probation | 100% considered course a good refresher that successfully updated their knowledge about legislation, procedures etc. |
| Advanced CP x 6 | 82 | Children's Centre, Children's Services, Education, Housing, Probation, Voluntary Sector, Health, Early Years | 100% felt course developed their understanding of referral process, made them more aware of role and responsibilities, and would assist them in making future professional |

| Name of course | Attendance | Agencies represented | Evaluation |
|---|---|---|---|
| | | | judgements. |
| Anti-Bullying x 1 | 12 | Children's Centre, Children's Services, Education, Housing, Probation, Residential | Info not available |
| Attending your first CP conference x 1 | 11 | Early Years, Probation, Health, Education | Info not available |
| Managing Allegations Against Staff x 2 | 61 | Children's Centres, Education, Early Years, Voluntary Sector, Residential, Children's Services, Fire Brigade | 98% felt course increased knowledge of roles of LADO, Police, HR etc., & developed knowledge of process for managing allegations |
| Child Sexual Exploitation x 2 | 38 | Children's Services, Education, Housing, Probation, Voluntary Sector, Police | 100% felt course increased their knowledge of issue and of grooming behaviour, and 90% felt more confident about identifying signs of exploitation. |
| Parental Substance Abuse x 1 | 17 | Foster Carer, Probation, Housing, Health, Education, Children's Centres, Children's Services | 100% felt course had increased understanding of substance abuse on parenting capacity, highlighted risks to children and showed useful interventions. |
| Safer Recruitment x 2 | 38 | Children's Services, Education, Early Years | 100% felt course increased understanding of offender behaviour, helped them identify key features that help deter unsuitable people, and increased understanding of policies and best practice. |
| Safeguarding Black & Ethnic Minority Children x 1 | 12 | Children's Centres, Children's Services, Education, Housing, Probation | 100% thought course increased their understanding further regarding how race and cultural issues have an impact on working effectively with BEM families. |

| Name of course | Attendance | Agencies represented | Evaluation |
|---|---|---|---|
| Forced Marriages & Honour-Based Violence x 2 | 38 | Children's Centres, Children's Services, Education, Fire Brigade, Probation, Voluntary Sector, Police, Housing | 100% said they understood better the difference between arranged and forced marriage, understood what honour-based violence was, & felt confident about identifying indicators. |
| Your role as a core group member x 1 | 5 | Social Workers (unemployed), Health, Children's Services, | Info not available |
| C & YP displaying sexually-harmful behaviour x 1 | 24 | Probation, Housing, Health, Education, Children's Services, Children's Centres | 100% felt course increased their understanding, ability to identify factors leading to behaviour, and confidence in offering support/advice. |
| MAPPA x 1 | 17 | Children's Centres, Children's Services, Education, Housing, Probation | 100% felt course improved their understanding of role of MAPPA, risk levels & assessment. |
| MARAC x 1 | 12 | Children's Centres, Children's Services, Education, Health, Health Housing, Voluntary Sector | 100% understood role of MARAC after course, and felt more confident about contributing to work of MARAC. |
| Engaging Fathers x 1 | 12 | Children's Centres, Children's Services, Probation | 100% had increased understanding of partnerships with all parents, and role, rights etc of fathers. |
| Emotional Abuse x 1 | 21 | Children's Centres, Children's Services, Education, Probation, Voluntary Sector, Health | 100% had increased understanding of EA impact, & increased confidence in identifying indicators. |

**Impact of training**

The development of processes to assess the impact of training has been an important part of Committee work. A pilot project was undertaken designed to help participants in training to identify actions for themselves or their organisation as an outcome of participation. Contact was made 3 months post training to establish if those had been achieved. Below is a sample of results:

| Child Protection Conference Training 24th September 2013 | | | | | |
|---|---|---|---|---|---|
| **Positive Impact** | | **Completed target from training** | | | **Comments** |
| **Yes** | **No** | **Yes** | **No** | **No opp yet** | |
| x | | | | x | I have only had one conference but did not need to phone the chair.<br><br>Yes definitely I felt quite confident attending my first conference due to the course. |
| x | | x | | | We are now ensuring parents are given the opportunity to read reports; children's views are being explored more but still needs further development.<br><br>Ensuring correct forms are filled in rather than using own school pro forma. |
| x | | | | x | I have not prepared a report for conference yet. However I have prepared other reports and felt confident in doing so. Followed your guidelines.<br><br>Yes, more confident in general with CP issues. |
| **Safeguarding Children and Young People training 4th October** | | | | | |
| x | | | | x | I have not yet come across any private fostering in my daily role but if I was to I would be more aware of what to do.<br><br>Safeguarding is part of my daily role and so it was a good refresher and I am now aware of the policies and procedures in Walsall as I have previously worked in another local authority. |
| x | | x | | | Discussed AFST[4] and MAST[5] at a team meeting as these are new to us, was good to share this information.<br><br>Re affirmed my existing knowledge and practice. |
| x | | | | x | Although I haven't had to report anything, if anything arose that did concern me I would report it.<br><br>I am aware of safeguarding issues and therefore would be able to recognise concerns more quickly. |
| | | x | | | I have logged a bruise under a child's eye with the CP officer – prior to the course I may have accepted the child's story without question i.e. fell off my bike. |

This indicates clear ownership of agreed personal targets from training where possible and improved knowledge and awareness following training. PPLD Committee will seek to continue to develop ways of ensuring training is worthwhile and has a positive impact on children and those who work with them.

[4] Area Family Support Team
[5] Multi-Agency Screening Team

# THE QUALITY ASSURANCE AND PERFORMANCE COMMITTEE

**Chair: Sally Roberts, Lead Nurse Quality and Partnerships, Walsall CCG**

The purpose of the Quality, Assurance and Performance Committee (QAAP) is to promote and assure the welfare of children and young people, through a multi-agency Quality Assurance and Performance framework. The group has met monthly, chaired by a member of WSCB with good attendance from multi-agency partners. Regular reports of QAAP activities are provided to WSCB and a series of recommendations for WSCB are also provided.

The work plan for the group was agreed with the following key objectives:

- To establish and sustain an effective learning and improvement framework to secure continuous improvement throughout the safeguarding and child protection system in Walsall.
- To implement and embed the learning and improvement framework across Children's Services and partners organisations.
- To review and develop the learning and improvement framework to ensure it is fit for purpose and makes a positive difference for children in Walsall

A series of work streams were undertaken as part of the QAAP activities during the year and are described below:

| Work stream | Progress | Next Steps |
|---|---|---|
| **Learning and Improvement Framework** | • LIF developed in line with multi agency contribution and agreement.<br>• Data leads identified and data extraction understood.<br>• Analysis template developed.<br>• LIF circulated for completion, analysis due September 2014. | Slippage in LIF analysis by one month – Oct 2013.<br><br>Refresh of data collection tool. |
| **Section 11 Audit**[6] | • S11 tool refreshed<br>• Training for completion developed and delivered.<br>• S11 tool completed multi agency.<br>• Additional support to | S11 analysis completed.<br><br>Review of current arrangements for next S11 underway.<br><br>S11 agency action plans and |

[6] A 'Section 11 Audit' is designed to allow the LSCBs to assure themselves that agencies placed under a duty to co-operate by this legislation, are fulfilling their responsibilities to safeguard children and promote their welfare.

| | | |
|---|---|---|
| | education re: completion of S11 tool provided. | assurance to be submitted Sept.<br><br>Full themed analysis of S11 learning multi agency due Oct.<br><br>Further refresh of S11 tool to be undertaken prior to next role out. |
| **Single Agency Audit** | • Template for single agency audit assurance developed.<br>• Single agency audit activity returns analysed.<br>• Further review of single agency process undertaken.<br>• Revised audit feedback template developed. | Audit pyramid developed.<br><br>Thematic learning overview of single agency audit activity to be undertaken.<br><br>Assurance of single agency audit activity and associated learning and impact. |
| **Multi Agency Audit** | • Timetable for multi-agency audit activity developed and agreed.<br>• Audit tool developed.<br>• Review of Neglect findings from national themed review undertaken. | Learning shared with PPLD, in order to cascade and embed through future learning opportunities.<br><br>Quarterly themed findings to be provided and shared through to PPLD. |
| **Parental Mental Health Review** | • In line with Ofsted thematic mapping exercise a local mapping exercise was undertaken.<br>• Comprehensive gap analysis document produced.<br>• Assurance provided with regards local analysis and findings. | Areas where gaps in local provision following mapping have been taken forward for development by relevant agency.<br><br>Provided an opportunity for sharing good practice.<br><br>Follow up of agency actions taking place. |
| **Deliberate Self Harm Policy** | • Recognition that current policy required review.<br>• Policy reviewed and revised in line with multi agency approach. | Policy currently out for consultation, for ratification Sept. |
| **Assurance of local Child and Adolescent Mental Health service (CAMHS) Tier 4 arrangements** | • Current arrangements for access to tier 4 are not meeting local need and demand. | Local commissioning arrangements reviewed, to ensure best possible local service for tier 3-4 provision, |

| | | |
|---|---|---|
| | • Assurance of local risk management processes scrutinised and assured.<br>• Consideration of impact to children and families considered in line with revised commissioning plans. | proposed model currently out for consideration. |
| **Anti-Bullying Strategy** | • Current strategy required refresh. | Strategy refreshed and updated.<br>PPLD have now received strategy. |
| **Early help and MAST Quality assurance** | • QAAP have been monitoring progress against MAST and Early help initiatives, with regards to quality and performance.<br>• Learning has identified more robust governance arrangements are required to support multi agency working. | Review of progress continues, this includes the multi-agency contribution and performance metrics. |

Additional quality assurance items have been addressed via QAAP and include: young carers, children missing from home and care, private fostering and looked after children health assurance.

# THE SERIOUS CASE REVIEW COMMITTEE

**Chair: Sue Butcher Assistant Director Children's Specialist Services (interim) Walsall Council**

The overall aims of the Serious Case Review Committee are to

- Support the WSCB to fulfil its responsibilities and functions as set out in Working Together to Safeguard Children (2013).
- Use a Learning and Improvement Methodology Framework to oversee case reviews in order to drive forward and embed improvements in safeguarding.

The SCRC is responsible for commissioning Serious Case Reviews (SCRs) and other learning reviews and ensuring that lessons are learned across the partner agencies in order to improve the quality and effectiveness of both strategic and operational practice thus improving outcomes for children and young people in Walsall. Additional meetings are held to:

- Consider specific cases and decide whether or not to recommend to the chair of the WSCB that an SCR should be undertaken,
- Consider the terms of reference for any SCR
- Set up the specific SCR panel.

The main Serious Care Review Committee (SCRC) has met on 4 occasions during the period covered by this report. It is chaired by the Assistant Director for Children's Specialist Services, Walsall Council and attended by senior managers representing statutory members of Walsall Safeguarding Children Board (WSCB). The SCRC's terms of reference state that members are expected to ensure a minimum of 80% annual attendance and if this is not achieved, member attendance will be escalated to WSCB level. Attendance for 2013/14 is not yet at the required level with only 2 representatives having attendance of 100%, 6 at 75% and 3 at 50%. This was escalated to the board in April 2014.

The SCRC also considers learning from those SCRs and learning reviews published by other local authorities particularly those from neighbouring or similar authorities. In 2013/14 it has looked at SCRs from Walsall, Dudley and Sandwell and Birmingham and had planned ahead to look at the 'review retrospective deeper analysis and progress report on implications of recommendations' following an SCR carried out in Coventry. The SCRC's remit is a challenging one. A recent national report[7] offers identification of emerging themes that indicate why lessons learnt from SCRs across the country have not been embedded in policy and practice and provides insights that may inform future policy, procedures and practice across difference disciplines, agencies and sectors. This will be an important reference document for the SCRC going forward.

[7] A Study to Investigate the Barriers to Learning from Serious Case Reviews and identify ways of overcoming these Barriers. Research Report DfE July 2014

**Partnerships and Governance**

The SCRC's terms of reference are reviewed on an annual basis. The current version is dated July 2013 and is to be reviewed in August 2014.

The SCRC provides written reports on its activities to the WSCB on a bi-monthly basis for consideration, discussion and challenge.

The committee does not currently have a vice chair and a recent request for nominations was unsuccessful. The SCRC and the WSCB will need to consider these arrangements going forward.

When the SCRC makes a recommendation to the chair of the WSCB whether or not to hold a Serious Case Review this decision is reviewed by a National Panel. The WSCB has referred to the panel on two occasions with the stated intention not to hold an SCR and on each occasion the panel has advised that a SCR should be carried out. The advice was taken on the first occasion and the WSCB chair is currently in liaison with them about the second case. Another case referred to the WSCB for consideration of a serious case review was deemed by the chair of the WSCB not to have met the criteria for such a decision.

Chapter 4 of Working Together 2013 provides that there will be a **national panel** of independent experts to advise Local Safeguarding Children Boards ('LSCBs') about the initiation and publication of Serious Case Reviews ('SCRs'). The role of the panel will be to support LSCBs in ensuring that appropriate action is taken to learn from serious incidents in all cases where the statutory SCR criteria are met and to ensure that those lessons are shared through publication of final SCR reports. The panel will also report to the Government their views of how the SCR system is working.

The panel's remit will include advising LSCBs about:

- Application of the SCR criteria;
- Appointment of reviewers; and
- Publication of SCR reports.

LSCBs should have regard to the panel's advice when deciding whether or not to initiate an SCR, when appointing reviewers and when considering publication of SCR reports. LSCB Chairs and LSCB members should comply with requests from the panel as far as possible, including requests for information such as copies of SCR reports and invitations to attend meetings.

Walsall Children's Services was the subject of an improvement notice throughout the period referred to by this report and reported to an independently chaired Improvement Board with representation from partner agencies and the Department for Education. Briefings on the SCR undertaken during this time referred to as W3,

were provided to the Improvement Board on a regular basis. The chair of the WSCB was a member of the Improvement Board and the chair of the Improvement Board and the representative from the DfE have both attended WSCB meetings as participant observers.

The panel set up to conduct the SCR W3 was a multi-agency panel chaired by the Head of Service for Probation who had not had any previous involvement with the family. The SCRC met with the panel in February to consider the SCR overview report written by an independent author and the report was presented to and approved by the next meeting of the WSCB. The Report was formally published at the end of March 2014.

The Report identified a number of systemic weaknesses or individual failings:

- A failure across Health agencies to ensure that all information relating to W3 was available in a single set of community records
- The focus within the Children with Disabilities Team (CWDT) generally (save for a notable exception) being on respite for parents more than the needs of the child in question or siblings
- An arrangement whereby case closure by Children's Social Care resulted in termination of a current domestic abuse risk assessment (DARA)
- The inability of the 'Think Family' initiative to locate records of its involvement during 2010
- A failure of a parent support adviser to seek advice from senior school staff and/or liaise sufficiently with relevant other agencies
- Children's Social Care leaving a student to deal with issues that required a safeguarding response by a registered social worker in July 2011
- A low level of supervision within Children's Social Care and a high turnover of social workers from September 2011 to March 2013
- Insufficient inter-agency challenge at times when staff in one agency were justifiably aggrieved about the performance of another
- A poorly conducted joint investigation by Police and Children's Social Care of W3's allegations of abuse in late November 2012
- Acceptance by a Police call operator in 2013 of mother's assurance a 999 call was a child playing rather than a call for help
- Failure of involved social work staff to inform W3's school (and other partner agencies) promptly of his injuries in mid March 2013

However, some examples of good practice were identified in the Review: these included responses of a team manager and an independent reviewing officer in Children's Social Care, a Police call handler, reporting of concerns by a Domestic Violence Forum worker and by W3's school of observed injuries, sensitivity of ambulance crew and deputy head teacher and some recent initiatives taken by the GP Practice involved.

**Capacity, Capability and Culture**

The SCRC's workload was considerable, particularly when taking into account the work to complete the SCR on W3 who was part of a large sibling group with many complicating factors. It is to the credit of everyone involved that the overview report

was published on schedule in March 2014. [Note: Concern was expressed in some quarters that the media interest in this report was unreasonably focussed on Walsall Children's Services and although this view is not shared by all agencies it is a matter for consideration when publishing reports in the future.]

Training is provided for authors of Individual Management Reviews (IMRs), this is the report agencies involved with the child in question contribute to the overview report for an SCR.

Some of the papers submitted to the SCRC by partner agencies and in particularly those relating to one matter that was not subsequently recommended for an SCR, were of a poor quality and had to be returned to their authors for amendment. In addition some documents are not received until after the set deadlines and may have to be tabled at a meeting. This is not an appropriate way in which to make important decisions for and about children.

The work of the SCRC in 2013/14 has been largely reactive i.e. considering cases as they are referred in for discussion but reflection at a recent SCRC meeting has determined that the committee needs a pro-active dedicated work plan by which to measure its progress even if some of the actions have to be deferred to ensure that there is the capacity to consider a referral for an SCR. Some tasks were not completed by one member of the committee because of lack of capacity before leaving to join another authority.

The SCRC meeting on 7th February 2014 focussed on learning lessons and it was helpful to have the chair of the PPLD in attendance to consider how to best support 'learning lessons'. Reciprocal arrangements such as this will be useful going forward.

In 2014/15 the SCRC will be embedding a learning pathway encompassing different methods for learning lessons from single agency reviews up to and including SCRs.

**Quality and Effectiveness of Frontline practice**

The most important question is what difference have we made for children and young people in Walsall**.** Certainly the Early Help Thematic Inspection carried out by Ofsted in January 2014 noted that staff were aware of the lessons from serious case reviews but this is not proof of impact.

The SCRC has an important role in monitoring the implementation of action plans from SCRs but a Board challenge is that agencies are not yet adequately prioritising updating them so it is not yet possible to gauge improvements in practice. Multi-agency audits need to be embedded across the partnership to evidence impact going forward.

The national report referenced above makes recommendations to promote learning from SCRs. The most appropriate to Walsall's SCRC are noted below and taking them forward locally on behalf of the WSCB could form basis of the SCRC's work programme going forward:

**Recommendations**

1a) Develop nationally learning and auditing tools which can be used locally to increase awareness of the key themes emerging for SCRs and to promote practice enhancement and impact.

1b) Design and develop evidence based learning 'tools' applicable nationally to facilitate collective but also targeted and tiered learning.

2) Key learning foci that emerge from analysis of SCRs nationally include the importance of:

   a) Learning to challenge - learning to 'think the unthinkable' including working with non-compliant parents/carers; confidence to challenge apparent compliance and to ensure all the 'unseen and unheard' have been investigated for example the 'hidden man of the household'; child and young person; other voices not in the system such as grandparents and neighbours; and other underestimated sources.

   b) Learning together with and from front line practitioners, strategic managers and the Private, Voluntary, Independent and third sectors;

   c) Learning through supervision.

   d) Learning for action and in action;

   e) Learning together - with a strong focus on multi professionalism;

3) Develop a national accessible database for all practitioners to access SCR 'Executive Summaries' with on-going key themes identified for learning. Dissemination of regular themed reports in a variety of formats to facilitate different professional and agency audiences.

4) Ensure clear accessible guidelines to enable confidence across all disciplines in information sharing, thresholds and systematic recording systems and measuring impact.

5) Develop a Continuous Professional Development (CPD) programme for all practitioners to enable deeper learning to overcome obstacles to good practice by developing and consolidating 'hidden' interpersonal skills as well as legal and work based requirements in all forms of learning environments, supervision and professional development.

6) Cross disciplinary course development from initial training for all practitioners in the future to include reflection on the drivers that impact on different professional groups for example, health, education, social care and the private, voluntary, independent and third sectors.

7) Capture within local and national reporting structures the recording of how the learning and practice changes following SCRs are being taken forward.

# THE CHILD SEXUAL EXPOITATION AND MISSING CHILDREN COMMITTEE

## Chair: DCI Jayne Parry followed by DCI Jenny Skyrme

### Introduction

1.1 At the WSCB Action Planning event on the 22nd May 2013, Independent Chair Robert Lake requested that a Short Life CSE Task Group consisting of Board members be formed to devise a CSE Strategy for Walsall; and report back to WSCB at the September meeting.

1.1.1 DCI Jane Parry was nominated as the Chair. The group met twice, once in July and once in September. This initiative reflected the decision to place 'child sexual exploitation' in one of the WSCB 5 priorities for 2013/14 and the priority contained within the Children and Young People's Plan; to reduce the harm caused by child sexual exploitation (CSE) including children missing from school, care and home.

1.1.2 The group's purpose was confirmed as to develop the CSE Strategy for WSCB; to establish a process between multi agency partners in Walsall for the identification and protection of children at risk of or being sexually exploited; the scale and profile of CSE offending; and action to pursue, disrupt and prosecute CSE offenders.

### 2. CSE – Strategy & Delivery Plan

2.1 A draft CSE strategy and draft CSE delivery plan were presented to the WCSB for sign off on 18th September 2013.

2.2 The related report presented at the September meeting made the following recommendations:

- WSCB endorses the CSE Strategy
- WSCB endorses the CSE Delivery Plan
- WSCB distributes the Strategy and Delivery Plan to partners
- The current CARE Panel are rebranded and become the CSE/Missing sub group of WSCB to co-ordinate multi agency operational activity to safeguard and protect children from CSE
- WSCB provide clear terms of reference and an Operating Protocol for the sub group
- The CARE Panel will continue in its current format whilst this work is being expedited
- WSCB requests a new CSE Steering Group that will oversee the implementation of the CSE Strategy, and progress the Delivery Plan

- WSCB identifies a Chair for the CSE Steering Group
- WSCB tasks the CSE Steering Group to provide a quarterly update on progress against the Delivery Plan
- WSCB endorses the use of the regionally agreed CSE Risk Assessment Tool; CSE Screening Tool; Workforce Education and Induction Pack and Performance Framework to enable the CSE Steering Group to progress implementation of the Strategy before the next WSCB meeting

2.3 All report recommendations were adopted at the WCSB meeting and have subsequently been implemented.

2.3.1 The Board also resolved that the:

- Board endorsed a WSCB CSE/Missing Committee under Board governance, meeting monthly to coordinate CSE and refine the delivery plan, monitor impact and outcomes, and have a clear link to regional developments.
- Links will be made with the WSCB Quality and Performance and Policy, Procedure, Learning and Development Committees.

Both action areas above have also been implemented in full.

2.4 The Child Exploitation and Missing Committee (CEMC) confirmed its purpose as being responsible for ensuring the effective partnership working of key agencies who respond to children at risk of sexual exploitation, those being sexually exploited and/or those that are missing/absent from home.

2.4.1 As agreed the group met monthly (first meeting was 8th November 2013), during the period of the annual report.

2.5 To support the strategic activity of the CEMC a 'new' operational group was established, 'Child Exploitation and Missing Operational Group' (CMOG).

2.5.1 The role of the Operational Group (CMOG) has been confirmed as to:

- Consider only the high level/complex cases (to include trafficking)
- Look at learning and best practice
- Look at barriers to delivery, and escalate to the strategic committee where necessary
- Look at locations and perpetrators
- Look at operational data, themes and mapping and move forward with the delivery plan

2.6 The WSCB Police Lead (DCI Jenny Skyrme), for the period of the report chaired the CEMC with the vice chair being the Children's Services Head of Integrated Young People's Support Service (Alan Michell)

2.7 The November meeting extended memberships to include representation from Education, Probation and Walsall Local Policing.

**Further progress**

3.1 The CSE strategy and delivery plan were enhanced to include objectives as defined within the Walsall Children and Young People's Plan 2013 – 2016, the Association of Chief Police Officers Child Exploitation Action Plan (v.9 March 2013) and the Regional Safeguarding Network, Missing, Sexual Exploitation and Trafficking Sub-Group Action Plan 2013-2014 and have been refreshed and published on the website.

3.2 CSE briefing toolkit has been rolled out to partners.

3.3 implementation of Police Problem profile for Walsall considered alongside youth gang activity and other related agenda's.

## 4 Next Steps

4.1 Consider adoption and implementation of the CSE strategic sub-group common standards, risk assessment tool and performance framework when adopted regionally.

4.2 Consideration of developing a specific CSE co-ordinator post/function.

4.3 To review both CME strategy a related delivery plan – September 2014.

4.3.1 Provide feedback to the April/May WSCB in relation to progress made against the CMEC delivery plan, highlighting any barriers to delivery or gaps in service provision.

4.4 Develop a programme of audit activity in line with the established audit plan for 2014/15 and in conjunction with other sub-committees of the Board.

4.5 Devise a missing and trafficked strategy to accompany the CSE strategy.

# THE CHILD DEATH OVERVIEW PANEL

## Chair: Manjeet Garcha Executive Nurse, Commissioning: Wolverhampton

The Child Death Overview Panel (CDOP) process was first introduced on 1 April 2008. CDOP works in partnership across Walsall and Wolverhampton Safeguarding Children Boards and its function is to establish procedures to ensure a coordinated response to all child deaths.

Copies of all Child Death Review processes and procedural documentation are available on the Walsall Safeguarding Children Board website (www.wlscb.org.uk).

Networking

Good links have been established with the following.

- CDOP contacts across the West Midlands Regional Network
- Coroner's Office
- Registrar
- Child Health Information Services
- Palliative Care
- Acorns Hospice
- Bereavement Services Helplines
- Neighbouring LSCBs

Activity\Developments

- Guidance notes were received from the Department for Education (DfE) for the completion of child death preventable data collection for the year 2012\13. The data on behalf of Walsall was submitted 23 May 2014 within the required deadline of 31 May 2014.
- Following the 'sleep safe' campaign launched in October 2012, there has been one reportable child death which has involved co-sleeping as a modifiable factor.
- Promotion of risk awareness for families around smoking in pregnancy and secondary smoking are areas of work identified for further development by the Panel.

### Walsall Child Death Data and Trend Analysis

An overview of Walsall child death statistics covering the period 1 April 2013 to 31 March 2014 is as follows:

### Child Population and Mortality Rates

Around 26% of the population of Walsall is under the age of 20 and 6.9% of the population are children aged 0-4 years.

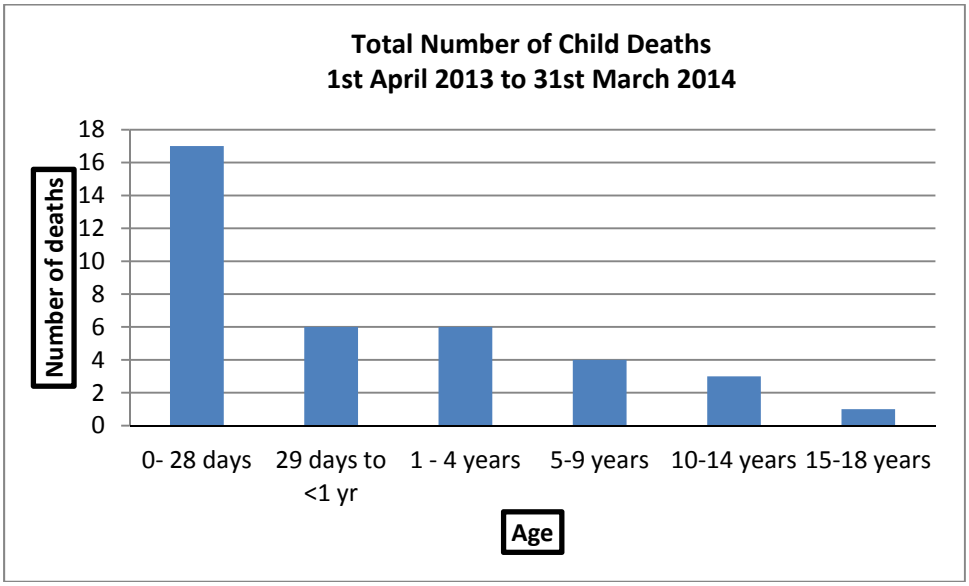
29.2% of children aged under 16 years are living in poverty. The rate of family homelessness is similar to the England average.

| Indicator | Local value | England average | Regional average |
|---|---|---|---|
| **Children (age 0-4 years) 2012** | **18.600** | **3,393,400** | **361,300** |
| **% of total population** | **6.9%** | **6.3%** | **6.4%** |
| **Children (age 0-19 years) 2012** | **70,400** | **12,771,100** | **1,392,800** |
| **% of total population** | **26.0%** | **23.9%** | **24.7%** |
| **% of children living in poverty 2011 (age under 16 years)** | **29.2%** | **20.6%** | **23.2%** |
| ***Data source: population estimates, ONS midyear estimates 2012*** | | | |

The health and well being of children in Walsall is generally worse than the England average. Both infant and child mortality rates are poorer than the England average.

| Indicator | Local value | England average | Regional average |
|---|---|---|---|
| Infant mortality rate ***(Per 1,000 births age under 1 year 2009-2011)*** | 7.6 | 4.3 | 5.9 |
| Child mortality rate (age 1-17 years) ***(Directly standardised rate per 100,000 children aged 1-17 years 2009-2011)*** | 18.3 | 12.5 | 12.8 |
| ***Data Source: ChiMat and ONS*** | | | |

**Total Number of Child Deaths in Walsall**



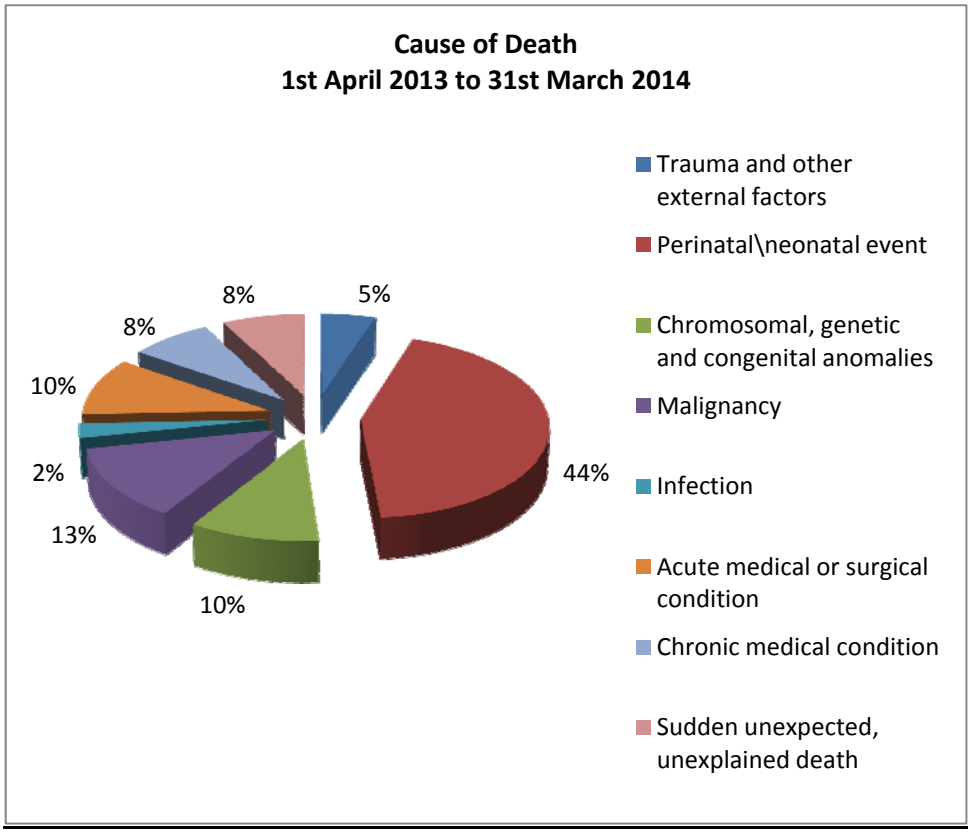

The total number of child deaths occurring in Walsall for the period is 37 of which 30 were expected deaths and 7 were unexpected deaths. 62% of the total number of deaths occurred in the first year of life.

Trend patterns indicate a marginal increase in the number of expected deaths for the year 2013\14 in comparison to the previous two years, whilst the number of unexpected deaths reportable for the year remains unchanged in comparison to the previous two years.

| Indicator | 2013\14 | 2012\13 | 2011\12 | 2010\11 | 2009\10 | 2008\09 |
|---|---|---|---|---|---|---|
| Expected | 30 | 29 | 36 | 27 | 30 | 34 |
| Unexpected | 7 | 6 | 7 | 13 | 10 | 5 |
| **Total** | **37** | **31** | **33** | **35** | **41** | **39** |
| **Data Source: CDOP statistics – actual number of deaths** | | | | | | |

Of the 7 unexpected deaths, there have been no referrals which have been deemed to meet the serious case review criteria. One child death resulted from a road traffic accident, the first road traffic fatality recorded in Walsall since the commencement of the child death review processes in 2008.

**Percentage Distribution of Cause of Death**



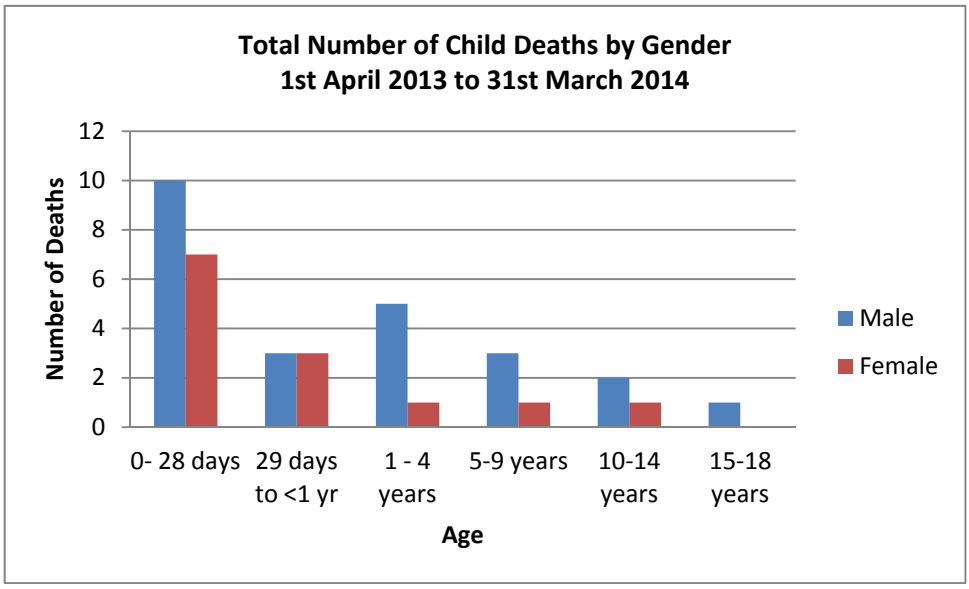

Perinatal\neonatal deaths equates to 44% of the total number of deaths reported during the year. A more detailed trend analysis for this age group is detailed below.

- 13% of deaths were categorised as malignancy comprising solid tumours and leukaemias

- 10% of deaths were categorised as acute medical\ surgical condition, namely acute asthma and sudden unexpected deaths with epilepsy;

- 10% of deaths were categorised as chromosomal, genetic and congenital anomalies.
- 8% of deaths were categorised as chronic medical condition.
- 8% of deaths were categorised as sudden unexpected deaths.
- 5% of deaths were categorised as Trauma and other external factors, namely road traffic fatality and airway obstruction.
- 2% of deaths were categorised as Infection.

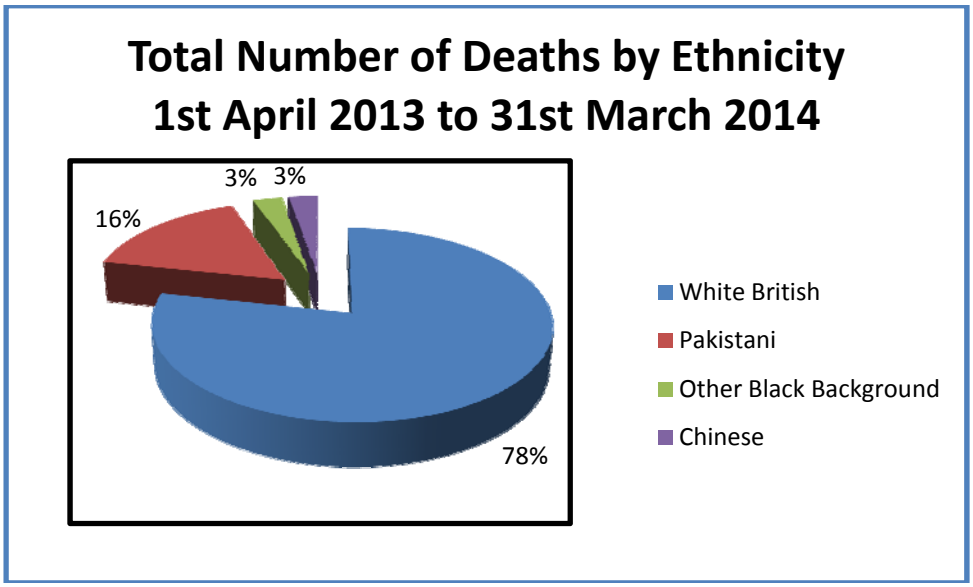
## Total Number of Child Deaths by Gender




There is a higher ratio of male deaths (65%) compared to female deaths (35%) for the period which is reflective of trends both regionally and nationally.

/ continued .....

**Percentage Distribution of Child Deaths by Ethnicity**




Out of a total of 37 child deaths, the highest proportion 78% had ethnicity White-British. 16% of child deaths occurred with Pakistani ethnicity; and 3% had Chinese or Other Black background ethnicity respectively.

**Neonatal Deaths**

Health protection and prevention of ill health factors in pregnancy and during infancy are mixed. Smoking in pregnancy, low birth weight (<2500g) and breastfeeding initiation within Walsall are worse than the England average. Whereas health protection factors, namely antenatal assessment by 12 weeks, MMR immunisations and Diphtheria, Tetanus, Polio, Pertussis, Hib immunisations are better than the England average.

| Indicator | Local value | England average | Regional average |
|---|---|---|---|
| Live Births 2012 | 3,816 | 694.241 | 73,940 |
| Breastfeeding initiation % | 63.3 | 73.9 | 67.9 |
| **Smoking in pregnancy %** | 15.7 | 12.7 | 14.2 |
| **Low birth weight (<2500g) %** | 10.2 | 7.3 | 8.2 |
| **Antenatal assessment by 12 weeks %** | 90.7 | 87.5 | N\A |
| **Completed MMR (by age 2 years) %** | 97.0 | 92.3 | 92.7 |
| **Completed Diphtheria, Tetanus, Polio, Pertussis, hib immunisations %** | 98.8 | 96.3 | 96.6 |
| ***Data Source: ChiMat 2012\13*** | | | |

The highest number of reported deaths occurred in the age group 0-28 days (Neonatal).

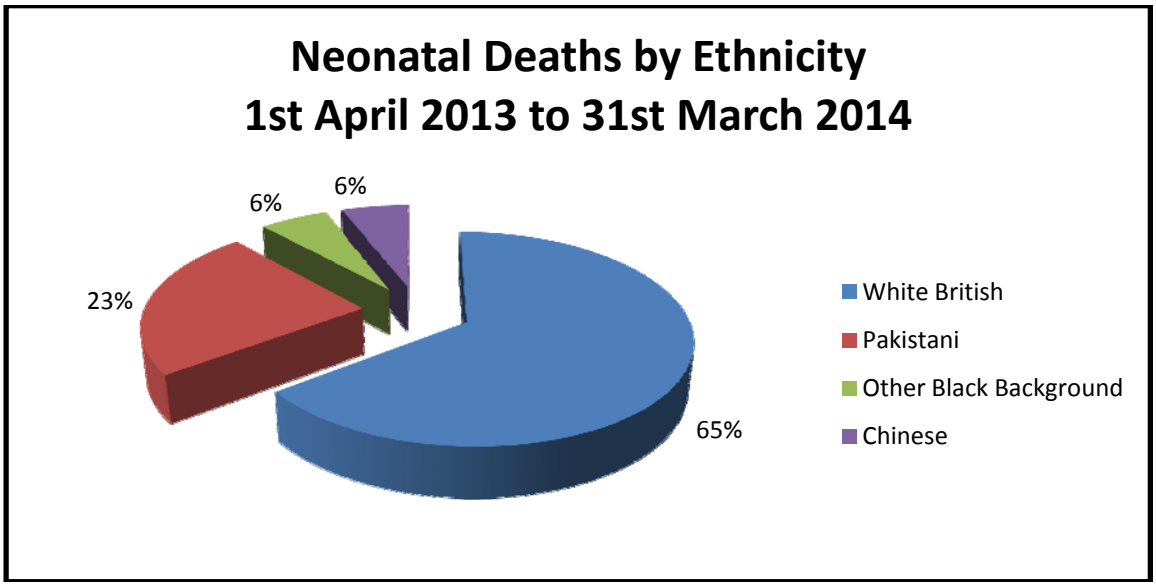
There is a regional variation in registering live births according to gestational age category. For instance, an infant born at 20 weeks gestation may be regarded as a

miscarriage in the North East but as a live birth and then subsequently a neonatal death in the West Midlands.

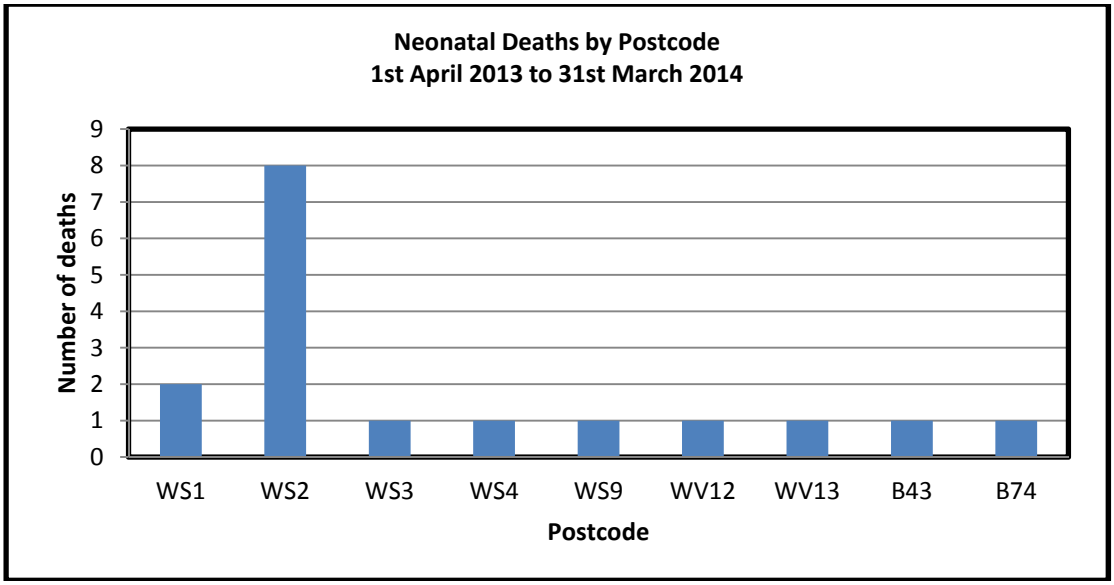
A live birth occurs when an infant shows some sign of life at birth, for example, breaches or shows evidence of life such as voluntary movement, heartbeat, pulsation of the umbilical cord or definite movements of voluntary muscles.

17 neonatal deaths have arisen in Walsall this year and the main cause of death being due to immaturity related conditions and congenital anomalies with an average gestational age category of 26 weeks born to mothers whose average age was 26 years. There has been a slight decrease in the number of deaths this year in comparison to previous year (20) however; no discernible factors have been identified to explain the reason for this decrease.

Of the total number of neonatal deaths, 17 recorded, 65% had ethnicity White-British, 23% had ethnicity Pakistani, 6% had ethnicity Chinese and Other Black Background respectively.




The geographic distribution of neonatal deaths is detailed below with the highest proportion of these deaths occurring in Pleck, Bentley and Leamore (WS2); a recognised area of socio-economic deprivation within Walsall.




## Infant Mortality

The infant mortality rate of 7.6 per 1,000 births (age under 1 year) in Walsall is worse than the national average of 4.3. Walsall has the worst infant mortality rate of 7.7 per 1,000 nationally.

Overall CDOP trend analysis for infant deaths under 1 year indicates a marginal decrease in the number of reportable deaths year on year (the year 2011\12 being the exception).

| Age | 2013\14 | 2012\13 | 2011\12 | 2010\11 | 2009\10 | 2008\09 |
|---|---|---|---|---|---|---|
| 0-28 days | 17 | 18 | 23 | 16 | 22 | 23 |
| 29 days to <1 year | 6 | 6 | 10 | 12 | 7 | 6 |
| **Total** | **23** | **24** | **33** | **28** | **29** | **29** |
| **Data Source: CDOP statistics – actual number of reportable deaths** | | | | | | |
| | | | | | | |

# THE WORK OF THE LOCAL AUTHORITY DESIGNATED OFFICER (THE LADO)

## The Management of Allegations Against People Who Work with Children

**LADO: Alan Hassall**

**Summary**
The purpose of the LADO Annual Report is to provide an overview of the Local Authority Designated Officer role, summarise and analyse data relating to the allegations received in 2013-14 and highlight key areas for further development. The report focuses on the management of allegations or concerns and the process, monitoring and evaluation of these allegations, within the wider context of Walsall Safeguarding Children Board's work in respect of safer recruitment and employment practice, and guidance and support for safer working practices across the children's workforce.

**Introduction**
The purpose of the Local Authority Designated Officer (LADO) and the procedures for the management of allegations against those who work in a position of trust with children and young people[8] is to help ensure that children are safeguarded from abuse and exploitation. These procedures relate to those who work with children in all settings including those who work in care and education settings, health, leisure or faith settings.

The procedures, *Allegations of Abuse against Persons who Work with Children (including Allegations Against Carers and Volunteers*), are based on the framework for dealing with allegations made against an adult who works with children, detailed in Working Together 2013, Chapter 2, paragraph 4.

An allegation may relate to a person who works with children who has:

- behaved in a way that has harmed a child, or may have harmed a child;
- possibly committed a criminal offence against or related to a child; or
- behaved towards a child or children in a way that indicates they may pose a risk of harm to children.

Walsall Safeguarding Children Board's procedure, *Allegations of Abuse against Persons who Work with Children*, details the operation of these functions in Walsall. Working within this guidance should help ensure that allegations are dealt with consistently and fairly.

[8] The procedures, *Allegations of Abuse against Persons who Work with Children (including Allegations Against Carers and Volunteers*), are based on the framework for dealing with allegations made against an adult who works with children, detailed in Working Together 2013, Chapter 2, paragraph 4.

These procedures apply to any adult who works with children or young people; this could be in the capacity of a staff member, foster carer, volunteer or professional. They apply to those in paid employment and voluntary activity and are relevant to a person's behaviour within their own family or home circumstances where this could indicate risk in their role in a position of trust.
In consideration of a concern or allegation, there are three strands:

1. A police investigation of a possible criminal offence.

2. Enquires and assessment by Children's Social Care about whether a child is in need of protection or in need of services.

3. Consideration by an employer of disciplinary action in respect of the individual.

The LADO in Walsall regularly works with LADOs in other local authorities where individuals may undertake activities with children within different local authority boundaries. Further the LADO will liaise with agencies outside of Walsall including statutory, private and voluntary organisations and governing bodies as well as other organisations where allegations relate to those working in Walsall but whose employers may not be local (for example national independent fostering agencies and social work teams out of borough who have children placed in Walsall).

**The LADO Role and Responsibilities**
The key elements of the LADO role are to:

- Be involved in the management and oversight of individual cases.
- Provide advice and guidance to employers and voluntary agencies.
- Liaise with the police, social care, Crown Prosecution Service and other agencies as required.
- Monitor the progress of cases to ensure that they are dealt with as quickly and consistently as possible with a thorough and fair process.
- Ensure that information on the management of allegations is collated and that the relevant data on activity and outcomes is made available on a quarterly basis.
- Meet with Senior Named Officers to monitor organisational responses to allegations made against professional, staff members, foster carers or volunteers. This must include police, health, education and senior management responsible for Looked After Children.
- Identify themes/issues regarding the safety of children and ensure that these are communicated so that lessons can be learnt.
- Demonstrate clear leadership and develop sound governance, accountability and scrutiny processes across all agencies involved with the implementation of these procedures.

**Timescales**

Upon receipt of an allegation the following timescales apply:

- All allegations should be reported to the LADO immediately.

- The employer should report to the LADO within one working day. (Discussion will take place between the employer and the LADO in relation to any immediate risk assessments or safeguarding action required).
- A Position of Trust meeting will be called within 72 hours if there are immediate safeguarding concerns.
- A Position of Trust meeting should take place within five working days.
- A criminal investigation should be started within four weeks.
- An expectation of 80% of such cases is resolved within one month, 90% within three months and all but the most exceptional cases completed in one year.

**Local Arrangements**

In Walsall the LADO is situated in the safeguarding service and during the 2013-2014 reporting period the designated senior officer (DSO) is the Head of Safeguarding. The responsibility for chairing the majority of Positions of Trust (POT) Meetings belongs to the LADO with the DSO covering in the LADO's absence. Previously in Walsall this role had been shared between various operations managers.

In 2012 plans were put in to place to recruit a LADO to a newly created post. Whilst this was taking place an interim LADO was recruited. Sadly successfully recruiting a suitable permanent LADO took longer than desired and three interims took this post between June 2012 and January 2014 when the current, permanent LADO took up post. The presence of a permanent LADO should better ensure consistency, improve visibility and assist in developing and maintaining relationships across agencies as well as allow the further development of training, workshops, briefings and reporting and recording systems.

There is designated LADO administration for the post, which is responsible for minute taking, recording, maintaining the database and the organisation of meetings to improve the effective and efficient delivery of the LADO functions.

**Local Activity**

1. There have been 239 contacts recorded by the LADO in 2013-14. This compares to 180 contacts in the reporting period 2012-13. A contact could be a referral relating to an allegation or an enquiry for advice and guidance.

2. The number of contacts to the LADO has seen a 33% increase compared to that of 2012-13 (when there had been a 43% increase on 2011-12). Details of referrals and trends will be explored in the following section.

3. All referrals to the LADO are recorded on the LADO database whether they proceed to a POT meeting or not, it is also recorded if advice is provided. This is in response to learning from high profile cases nationally.

4. The joint working arrangements with the Police Child Abuse Investigation Unit (CAIU) and the public protection unit in Walsall are good. Attendance at the meetings is high and investigations are usually progressed swiftly and outcomes provided.

5. Work is ongoing with schools and early years settings via the safeguarding advisors; the allegations management process is featured in all level one courses and during safeguarding visits to schools and early years providers. A new safeguarding advisor to early years was appointed in February 2014 to support this work. Safeguarding workshops take place throughout the year and key safeguarding information is shared and the LADO role and processes reinforced.

6. The LADO meets regularly with education and early years safeguarding advisors and alerts them to all contacts from these settings, they attend the majority of relevant POT meetings.

7. There are regular regional LADO meetings that take place, allowing for development and consistent practice across the wider region. Key lessons learned are shared and information from high profile cases and serious case reviews are considered. 2014 has also seen the first national LADO conference attended by the Walsall LADO, which prioritised the development of consistency as well as sharing learning.

8. The LADO now undertakes regular interface meetings with key managers in Initial Response, Schools and Early Years, Family Placements etc.

9. Since coming in post in January 2014 the LADO has also undertaken a series of visits to settings to build working relationships and better ensure the understanding and effective use of procedures and to offer support and guidance. These have included schools, other education providers and children's homes and briefings for designated staff in a variety of settings including health and early years. This will continue in the 2014-15 and will include work with faith settings.

10. The LADO has attended the team meetings of key teams to build working relationships and better ensure understanding and effective use of procedures.

11. Changes have been made to the LADO recording systems to better capture all enquiries made and key information that will be helpful in identifying trends and areas for development. This will ensure more consistent data capture which can be better exploited in the next reporting year. This should improve tracking and reporting as well as providing clear outcomes to all those about whom there has been a POT meeting.

12. Following a recommendation from a previous serious case review the LADO has also presented at a GP event to raise awareness.

**Areas for development from 2012-13 report**

The following areas were identified in the 2012-13 report for further development in 2013/2014:

1. *To maintain the LADO data base on a monthly basis.*
   LADO database is updated on a weekly basis.

2. *Letters to be sent to all adults about whom allegations are made with an outcome and a copy to their employer.*
   All adults about whom there is a Position of Trust meeting are now provided with an outcome letter with a copy sent to their employer. In the case of those for whom the allegation or concern does not progress to a meeting it is agreed with the employer how they will be advised.

3. *Ongoing targeting of health professionals, the voluntary and third sectors, also sports organisations.*
   The LADO has presented at events and briefings which have included health professionals, the private and voluntary sector as well as individual liaison with private, voluntary and sports bodies. The LADO has met with key personnel in sports across the borough to develop relationships and identified opportunities for further awareness raising.

4. *Specific targeted work with the Mosques, with the view of continuous interface meeting to be undertaken. Along with providing support with safer recruitment and training where identified.*
   There has been ongoing liaison with individual mosques, the Union of Muslim Organisations and the police. The LADO has supported and contributed to the development of a new Masjid Child Safeguarding Policy led by Community Safety Services.

5. *Establish regular local LADO workshops with Chairs, Family placements, Human resources, police, and other key agencies every six months to share key learning points.*
   The LADO has contributed to development and learning with all these groups, however, not in the form of workshops. This is to be considered and the best mechanisms for sharing learning identified for 2014-15.

6. *To continue to contribute to the regional LADO network and sharing regional learning across Walsall.*

The LADO has attended and contributed to regional and national LADO network meetings.

7. *An annual presentation WSCB undertaken by the LADO/DSO along with Education safeguarding officers.*
   This presentation was delivered.

8. *Ongoing work with Walsall Safeguarding Children Board regarding the relevant website pages, along with meeting to be held on a monthly basis to ensure all new information local and national is added to the website and disseminated.*
   The LADO meets regularly with the Safeguarding Board Business Manager providing updates and has reviewed the current pages and contributed changes. However further work is needed in 2014-15 to develop this.

9. *Consideration of ongoing impact of the development of Academies and on the free schools on the relationship with the LADO and interface with safeguarding arrangements in respect of ongoing management of allegations.*
   This has been kept on the agenda and the LADO has now visited a number of Academies and spoken with others by telephone to build working relationships.

10. *Updating procedures and policy to reflect the new Disclosure and Barring Service (DBS).*
    New DBS procedures now form part of LADO consideration and recommendations for referral at meetings; this will be included in any future policy and procedure review.

**2013-14 LADO contacts detailed information**

| Total 239 contacts | Figures | Percentage | From last year |
|---|---|---|---|
| Education | 97 | 41% | 32 (49% +) |
| Foster Care | 37 | 15% | 2 (5% -) |
| Early Years | 17 | 7% | 10 (142% +) |
| Residential | 26 | 11% | 4 (18% +) |
| Health | 11 | 5% | 5 (125% +) |
| Faith | 11 | 5% | 6 (120% +) |
| Social Care | 11 | 5% | 8 (266% +) |
| Transport | 9 | 4% | 9 (50% -) |
| Other | 16 | 7% | 1 (6% -) |

**Chart 1: Breakdown of contacts to employment type received 2013/14.**

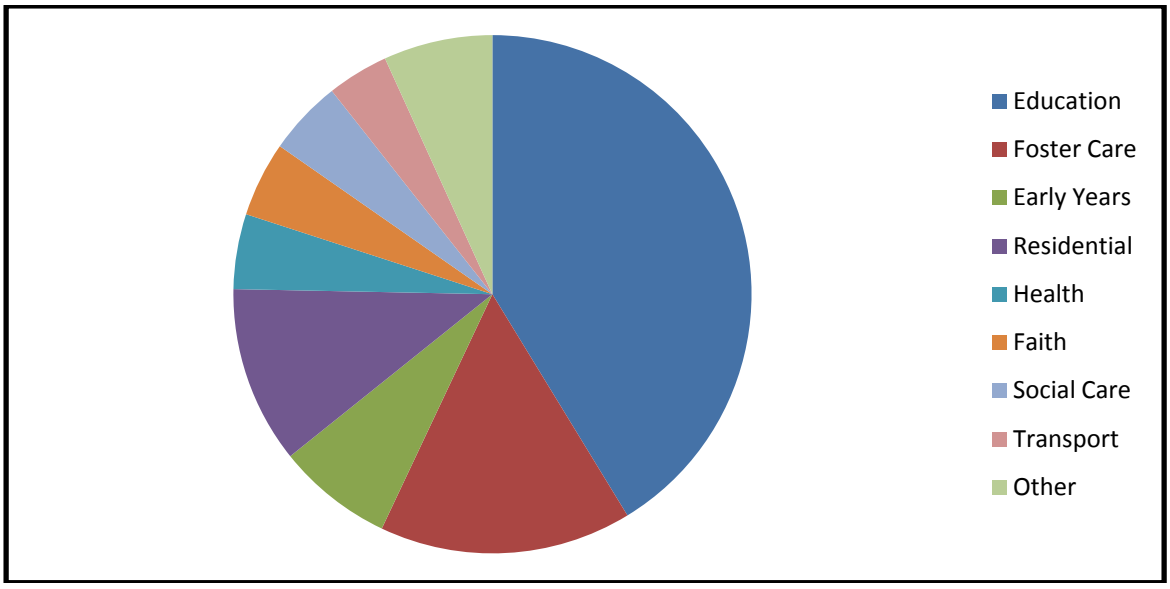



**Chart 2: Breakdown of contacts to employment type received 2012/13 in Pie Chart format.**

**Chart 3 Nature of allegations**

| Abuse | Contacts | Meetings | % of contacts gone to meetings |
|---|---|---|---|
| Sexual | 30 | 7 | 23% |
| Physical | 120 | 46 | 38% |
| Emotional | 36 | 8 | 22% |
| Neglect | 53 | 7 | 13% |
| Total | 239 | 67 | 28% |

**Chart 4: Breakdown of setting type of allegations received as a contact and then progressing to a meeting.**

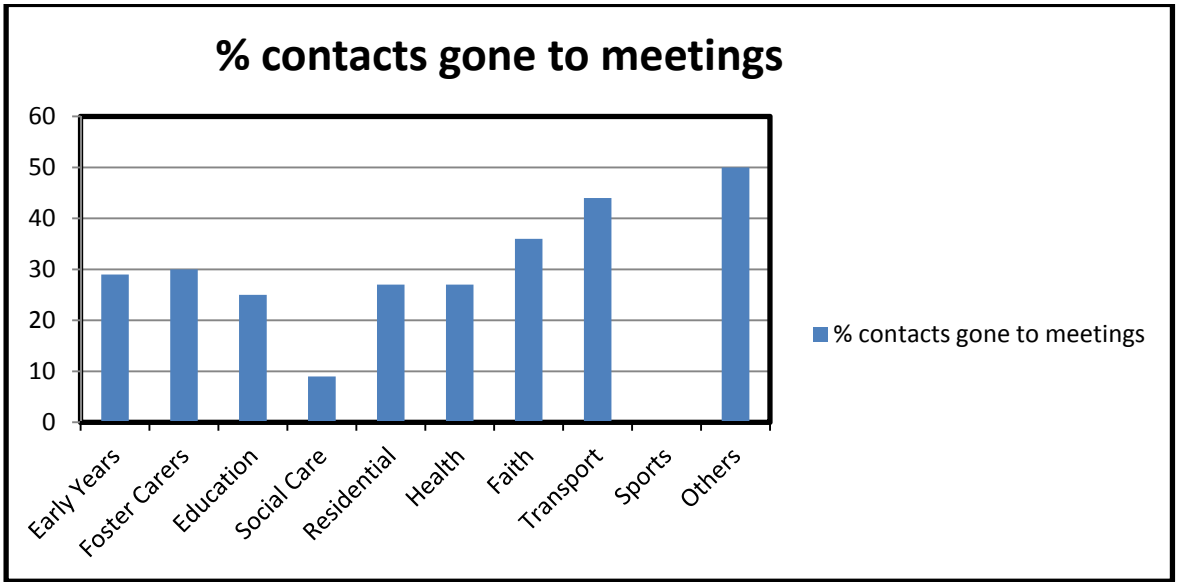



**Chart 5: The percentage of referrals in each setting progressing to Position of Trust meetings**

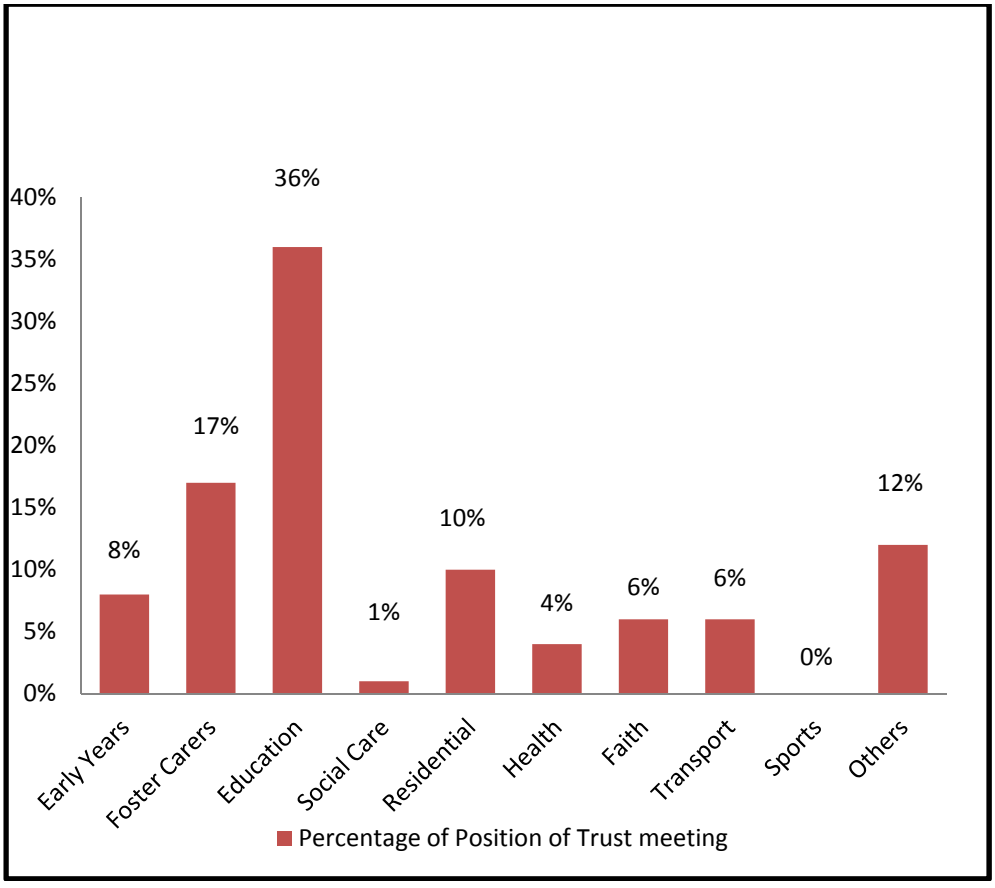


**Chart 6: The percentage share by setting of cases that progressed to Position of Trust meetings**

***OUTCOME OF ALLEGATIONS***

| Outcome of allegations | | | | |
|---|---|---|---|---|
| Outcome of allegations | Contact | Percentage | Meetings | Percentage |
| No further action. | 143 | 60% | 1 | 2% |
| Unsubstantiated | 34 | 14% | 35 | 53% |
| Employer Action | 3 | 1% | 2 | 3% |
| Substantiated | 11 | 5% | 12 | 17% |
| Malicious | 2 | 1% | 1 | 2% |
| Information only | 28 | 11% | 0 | 0% |
| Ongoing | 7 | 3% | 6 | 9% |
| Unfounded/False allegation. | 11 | 5% | 10 | 14% |

**Chart 7: Breakdown of outcomes for contacts and meetings in figures and percentages**

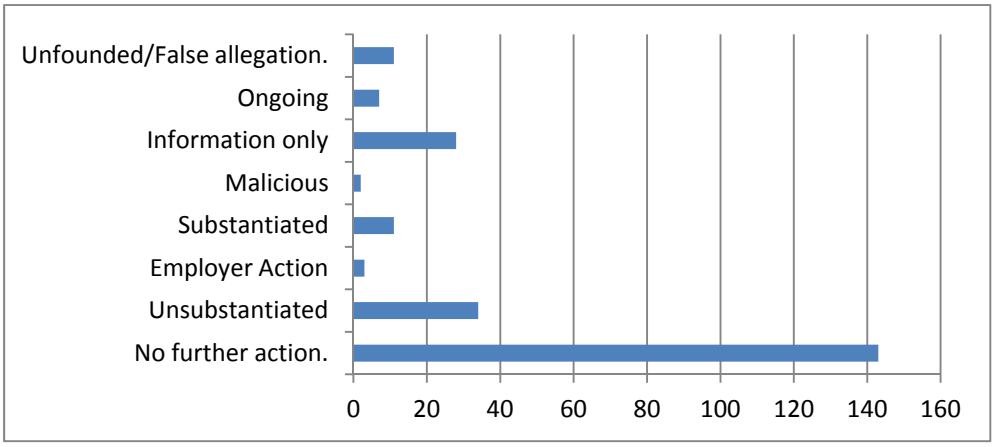
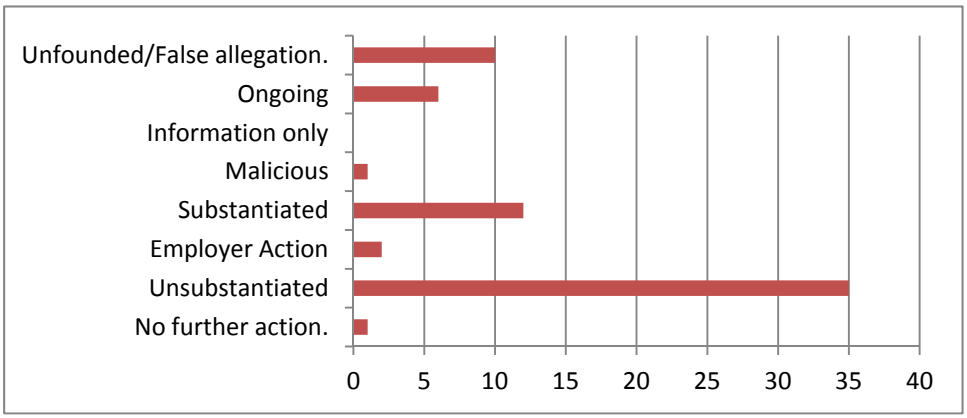



**Chart 8: Bar chart of outcome relating to contacts progressing to Position of Trust meetings**



**Analysis and Actions:**

a. There is an ongoing trend of increasing enquiries/referrals to the LADO. There are a number of factors that could be influencing this increase including the impact of the Walsall Safeguarding Children Board Training Programme relating to relevant guidance and procedures. Courses to raise awareness of the allegation process and the LADO role have taken place throughout 2013 and 2014. Further there has been the appointment of a permanent LADO in January 2014 who has undertaken further work to raise awareness in the final months of this reporting period building on the work of interim LADOs previously. Due to changes in LADO personnel there may be (by changing LADO personnel) small differences in interpretation of what constitutes a LADO enquiry which may have had a small impact on the recorded number of referrals.

b. 72% of initial POT meetings were held within the target five days of initial referral. The average amount of days for an initial POT meeting was 5.75 days. There is no previous comparable data but this demonstrates that the target is achieved in a majority of cases. A small number of cases with longer delays have pushed this average up. Various factors can lead to delay and these are monitored and addressed on a case by case basis. Often it is to ensure that there is appropriate attendance and cases would still be managed in the interim. It would be anticipated that performance against this standard can be improved.

c. Continuing the trend identified in last year's report, physical abuse is by far the biggest category of abuse leading to a referral to LADO and is more likely to progress to a POT meeting. These allegations are perhaps the easiest to identify and for young people to disclose, further it may illustrate that the type of abuse/allegation most common in settings is physical abuse. There has been an increase in the percentage of neglect cases leading to POT meetings up from only 6% to 13% which may indicate that these cases are being better identified and progressed.

d. Despite a significant increase in the number of referrals to LADO there has actually been a decrease in the number of referrals that have progressed to POT meetings (64 referrals down from 75). This represents 27% of referrals progressing to POT meetings in 2013-14 as opposed to 39% in 2012-13. The increase in referrals but reduction in proportion of those requiring meetings may in part be due to increased awareness but referrals not meeting the criteria, illustrating the need for further embedding of procedures. However, the LADO role is, to a large extent, one of advice and guidance and the increase in referrals may indicate the increasing use of the role in this way which is encouraging. The reduction in the total number of cases progressing to meetings could be as a result of changes in LADO personnel adopting a different approach with more emphasis placed on initial evaluation and management of enquiries by the employer in conjunction with the LADO which can ensure a

speedier and more proportionate response. This approach is in line with Safeguarding Children in Education guidance issued in 2014.

e. The Education sector remains the biggest source of referrals which is perhaps to be expected given the levels of contact with children and the usually well established pathways for referring concerns. There has been an increase in referrals from last year although not to same extent as other settings which may illustrate that the processes are becoming more embedded. It is important to highlight that these figures pertain to teaching and non teaching staff, this will include caretakers and lunchtime supervisors. All contact that is received in relation to education is discussed with education safeguarding advisors who can offer advice and respond to any concerns or trends. They are invited to, and attend, the majority of POT meetings relating to referrals in the education sector.

f. Allegations against foster carers accounted for 15% of referrals to LADO in 2013-14, in 2012-13 this was 21%, and the total number of referrals has fallen slightly. This figure includes allegations against carers provided by independent fostering agencies. However, 30% have progressed to POT meetings as opposed to 20% last year. This is opposite to the trend for other sectors where there was an increase in referrals but fewer contacts were progressing to meetings. This may indicate that there was a higher proportion of more concerning referrals but that they were being appropriately made.

g. The biggest percentage decrease in referrals has been with regard to transport staff working with children. In 2012-3 there had been 18 referrals (9% of total) accounting for 20% of cases going to POT meetings. In 2013-14 this dropped to 9 referrals (3% of total) accounting for 6% of meetings. There are a number of reasons that this figure may have gone down including increased support to, and engagement with, operators and better communication between, operators, schools and the local authority. Operators show signs of having developed a more professional approach and better understanding of the needs of vulnerable children.

h. There has been a significant increase in referrals from Early Years up from 7 to 17 although the percentage share in terms of total enquiries has risen only slightly. However, it is an encouraging trend that awareness and training appears to be beginning to have an impact. This is likely to have been assisted by the appointment of an early years safeguarding advisor.

i. There have also been increases in referrals from health settings although as a percentage share of total referrals these have risen only slightly. Again increased awareness would appear to be impacting these figures.

j. A more significant increase can be seen in Social Care referrals although the numbers are still small (up from 3 referrals in 2012-13 to 11 in 2013-14) and are

only 5% of the total. This figure includes social workers but also those working within youth settings within the Local Authority.

k. The residential sector has shown a small increase in referrals and is the third highest sector. Given the nature of the setting it would be expected that there would be a significant number of referrals. Referral pathways within this sector would appear to be good.

l. In 2013-14 there have been a number of referrals relating to physical abuse within mosques and madrassas which account for the majority of referrals in the faith sector. These cases have proved difficult to manage, as often children and parents will not pursue complaints after an initial disclosure and it has proved difficult to pursue action against individuals. A similar experience has been reported by LADOs at local and national network meetings. The Walsall LADO has liaised with Community Safety and advised on a new Masjid child protection policy and will continue to work with faith groups to embed this to ensure children in these settings are kept safe and that any allegations against those who work in positions of trust are reported and effectively investigated. None of these allegations have been raised by workers within the setting itself but have been raised by children making complaints to others elsewhere, often at school. It is encouraging that children can make complaints to trusted professionals, but this indicates that further work is needed to engage faith settings directly and open up communication of concerns.

m. The increasing amount of private child care providers, private tuition etc continues to be a challenge as, along with other settings such as faith settings, there is often a lack of a formal 'employer' or human resources support and legal advice for these settings to access when dealing with allegations. There can also be a lack of knowledge of the working process involved in relation to issues pertaining to people that work in a position of trust with children and young people. It has further been identified that when staff, particularly in education, are effectively 'self employed' and placed through an agency there are fewer options to address concerns or investigate if there is no ongoing police investigation.

n. As was the case in 2012-13 there have been very few contacts/referrals in relation to Sports, Health, and Police employment sectors in 2013-14. This is an area for further development. There has been work to raise awareness and build relationships in these sectors and this will be ongoing. However, it is likely that due the nature of the settings and contact with children these may remain smaller than other settings. However, sports settings have contact with children more than any setting other than education and this number does, therefore, appear low.

o. When looking at types of outcome that have been recorded at POT meetings the biggest change has been where 'Employer Action' has been recorded which has

shown a marked decrease from 2012-13. This may indicate changes in recording where outcomes relating to the allegation being substantiated or not are more likely to be recorded. This will require ongoing review. The number of unsubstantiated allegations has increased particularly when cases have gone to POT meetings (up to 53% from 32%). As there has not been a corresponding fall in substantiated allegations (which has also risen albeit only slightly) it may be that this option is being more frequently recorded so that a decision on the allegation is reached. Very often with unsubstantiated allegations further employer action is required and it may be that this figure reflects a different approach to categorisation instead of the use of 'Employer Action'. The LADO will review and attempt to ensure there is consistency in the understanding of the use of these categories.

p. The number of substantiated allegations when a case has progressed to a meeting has remained fairly stable. However, it is important that where there is sufficient concern matters are fully investigated, the low number does not mean that the concerns in many cases were unwarranted. Frequently there is not enough evidence to substantiate an allegation, often being one person's word against another. The process, however, allows for learning and identifying any action that can be taken to improve practice and better protect children as well as adults from further allegations. Further the recording of the event allows for monitoring trends and alerts to any similar concerns or allegations which can be considered in the light of any previous concerns.

q. There remains only a relatively small number of allegations that are recorded as being unfounded or false (whereby it is felt that there is no foundation to the allegation) in some cases this may not be because the 'allegation' is unfounded but that, upon consideration, it did not amount to harm or risk of harm to a child, there is an even smaller number whereby the allegation is regarded as malicious.

**Recommendations and actions**

In the year 2014-15 the LADO will:

- Review and update relevant procedures in light of new guidance (DBS, Working Together 2013, Keeping Children Safe in Education).
- Continue efforts to establish and cement relationships with sports, faith and health settings. To include training, workshops, briefings, attendance at events, visits to settings and meetings with key personnel.
- Develop more effective quality assurance and reporting systems regarding LADO functions following improvements in the recording and gathering of data. This will include better understanding the appropriateness of referrals and quality assurance of those not reaching POT meetings to ensure that there is an effective response.

- Support the implementation of the Masjid Child Safeguarding policy including visits to specific settings and contribution to events organised in the coming year.
- Liaise with Walsall Children's Safeguarding Board with regard to the further development of the website.
- Consider the best methods for sharing learning amongst key teams and agencies.

**/Continued .....Financial Matters.**

# FINANCIAL MATTERS

**Accountant: Lynn Harvey**

## 1. Purpose

This report provides a breakdown of the year end financial position for the Walsall Safeguarding Children Board for 2013-14.

## 2. Financial Year 2013-14

### 2.1 Budget 2013-14

The expenditure budget for the WSCB in 2013-14 is detailed below. It was made up from three separate contributions.

| | |
|---|---|
| LA Funding | £111,945 |
| Partner Income Target* | £76,184 |
| Carry Forward of CWDC Munro Funding** | £7,875 |
| | **£196,004** |

* Partner Income target represents the target partner contributions and training income required based on 2013-14 spending plan. Please see section 2.3 for breakdown of actual contributions received and shortfall in 2013-14.

** In 2011-12 we received funding from the now defunct CWDC to implement findings from the Munro report. We carried £26,585 forward into 2012-13 where it funded work done by Review and Child Protection Co-ordinator from September 2012 to March 2013. The remaining £7,875 was carried forward into 2013-14.

### 2.2 Actual Expenditure 2013-14

Below is a breakdown of expenditure for the board and its related activities within 2013-14.

| | | Notes |
|---|---|---|
| **Employees** | | |
| WSCB Board Manager | £22,653 | (1) |
| WSCB Business Manager (Agency) | £25,702 | (2) |
| WSCB Training & Development Officer | £42,360 | |
| Admin Assistant | £25,746 | |
| CDOP Co-ordinator | £13,459 | (3) |
| Staff Travel | £816 | |
| | **£130,736** | |

**Other Costs**

| | |
|---|---|
| Independent Chair of the Board | £47,450 |
| Serious Case Reviews | £29,855 |
| Tri-X - Update for procedures manual | £3,000 |
| Section 11 Audit Tool | £3,000 |
| Catering Staff Workshop | £84 |
| Mobile Phone recharges | £516 |
| IT expenses | £2,681 |
| (Over) / Under achievement of income | £514 |
| | **£87,100** |
| Total Spend | **£217,836** |

From this we can identify an over spend on budget for 2013-14 of **£21,832**.

Notes

(1) The WSCB Board Manager was vacant from April to October 2013 and was appointed to on 21st October 2013.

(2) Due to vacant Board Manager, agency worker was in place from the start of the year to June 2013.

(3) The CDOP Co-ordinator is part funded by Wolverhampton City Council. The above costs are showing Walsall LA funded part of the post only.

## 2.3 Performance against income targets

Within the budget there was a target for income contributions of £76,184 for 2013-14. The Safeguarding Board aims to achieve this through annual partner contributions and income generated through training. We under achieved on our income targets for 2013-14 by £514.

**Annual Contributions**

| Partner | Description | Value |
|---|---|---|
| | | |
| Walsall Healthcare NHS Trust | Contribution towards the WSCB agenda for the financial year 2013-2014 | £5,000.00 |
| Staffordshire & West Midlands Probation | Contribution to WSCB from Staffordshire and West Midlands Probation Trust for financial year 2013-2014 | £3,000.00 |
| West Midlands Police Authority | Financial contribution to WSCB for financial year 2013-2014 | £15,020.00 |
| Education | Contribution to Safeguarding Board 2013-14 | £10,000.00 |
| CAFCASS | Contribution to Safeguarding Board 2013-14 | £550.00 |
| CCG | Contribution to Safeguarding Board 2013-14 | £35,000.00 |
| | | |
| | | **£68,570.00** |
| | | |

**Training Income**

| Partner | Description | Value |
|---|---|---|
| | | |
| Training Income | Including Non attendance income | **£7,100.00** |
| | | |

| | |
|---|---|
| Total income in year | **-£75,670.00** |
| Income target | **-£76,184.00** |
| Under achievement of income | **£514.00** |

**Comment from WSCB Chair: Robert Lake**

As shown above, the WSCB's budget is made up of contributions from each of the main statutory agencies represented on the Board. The major contribution comes from the Walsall Borough Council through the provision of Board support staff, accommodation etc. Arguably, the Council's share is disproportionately high and, in common with all agencies, pressures on budgets generally mean that the level of contribution from the Council and from the other agencies will be difficult to maintain. The Board does all that it can to control and even reduce spending but with new

demands being made (for example, the recommended creation of a Coordinator for the CSE work and the need for a statistical analyst) it is a challenge to work together to achieve better outcomes for children with less or even the same income.

On a point of detail, the fact that the 2013/14 was overspent is not least due to the significant costs associated with the preparation of the W3 Serious Case Overview Report. While each agency makes a contribution to the preparation of SCR's through staff time, especially the independent management reviews and representation at SCR Panels, the considerable costs for the Independent Care Reviewer tend to fall to the local authority. Going forward, we need to spread this load, either in cash or in kind, across all the WSCB member agencies.

**/Continued.....Board Attendance.**

# BOARD ATTENDANCE 2013/14

| Board Attendance April 2013-End March 2014 | | | | |
|---|---|---|---|---|
| **Agency** | **First Name** | **Surname** | **Title** | **% Attendance by Agency** |
| **Independent** | | | | |
| | Robert | Lake | Independent Chair | **100%** |
| **Lead Member (Participating Observer)** | | | | |
| | Councillor | Andrew | Councillor (CS)/Lead member | **63%** |
| **WMBC Children's Services** | | | | |
| | Rose | Collinson | Interim Executive Director (CS) | **100%** |
| | Sue | Butcher | Interim Assistant Director (Specialist CS) | **75%** |
| **WMBC Targeted and Prevention Services** | | | | |
| | Alan | Michell | Head of Service - IYPSS (YOS) | **100%** |
| | Varies | | Young People's Representative | **50%** |
| **NHS Walsall (now Clinical Commissioning Group)** | | | | |
| | Sally | Roberts | Walsall CCG Lead Nurse | **100%** |
| | Amanda | Viggers | Designated Nurse for Safeguarding Children Walsall Clinical Commissioning Group | **100%** |
| Walsall Healthcare NHS Trust | | | | |
| | Sue | Hartley | Director of Nursing | **100%** |
| Staffordshire and West Midlands Probation | | | | |
| | Jamie-Ann | Edwards | Head of Walsall Probation | **75%** |
| **Schools** | | | | |
| | Keith | Whittlestone | Head Teacher - Secondary | |
| | Lynne | Cherry | Head Teacher - Primary | **38%** |
| **West Midlands Police** | | | | |
| | Jenny | Skyrme | Temporary DCI | **100%** |
| **Walsall College** | | | | |
| | June | Morrow | Director of Student Journey | **100%** |
| **CAFCASS** | | | | |
| | Martin | Banks | Service Manager | **63%** |
| **Lay Members** | | | | |

| | | | | |
|---|---|---|---|---|
| | Clair | Johnson | Lay Advisors | |
| | Azra | Bibi | Lay Advisors | **38%** |
| **DWMHPT** | | | | |
| | Rosie | Musson | Head of Quality and Innovation | **63%** |
| **WMBC Adults Services** | | | | |
| | Suzanne | Joyner | Head of Community Care | **(new member Nov 13) 20%** |
| **Public Health** | | | | |
| | Isabel | Gillis | Director - Public Health | **75%** |
| **CDOP** | | | | |
| | Manjeet | Garcha | Chair of CDOP | **(New member Sept 13) 33%** |
| **NHS England** | | | | |
| | Fay | Baillie | Director of Nursing for Birmingham, Solihull and the Black Country Area Team | **(New member July 13) 29%** |

**/Continued .....Chair's Concluding Remarks**

# CHAIR'S CONCLUDING REMARKS AND A LOOK FORWARD INTO 2014/15

For the WSCB, 2013/14 was a year of development in terms of our self awareness, governance, structures and partnership working. By the end of the period we were far better placed to ensure that all relevant agencies in Walsall are working together to safeguard children and young people, to coordinate and monitor that work and to hold each other to account for the effectiveness of our individual agency work and of inter-agency, partnership arrangements.

My thanks to all Board members and their support staff and, indeed, to the Board's own support staff for a year of hard and committed work. This really is a partnership in which all can make an equal and vital difference for the Borough's children and young people. As I said in the introduction to this report *there can be no greater responsibility than working to ensure the safety and protection of children and young people.* I believe that the WSCB is now able to exercise that responsibility effectively.

But, we will not be resting on our laurels. Indeed, in July 2014, we undertook a major self evaluation exercise with particular reference to:

- The Ofsted single inspection framework;
- Findings from Ofsted inspections of Walsall's child protection and early help services during 2013/14;
- The requirements set out in the 2012 DfE Improvement Notice;
- Learning from local and national serious case reviews.

This self-assessment was influenced by the Board's development during 2013/14 and provided a key point of reference for identifying priorities and focusing our activity and resources going forward. It is recognised that this is a snapshot at a particular point in time and that self-assessment will need to be a continuously developing process which will build on the evidence-base and template for this piece of work.

The main findings were as follows:

**Our Strengths**

| **Engagement from strategic partners is good** |
|---|
| • There is significant improvement in attendance by partners who are actively engaged in delivery-focused board and committee arrangements<br><br>• Linkage between committees and the board is improving to ensure that key actions are followed-up and delivered<br><br>• Protocols are in place to align the WSCB with the Children and Young People's Strategic Partnership and the Health and Wellbeing Board |

| A well-established Learning & Improvement Framework is being delivered |
| --- |
| • The board maintains a rigorous focus on delivery of the Learning & Improvement Framework across the partnership<br>• A WSCB website has been launched to enable easier access to information and resources<br>• Feedback on the quality of training is swiftly incorporated into planning and delivery to ensure that training is relevant and effective |

| Key policies and procedures are in place and regularly reviewed |
| --- |
| • Committee arrangements support the board in ensuring regular review and challenge of partnership safeguarding policy and procedures<br>• A schedule of all critical safeguarding policies is in place ensuring that all policy is actively reviewed, changes implemented and quality assured |

| The WSCB undertakes regular reviews of it's effectiveness and impact |
| --- |
| • Outcomes of 6-monthly reviews inform WSCB approach and are reported to partners<br>• The board has introduced a self-assessment tool - linked to the Ofsted review criteria<br>• The board has completed the migration of key priorities from the Improvement Plan and is well-positioned to drive forward improvements to safeguarding and child protection in Walsall |

| Learning from national & local SCR's, management reviews and reviews of child deaths is swiftly incorporated into local policy & practice |
| --- |
| • Local and national SCR outcomes, management reviews and reviews of child deaths form substantive board and committee agenda items, with outcomes and decisions clearly recorded and actions progressed<br>• The Child Sexual Exploitation and Missing Children Committee provides a sharp focus on this priority group of vulnerable children and young people<br>• Information sharing between partners is improving, reflecting learning from national and local experience |

## Our Improvement Priorities

| **Further evidence influence and impact of the WSCB and the partnership** |
|---|
| • Increase the pace and extent of ongoing review and challenge of the WSCB and the partnership<br>• Further strengthen performance management and quality assurance arrangements with the assistance of the Quality Assurance & Performance Committee<br>• Improve arrangements for evidencing impact on outcomes for children and young people |

| **Embed the transfer of priority objectives and accountabilities from the Improvement Board** |
|---|
| • Strengthen the use of timely and accurate data to inform decision-making<br>• Appoint a dedicated data analyst post and engage with strategic data leads from across the partnership to further improve information sharing<br>• Drive-forward systematic action and enquiry based on robust information |

| **Implement a multi-agency case file audit process** |
|---|
| • Ensure learning is swiftly applied across partner agencies from the rolling programme of thematic multi-agency case file audits across partner agencies<br>• Review and develop the Learning & Improvement framework to reflect ongoing learning from the audit programme<br>• Embed a culture of robust support and challenge between partners, building on the learning from multi-agency case file audits |

| Support partners to implement multi-agency thresholds and information sharing protocols |
|---|
| • Actively support partners to implement threshold arrangements across the safeguarding and child protection system<br>• Work with partners to understand and apply best practice in information sharing<br>• Strengthen the understanding, engagement of all key partners in the development and delivery of safeguarding and child protection services |

| Agree a rigorous and focused work programme |
|---|
| • Undertake a deep-dive review on arrangements for supporting children and young people placed outside of the authority<br>• Take a strong lead on driving forward work across the partnership to strengthen the voice and influence of children and young people<br>• Strengthen links with the Corporate Parenting Board to align and support action to improve outcomes for looked after children |

**Clearly, there is much work for the WSCB to do but in 2013/14 we made a good start in achieving our Partnership objective of being "Better Together for Children".**

Robert Lake
Independent Chair
1st September, 2014.