Tri-borough Local Safeguarding Children Board

Annual Report 2013/14 for Hammersmith & Fulham, Kensington and Chelsea, and Westminster

Foreword

This is the second report of the work of the local multi-agency arrangements for safeguarding and promoting the welfare of children and young people across the areas of Hammersmith and Fulham, Kensington and Chelsea and Westminster. The Local Safeguarding Children Board was established as a tri-borough board in April 2012. This report covers the period April 2013 to March 2014.

The LSCB is a statutory body and partnership. It is responsible collectively, as a Board, for the strategic oversight of child safeguarding arrangements by all agencies. It does this by leading, coordinating, developing, challenging and monitoring the delivery of effective safeguarding practice by all agencies across the tri-borough areas. Whilst it is not responsible or accountable, as a Board, for *delivering* child protection services, the LSCB does need to know whether or not systems are working well in each of the agencies so that children and young people are safe and that the services are delivered in a way that makes a positive difference to their lives. That is why it is so important that we continue to build on the mechanisms we established last year to consult and engage with children and young people on the difference services are making.

Members of the Board are very senior managers in each of the statutory and other agencies represented on the Board. There are also four lay members of the Board. I am an independent Chair of the Board and this is my second year in this role. One of the Board's strengths is the commitment and engagement of each of the agencies and the open and honest participation of senior people in the Board's work. All members of the Board want to make sure there are better outcomes for children and young people from both single-agency and multi-agency work; they understand that this will require change and challenge as well as commitment and a continued investment in best practice by front-line staff.

In the conclusion of this annual report you can read about many of the strengths and achievements from the last year. You will also see that there are many areas where we can do even better. The LSCB wants to make sure that the' journey' children and young people take is a safe one and one that equips them well for adulthood. That is why in the next year we will work with other partnership groups so that "safeguarding is everyone's business".

This is a busy LSCB, covering a large and diverse part of London. There are many opportunities for children to thrive and do well and many chances for young lives to be badly affected by circumstances and abusive relationships. The role that front-line work plays in intervening and mediating must be timely and focussed on securing positive outcomes for children. The LSCB takes very seriously learning from case-work, ensuring there is strong management oversight and that there is accountability at all levels for work with children.

So whilst the LSCB is a strategic body, the operational work undertaken by all agencies, singly and together, must deliver on our ambitions for children and young people across the three boroughs. Whilst we focus on early help, child protection and looked after children, we will continue to prioritise an outward focus on learning from others and anticipating key areas for improvement as we develop and deliver on safeguarding in 2014/15.

Jean Daintith
Independent Chair

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Executive summary

This is the second annual review of the effectiveness of the Tri-borough Local Safeguarding Children Board (LSCB) for Hammersmith & Fulham, Kensington and Chelsea, and Westminster.

Working Together 2013 requires each LSCB to publish an annual report on the effectiveness of safeguarding and the promotion of the welfare of children in the local area. The report recognises the achievements and progress that has been made in the three boroughs as well as providing a realistic assessment of the challenges that remain.

The role and scope of the Tri-borough LSCB is considerable. Agencies working with children and families across the three boroughs work well together and have made significant developments to strengthen local safeguarding practice. Key achievements from 2013/14 include:

The publication of the Threshold Guidance and a Local Assessment Protocol, for staff in all agencies working with children, to assist in decision making about how to help families with different levels of need.

The roll out of the Multi-Agency Safeguarding Hub (MASH) across all three boroughs to help improve decision making at the point of referral, through rapid and rigorous information sharing.

Improved multi-agency response to children at risk of sexual exploitation through the development of a Child Sexual Exploitation (CSE) strategy – setting out how agencies will work together – and the introduction of the Multi-Agency Sexual Exploitation (MASE) panel which provides a strategic overview of cases and quality assurance in respect of investigations, case work, and outcomes for children.

Strengthening of local safeguarding networks, including better links with voluntary and community sector, through the three local Partnership groups.

Establishment of Section 11 panel which has promoted improved standards of safeguarding within partner agencies.

Development of the LSCB's training program that includes E learning and new specialist courses, based on local priorities and need.

The publication of a regular LSCB Newsletter which is promoted across all agencies.

The strengthening of the LSCB's relationship with the community, faith and voluntary sector and specific work on areas such as female genital mutilation and translating services.

Young people contributing more significantly to the safeguarding work of the Borough.

Areas for development, or where progress is not as good as the LSCB would want it to be, are highlighted throughout the document and summarised in section 14. Going forward into 2014/15 the Board has agreed that neglect is a cross-cutting theme that needs to be highlighted across all the other priorities. Responding to national issues at a local level, such as female genital mutilation, will also be high on the LSCB's agenda as will getting the local multi-agency response right regarding child sexual exploitation, gangs, missing young people, and suicide risk.

1. Introduction

1.1 This is the second annual review of the effectiveness of the Tri-borough Local Safeguarding Children Board (LSCB) for Hammersmith & Fulham, Kensington and Chelsea, and Westminster.

1.2 Working Together 2013 requires each LSCB to publish an annual report on the effectiveness of safeguarding and the promotion of the welfare of children in the local area. The report will be publically available and submitted to the Chief Executive and Leader of the three local authorities, the local Police and Crime Commissioner and the chairs of the three borough's Health and Wellbeing Boards.

1.3 The annual report should:

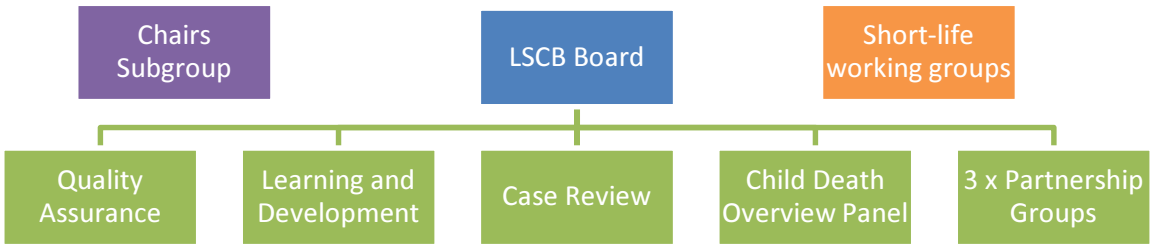
- Provide an assessment of the effectiveness of local arrangements to safeguard and promote the welfare of children;
- Recognise the achievements and progress that has been made in the three boroughs as well as providing a realistic assessment of the challenges that remain;
- Demonstrate the extent to which the functions of the LSCB are being effectively discharged
- Include a clear account of progress that has been made in implementing actions from individual Serious Case Reviews.

1.4 In order to establish the effectiveness of local safeguarding arrangements, and of the LSCB itself, the report will evaluate the standing work of the Board – such as training, case reviews, and Child Death Overview Panel – and the safeguarding of priority groups. It will also measure progress against the LSCB priorities for 2013/14 as set out in its Business Plan.

2. Background and Context

2.1 The three local authority children's services within the London Borough of Hammersmith & Fulham (LBHF), Royal Borough of Kensington and Chelsea (RBKC) and the City of Westminster created a Tri-borough Children's Service in 2012 under one Director of Children's Services. This led to the formation of a single LSCB in April 2012. This report therefore looks at safeguarding practice across all agencies in the three boroughs.

2.2 The Board is chaired by the Independent Chair of the LSCB and meets four times a year. The Board includes a range of local agencies which are outlined in Appendix A. In addition to the quarterly meetings, the Board has two half-day development sessions or extra-ordinary meetings and holds special events for members' learning from case reviews. Much of the business of the Board is taken forward by its subgroups which meet between Board meetings. Each borough also retains a partnership group which has an important role in channeling issues up to, and disseminating messages from, the main Board.



2.3 In addition to the standing subgroups the LSCB create short-life improvement groups which consider specific issues of concern to agencies; in 2013/14 the LSCB managed two groups on children missing from home and care and prevention of suicide amongst young people.

2.4 The Board, and the wider work of the LSCB, is supported by a small team lead by the LSCB Manager. The team includes a business support function, Training Officer, and two recently recruited Community Development workers. The LSCB outturn figures for 2013/14 are provided in appendix B. These indicate the financial contributions received from partner agencies and detail the reserves carried forward from the former three borough-based Boards. The expenditure, largely relating to salary costs is shown for 2013/14.

2.5 The LSCB manages its work through its annual Business Plan. The Business Plan is structured around four themes: early help and prevention of harm; better outcomes for children subject to child protection plans and those looked after; practice areas to

compare, contrast and improve together; and continuous improvement in a changing landscape. Priorities for action by the LSCB are informed by the continuous review of performance information and case review, local issues and practice, and emerging regional and national priorities, and agreed through dialogue with all agencies.

2.6 This annual review captures the work of the Tri-borough LSCB in its second year of operation. As the LSCB has continued to established itself as a Tri-borough board, further children's services have been merged across the three boroughs, such as those for Looked After Children. The LSCB has ensured that partners can continue to focus on specific local issues through the borough-based partnership groups whilst retaining oversight.

2.7 The LSCB serves children across three boroughs located in the centre of London where there is a diverse population with extremes of poverty and wealth.

- Between the 2001 and the 2011 Census the population of Hammersmith & Fulham and Westminster has risen. The population of Kensington and Chelsea has declined. The population is LBHF: 182,500 (+10%), RBKC: 158,600 (-0.2%), WCC: 219,400 (+21%).
- Kensington & Chelsea is the country's second most densely populated area (Islington is the most densely populated) Hammersmith & Fulham is sixth and Westminster is seventh.
- The population turnover (churn) is high in all three boroughs: Westminster is the highest in London, Hammersmith and Fulham is the fourth and Kensington and Chelsea is the sixth.
- In Hammersmith & Fulham 20% of the population are aged 0 to 19 years, 19% in Kensington and Chelsea and Westminster.
- An estimated 86,600 children under 16 in the tri-borough: LBHF (+9%), RBKC (-2%), WCC (+33%).
- 23% of all households in LBHF contain dependent children; 19.5% in RBKC and 19% in WCC.
- 15,000 (46%) children in LBHF are from Black and Minority Ethnic (BAME) group; 10,300 (38%) in RBKC and 20,500 (57%) in WCC.
- WCC has seen a 73% increase in the non-Christian under 16s population; 41% in LBHF and 2% in RBKC.
- 17% of LBHF children have other (non-British) national identities; 28% in RBKC and 23% in WCC.
- Foreign-born children made up 14% of all children in LBHF; 21% in RBKC and 19% in WCC.
- All three boroughs have a higher percentage of lone parents not in employment than national (40.5%) and London (47.8%) rates with Westminster ranked second highest nationally (Tower Hamlets has the highest percentage)

2.8 As at the 31 March 2014, across the three boroughs there were:

- 354 children subject to child protection plans. 163 were in Hammersmith and Fulham, 92 in Kensington and Chelsea and 99 in Westminster. Compared with previous years this is a reduction in numbers.
- 476 Children were in Care across the three boroughs. Hammersmith and Fulham (204), Kensington and Chelsea (99), Westminster (178).
- 400 Children became subject to a child protection plan across the three boroughs during 2013-14. Hammersmith and Fulham (195), Westminster (106) and Kensington and Chelsea (99).
- 5,751 referrals were received across the three boroughs Hammersmith and Fulham (1,801), Westminster (2,342) and Kensington and Chelsea (1,808).

2.9 A Tri-borough LSCB works well for partners, in particular Health agencies, who report favourably on the Tri-borough arrangements; in particular in reducing the duplication of senior managers having to attend three different LSCBs. This has also had a positive impact on attendance and strength of input. It is more problematic for the Police at the level of Borough Command and the challenge of this is significant, especially as there have been changes in personnel during the past year. However, for the Metropolitan Police Child Abuse Investigation Team (CAIT) it is an advantage to attend only one LSCB rather than three, especially as the same CAIT covers seven boroughs.

2.10 As a Tri-borough LSCB there is a significant advantage in having best practice, learning and resources from the three boroughs shared across agencies. Three geographically small boroughs would be challenged in having the resources to run three boards with the attendant costs of having specialist posts to take forward some of the work of the Board. For example, it is probable that three single LSCBs would not have the funding to support the part-time development workers for faith and voluntary sector, and children and young people's participation.

3. Governance & Accountability

3.1 The Tri-borough Local Safeguarding Children Board was established in April 2012, so this review accounts for the work of the Board in its second year of operation. Governance arrangements continue to be embedded and were given additional momentum by the publication of Working Together 2013. The guidance highlighted the need for the LSCB to revisit a number of documents that support the Board's governance arrangements. As a consequence, the Terms of Reference of the Board and its subgroups have been refreshed as well as the 'Roles and Responsibilities' of members of the Board. The effectiveness of these new arrangements should be reviewed in 2014/15.

3.2 Over the course of 2013/14 the Board utilised the newly recruited four Lay Members, a representative from Wormwood Scrubs (the local Category B men's prison in Hammersmith and Fulham), and improved the commitment from schools. The four Lay Members have brought independent thinking to the Board as well as input to sub-groups, one of the short-life working groups, the scrutiny panel for Section 11 reports and ideas for web development. Three of the Lay Members have private sector experience and one of them contributes to the community safety arrangements at a local level with the Police. This wider membership has expanded the basis for engagement of local agencies but also presents a challenge to ensure that each is able to contribute and demonstrate their impact at Board meetings.

3.3 The Board has identified the need to be more rigorous in respect of monitoring the attendance of individual agencies and their contributions. Formal arrangements to monitor attendance, at the main Board and subgroups, are being developed, so that there is more formal evidence to present to challenge partners on non-attendance. There were concerns that there was a lack of regular strategic representation at the Board from the Police and Schools. Schools now have three Headteacher representatives and the Police representative attended meetings until the end of the year when she was promoted. It is important that safeguarding is not lost with Policing models changing at a local level. At a subgroup level, the Police have had a lead role in the development of MASH and have been a significant partner in addressing concerns for Missing Children.

3.4 During 2013/14 the Board and Chair have encouraged agencies to challenge each other at the Board meeting. There are various examples of this happening – for example regarding the drop in numbers of children going onto Child Protection plans and challenge towards Health on referrals of female genital mutilation – but on more occasions the Board has questioned, rather than directly 'challenged'. To some extent, this questioning style is indicative of the close relationship between partners operating across the three small boroughs but is also a result of significant day to day challenge outside of meetings and in other informal and formal ways. However, more explicit challenge at Board level is an area for development in 2014/15, with specific actions including:

- Promoting the expectation that individual agencies will evidence where they have made a challenge and for this to be updated in a 'challenge log';
- Subgroups to ensure a robust framework of challenge to improve practice;

- Child protection chairs to evidence their challenge of agencies and how this has made a difference to effective multi-agency working;
- Safeguarding Review Unit to provide the LSCB Quality Assurance Group with data on agency participation at Child Protection Conferences, including provision of reports and attendance;
- Training Subgroup to highlight performance of agencies attendance at training and provision of trainers
- Attendance of agencies at subgroups will be more closely monitored and followed up by chairs and brought to the attention of Chair and Chairs' group.
- LSCB chair will evidence the difference she has made following conversations with senior leaders

3.5 Other opportunities for agencies to challenge partners include through the multi-agency case audits, conducted by the Quality and Assurance Subgroup, which are brought to the Board for scrutiny, and development sessions about the learning from case and serious case reviews.

3.6 The Independent Chair of the LSCB meets regularly with key leaders in the Local Authority, including the Director of Children's Services, Lead Members for Children's Services and the two Chief Executives of the councils (one for Westminster and one joint CE for Hammersmith & Fulham and Kensington and Chelsea), to ensure that the Chair is held to account for the effectiveness of the board. To ensure the robustness of these arrangements a protocol of joint working has been drafted between the LSCB and key partners and partnerships. This document, and steps to secure these arrangements, needs to be agreed by the Board at the earliest opportunity in 2014/15. Opportunities for senior officers outside of the three local authorities, to challenge the LSCB and Chair, at other agencies' board meetings have not been fully utilised. However, the recent work with the Health and Wellbeing Boards gives an impetus to mutual challenge.

3.7 A Joint Working Protocol between the LSCB and the three Boroughs' Health and Wellbeing Boards (H&WB) has also been developed; at the time of drafting this report the protocol has been agreed by Kensington and Chelsea's H&WB but not Hammersmith & Fulham's or Westminster's H&WB. This should be a priority for action. Representatives from the LSCB and H&WBs have met to discuss their respective governance arrangements, priorities and future plans and have started to work together on a H&WB priority regarding parental mental health.

3.8 Demonstrating the impact of both the LSCB and its subgroups on local safeguarding outcomes is an area that needs further work. Although there has been a strengthening of the Terms of Reference of subgroups there needs to be greater challenge of their effectiveness .The subgroups largely meet on a quarterly basis with the focus being on activities such as training ,case review and quality assurance, rather than the priorities of the LSCB .It is intended that the revision of their terms of reference will provide the opportunity for groups to be more challenging and focused on the priorities of the board and business plan.

3.9 The Business Plan for 2014/15 will also be more rigorous in setting SMART targets and specifying the intended impact and outcomes of the LSCB's work. There needs to be greater evidence of clear improvement priorities that deliver improved outcomes. This will be crucial to ensuring that the effectiveness of the board is easier to measure and partners are able to clearly articulate the value of the board.

3.10 LSCB partners should also be able to assess whether they are fulfilling their statutory responsibilities to help, protect and care for children and young people. Holding members to account is evidenced through Section 11 auditing, but this needs to have greater prominence at the whole Board meetings.

3.11 In order to secure the effective engagement of and communication with local partners, a multi-agency Partnership Group has been maintained in each of the three local authorities. The focus of these partnership groups is primarily early help/prevention of harm. Each of the partnerships are in differing stages of development and it would be useful for the chairs of the three partnerships to review the strengths and weaknesses of their groups and share learning and best practice. The chairs of LBHF and RBKC's groups should also consider adopting a clear programme of work, such as that operated in Westminster.

Hammersmith and Fulham's local partnership group was refreshed in November 2012. The group's purpose has been to raise the profile of safeguarding and welfare issues with local staff and practitioners working with children and families.

The group struggled to gain real commitment from all members, but this has improved and members now feel that the group has its own identity. In the past year the group has secured representation from the voluntary and community sector which has improved relationships and ensured their key involvement in the development of the FGM strategy and their contribution in the consideration of other important safeguarding issues i.e. domestic violence. Good engagement with the Safeguarding GP for Hammersmith & Fulham has improved local GP's understanding and response to risk issues.

The group is chaired by the Safeguarding, Review and Quality Assurance Manager for LBHF which means the agenda is often social care focused. The Chair has asked for a co-chair from another agency but this position is still vacant.

The most successful piece of work during 2013/14 for the group has been the development of a local multi-agency strategy on Female Genital Mutilation. Other areas of focus for the group during 2013/14 have been domestic violence and the impact of welfare reform.

Westminster Prevention of Harm

The Director of Family Services chairs Westminster's local partnership group titled 'Prevention of Harm'. The group has clear terms of reference and a good representation from a wide range of agencies. Each year the group sets itself a number of priorities for action which provides clarity of focus for the group. Additionally, the priorities ensure that the contribution of different agencies is clearly identified and this has in turn helped to build and sustain links between partners. The POH group has taken a lead role in developing Tri-borough initiatives around a range of safeguarding issues including early help, parental substance misuse, sexual exploitation, and work in the area of faith and culture.

During 2013/14 the Prevention of Harm partnership group focused on the following priorities: Housing and benefit changes; safeguarding across faith and cultures; parental mental health; parental substance misuse; sexual exploitation; and safeguarding in schools. All workstreams have 'smart' objectives set and are required to report on progress to the group at each meeting. The chair has plans to strengthen the robustness of the group's work by being more rigorous in specifying the outcomes that are to be achieved.

At the start of 2013/14 the chair introduced a 'what is causing you concern?' standing item on the group's agenda. This has given members an opportunity to pause, reflect and raise other issues not on the agenda if they felt that they were of concern and to probe for weaknesses in local safeguarding practice. Although many of the concerns raised are often resolved via signposting the process has raised a number of issues escalated for action by the chair and LSCB.

A key focus for **Kensington and Chelsea's local partnership** has been to understand organisational change and the impact on local safeguarding practice. During 2013/14 a number of partners have made presentations to the group including the Early Help Service, Health Services, and the Probation Service. These presentations have aided local practitioner and manager understanding of the changes and the impact on practice.

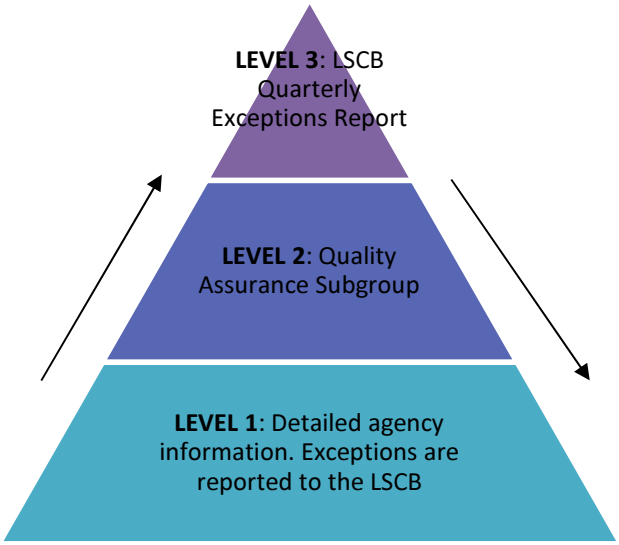
RBKC's partnership is chaired by the Joint Head of Safeguarding, Review and Quality Assurance. A constant core membership, with over ten agencies represented, has been maintained. Representation from the voluntary and community sector has been recently strengthened through the recruitment of a further member from this sector.

Key achievements of the group include:

- The development of a private fostering communication strategy and action plan for 2013-2016. This has informed the development of a Tri Borough strategy.
- Increased knowledge base for partners, and consultation discussion routes into safeguarding team.
- Securing regular attendance at the RBKC GP forum to keep local GPs informed of safeguarding developments and social work practice. One outcome of this improved collaborative working has been the design of a specific GP Report form for Child Protection Conferences to ensure that reports are focused and include the information the network requires.
- As a result of connections through the board, partners are more confident in reviewing multi agency interventions undertaken with families and formulating recommendations for improvement. Anonymously, the cases have been brought back to the Partnership for practice discussions and learning.
- Through the partnership safeguarding issues have been raised, and in particular cases direct challenge has been raised.

4. Quality and Effectiveness

4.1 The Quality Assurance (QA) subgroup takes a lead role in fulfilling the LSCB's scrutiny functions. At the start of 2013, under the direction of a new chair, the QA subgroup launched their Quality Assurance Framework. The framework provides the LSCB with an opportunity to scrutinise key information from agencies across the partnership, incorporating quantitative data, information about the quality of services, and information about outcomes for children, asking: how much, how good, and what difference. Exceptions are escalated up the different levels (see diagram) of reporting, for discussion and decision, with the results fed back down and action followed up by the QA subgroup or individual agencies.



4.2 All members of the QA group have a responsibility to report any concerns about the process of scrutiny undertaken within their agencies and share an ambition to challenge each other and improve the way agencies work together. Engagement by agencies at the subgroup is good; however, sometimes agencies, in particular education and schools, are not represented at the group. A recent initiative to improve attendance at the group has been undertaken by the chair.

4.3 The Quality Assurance subgroup examines a range of safeguarding information in a large data set designed to demonstrate "how much, how good, what difference". The data set has been effective in identifying patterns and themes within interagency safeguarding work. For example, the low child protection rates in Westminster were noted by the board in the July 2013 QA report. As a result, an analysis of child protection trends was undertaken and a report explaining the reasons was submitted to the Independent Chair of the board.

4.4 Some agencies have had difficulty in providing information because: the agency in question collects information regionally or with alternative boundaries and it is hard to distil on a tri or single borough basis; some agencies' systems to collect safeguarding data are still developing, for example aligning the definitions of 'missing' children so that each agency is using common criteria. There are also logistical issues with collating a data set from such a wide range of sources and the supply of regular information, which allows issues to be responded in a timely way. As a result, the QA subgroup has agreed to take agency information in the form that is provided within their organisations. The report includes information about a range of issues including those families in temporary accommodation, crime data, information about MASH activity and health data.

4.5 In addition to the general exceptions report provided to the LSCB, the QA subgroup has conducted a number of multi-agency themed audits of front-line practice concerning specific Board priorities: in 2013/14 this included domestic violence, children at risk of self-harm and

suicide, and children returning home following a period in care. The focus of audits has been closely aligned to topics on the agenda of the Board meetings and short life groups, thus enabling audit findings to supplement other topic related information presented to the Board. The audits have been led by officers independent and external to the LSCB and usually involve up to 15 cases from the three boroughs. The QA subgroup review the audits to identify strengths and weaknesses in current practice.

Spotlight on..... *children and young people returned home having been Looked After*

The majority of children in England enter care as a result of abuse or neglect. The most common outcome for them is to return home to a parent or relative. Research indicates that between a third and a half of children returning home to parents become looked after again for similar reasons and that about a third of those that stay at home still experience poor standards of care, including abuse and neglect.

An audit of 15 children and young people across the three boroughs who had returned home, having been Looked After, during the previous year identified a correlation in factors leading to episodes of care, in particular mental ill health in parents, parental alcohol and/or substance misuse and associated domestic violence. The audit also found that outcomes for children were variable; and concern that in a minority of cases there was evidence that there had not been enough improvement in home circumstances.

The audit demonstrated many aspects of good practice and effective partnership working to return children home from being looked after. It also highlighted potential deficits in direct work to help children make sense of what is happening, the provision of advocacy services, and the early identification of vulnerable children by adult mental health and substance dependency services.

In response to the audit, the LSCB has asked the Tri-borough Family Services leads to undertake further work to ensure there is a more structured framework for multi-agency involvement and sufficient focus on the reunification plan for children who are returning home from care.

4.6 The audits have been instrumental in providing insight into strengths and weaknesses in practice across the three boroughs. Arising from the audits, the LSCB has:

- Established a multi-agency short life working group to examine work with domestic violence victims and their children across the Tri-borough. A separate specific group has looked at the social work response to domestic violence, focusing on two key areas: improved engagement of male partners; building a trusted relationship with the women who are victims in order to avoid situations where they feel they have to lie to social workers.
- Learned lessons about services to children who may be victims of self harm or suicide. The key messages from the audit included a need to focus on early intervention work, not just those children who present at tiers three and four. More positively this audit found that there was good practice in the voice for the child being heard by professionals. The board recommended that multi-agency networks were effective in ensuring good communication between professionals

and members agreed to ensure such meetings take place when children are subject to self harm or suicide.

- The audit looking at young people who were subject to child sexual exploitation contributed to the work being undertaken to adopt a multi-agency response to such young people. As a result of this work, the LSCB endorsed the development of Multi Agency Sexual Exploitation (MASE) meetings, a monthly partnership group meeting led by Police and Social Care.

4.7 Audits identified for 2014/15 will focus on themes of sexual exploitation and neglect.

4.8 The LSCB has held a program of section 11 audits. The Quality and Assurance subgroup also review the outcomes of Section 11 audits that agencies undertake to assess whether they are fulfilling their statutory duties in relation to safeguarding. Members of the QA subgroup have met as a panel to scrutinise the Section 11 agency reports and provide peer challenge to the agency presenting the report. Results are reported to the Board but these could be given more prominence. Examples of good data collection and review through Section 11 audits include:

- Housing has worked collaboratively on Section 11 Audits and now provide specific information in respect of families living in temporary accommodation.
- The Police now provide quarterly returns through the London Safeguarding Board
- Probation has provided Section 11 feedback, which has included audit information.
- The establishment of a Section 11 panel to scrutinise agency S11 reports which reports to the Q&A Subgroup.

4.9 The LSCB only has looked at findings from local authority inspections but there is no systematic collation of inspection information from other partner agencies. (see also sections 11.1-11.4)The LSCB should consider whether to utilise the information from on-going school inspections, and from other agency inspections such as the police and those from the Care Quality Commission.

4.10 Individual agency developments to improve data and information about safeguarding (Level One of the LSCB Quality Assurance Framework) include:

- During 2013/14 Housing Commissioning has developed a 'Safeguarding Action Plan' which includes a number of actions to strengthen quality assurance, improve data intelligence and information sharing across agencies. Safeguarding is also now a standard agenda item at quarterly contract performance meetings with providers and discussed at the wider Strategic Housing Forum.
- During 2013/14 NSH England (NWL Area Team) has set up a Safeguarding Governance Group to monitor risks in the system. This group is chaired by the Chief Nurse. The group considers information supplied by health providers through the Safeguarding Health Outcomes Framework.
- The West London Mental Health Trust has developed and strengthened its quality and performance metrics for all safeguarding functions and embedded feedback mechanisms into governance structures. This has allowed the Trust Board to have greater knowledge of frontline safeguarding and clinical services are better able to reflect on how they discharge safeguarding responsibilities.

- The WLMHT has also developed a reporting mechanism to establish figures for the numbers of adult service users with dependents. This allows teams to narrow its focus on identifying and supporting children living in households where parents have mental illness.

5. Learning and Development

5.1 The learning and Development Group oversees the Tri-borough LSCB multi-agency training programme ensuring that the local children's workforce is equipped with the skills, knowledge and competencies to deliver services to children, young people and families which is based on sound safeguarding practice responsive to local priorities and national developments and learning. During 2013/14 the group has agreed a new Terms of Reference and developed a Learning and Improvement Framework and Strategy.

5.2 The LSCB training programme aims to use the expertise and knowledge of professionals working within the Tri -borough area to design and deliver the majority of the courses. However external trainers are commissioned for some specialist courses. Over the course of the 2014 there have been some changes in the membership and key roles of this subgroup. There is a new chair of the L&D Sub-group and LSCB Training Officer. In order to ensure continuity of the work of this subgroup these changes were managed through robust handover between the outgoing subgroup member and the new appointee.

5.3 As well as running the day to day LSCB training programme a number of projects have been completed during 2013/14, including:

- A review of Multi-Agency Safeguarding and Child Protection (Level 3) course. The purpose of this is to ensure the level 3 training continues to reflect local and national developments, initiatives and learning. Additional updates around MASH, as well as MASE and CSE risks, have been included and refreshed scenario exercises added.
- The development and commissioning of Joint Investigation Training for specific groups of professionals so promoting effective working between police and social professionals.
- The development of an Impact Evaluation Process, which will seek to measure the effectiveness of LSCB training in influencing and improving practice and so outcomes for children and young people. The LSCB is considering adopting the LSCB training evaluation schedule which measures knowledge prior to the course, immediately after the course, and three months afterwards.
- Introduction of a new and improved online Booking System from April 2013 which is more accessible and efficient
- The development of seven e-Learning modules which will be launched in September 2014, including the following modules:

  Introduction to Safeguarding Children (Level 1)
  Multi-agency Safeguarding and Child Protection (Level 3)
  Domestic Abuse
  Female Genital Mutilation
  Private Fostering
  Parental Mental Health and Safeguarding Children
  Parental Substance Misuse and Safeguarding Children

5.4 The e-modules were developed to offer a more flexible approach to the delivery of training and to better prepare the delegates attending a course when undertaken prior to attendance. The e- learning modules have been trialed by partner agencies prior to been launched and will be further evaluated in relation to uptake and feedback from delegates. Some e-learning courses will be mandatory prior to face-to-face training and others will be recommended.

5.5 A total of 1697 practitioners and managers undertook training commissioned or delivered by the LSCB during 2013/14. The most popular courses continue to be the mandatory safeguarding courses at level 1 and level 3. Health and Local Authority Children's Services delivered the most courses, totaling 71% of courses across the L&D programme.

5.6 Local Authority Children's Services staff had the highest attendance rate across the programme, accounting for 31% of all attendances. The voluntary sector (13.5%), early years settings (13%) and Central London Community Healthcare (11%) had the next highest attendances. These attendance rates roughly reflect the makeup of the children's workforce. The Police and Probation were underrepresented on LSCB training programmes and the reasons for this will be explored with partners on the L&D Subgroup.

5.7 Feedback from delegates, in relation to mandatory courses is very positive, with 95% of delegates stating that the course objectives were met. Delegates also rated their trainers highly in terms of their subject matter knowledge and understanding. Feedback from delegates is more variable for the specialist courses with responses varying from 90% to 60% stating the course objectives were met. There will be a review of the specialist modules to ensure that all course objectives match the course specifications. There will also be a review of managerial courses to ensure that the right balance between delivery and activities can be established. A planned development for 2014/15 is to conduct 'mystery shopping' of LSCB, and in particular internal agency, training courses to ensure they meet standards.

5.8 The LSCB training offer is continually reviewed to ensure that it responds to local priorities and demands. The L&D team has convened a number of focus groups with training participants, managers, subgroup members, trainers and safeguarding specialists to review the training offer. As a result the content of Safeguarding Training level 3 has been reviewed, and will include information on MASH and MASE arrangements, as well as the LSCB threshold document and local protocol. The focus group also identified that supervisors wanted more in-depth training on specific issues - such as gangs and working with male perpetrators of domestic abuse – and how to supervise practitioners who are working on cases which feature them.

5.9 In response to issues identified in the Faith and Cultures short life working group (potential child protection risks where there are language barriers) the L&D subgroup commissioned a 'interpreting project'. The main focus of the project has been to review how professionals engage interpreters for direct work, case conferences and other multi-agency meetings. The first session with workers will be held in July 2014.

5.10 As a result of national and local serious case reviews three learning events have been held for staff working across the three boroughs. In particular, there has been a focus on chronic neglect, disguised compliance in neglect cases, and the early identification and help for neglect. These workshops are generally very well attended and received by participants. In 2014/15 the LSCB are considering running additional lunch and learn workshops across different venues to engage staff around lessons learned and LSCB priorities for the year ahead.

5.11 A further case review workshop was held in November 2013 for head teachers and school staff regarding the learning from the Daniel Pelka serious case review in Coventry. As a result of the workshop staff from more schools are developing or strengthening a 'Team around the School' approach, identifying children where there are emerging patterns of potential chronic neglect through assessment of risk factors, consideration around thresholds for safeguarding and child protection and improving timely referrals to Early Help Services and/or safeguarding Services. This specific workshop complemented the ongoing safeguarding/CP training at an individual school level, for Designated Teachers and Designated Governors which also incorporated the learning from the Daniel Pelka SCR.

5.12 Information from Section 11 and multi-agency audits has helped to ascertain levels of compliance with safeguarding training and where additional support is required. In particular, the audits identified that most agencies had appropriate induction plans for staff, and signposted appropriate staff to the LSCB training programme. However, many agencies found it more challenging to demonstrate the impact of their training package and how to measure the effectiveness of their in-house training. The L&D subgroup has begun to look at ways to measure the impact of training and will cascade its findings to member agencies once further results are obtained.

5.13 The Section 11 audits have proved to be a useful tool in challenging agencies on their internal training offer and take-up and identifying potential LSCB wide training opportunities. The LSCB will need to ensure that we follow up with individual agencies at the 6 month review meetings where the quality of their Section 11 audit was poor or needed further clarification.

5.14 The new chair of the L&D subgroup has a number of priorities for 2014, including:

- The promotion of training amongst community and voluntary sector organisations to increase take-up;
- A focus on diversity issues such as forced marriage and FGM;
- Safeguarding issues around social media and internet safety
- Linking across to the training programme offered in adult services;
- Impact of domestic homicide;
- Ensuring all agencies have the highest standards in safer recruitment of staff; and
- Developing the L&D dataset to ensure that data reflects the quality of training not just the quantity.

6. Case Review and Child Death Overview Panel

6.1 The **Case Review subgroup** considers how local agencies can learn from national and local case review findings and oversees the implementation of action plans arising from local case reviews. Case reviews are considered in the event of serious injury or death of a child.

6.2 Over the course of 2013/14 the subgroup has finalised one Serious Case Review (SCR), started one SCR, and finalised one multi-agency review in Westminster. The subgroup will be reviewing if this level of activity is reasonable across the Tri-borough or if it is too low and whether this is possibly as a result of thresholds for investigation being too high or if there are unidentified barriers to the subgroup being informed of potential cases to review. The subgroup has also maintained an overview of case reviews led by other LSCBs, where one of the tri-borough agencies had prior involvement as well as prominent SCRs in other parts of the country.

6.3 The completed review of a teenager fatally stabbed by a group of young men identified the need to develop a formal response to safeguarding risks posed by being in a gang, outside of the child protection and case conference structure. A model for adolescent safeguarding has not yet been developed but is something that the Local Authorities' Safeguarding Review and Quality Assurance team will be piloting in 2014/15. All of those risks are currently formally managed and identified, but there is room for a more creative model that looks at how services engage adolescents more in the process.

6.4 The case also identified the valuable opportunity to engage young people at risk of gangs in A&E settings, called the 'Teachable Moment' in US practice. As a result, the Major Trauma Service and the Safeguarding Team at Imperial NHS Trust is working to raise funding for a pilot project involving embedding youth workings in A&E at St Mary's Hospital site; the workers will support victims of gang-related violence and sexual exploitation, facilitating the early identification and help of potential and actual victims.

6.5 A half day workshop for staff across the three boroughs' was delivered to disseminate the learning from two reviews of cases involving the sudden unidentified death of an infant in Westminster and Hammersmith & Fulham. Small, but significant, issues for practice were identified regarding the importance of reflective social work supervision and creating a culture of challenge, where necessary by schools if they feel that a child 's situation is not improving or no action appears to be being taken and the importance of escalating the concerns in these circumstances to Social Care . This learning point has also been incorporated in to ongoing single agency training with schools and has been reinforced by Statutory Guidance "Keeping Children Safe in Education " published at the start of April 2014.

6.6 These reviews also posed wider questions about the engagement of men in safeguarding work, in particular where the man is the perpetrator of domestic violence. The reviews highlighted that persistence is critical to engage men who wish to remain peripheral to the

intervention but are crucial to addressing the safeguarding issue. As a result of this issue being raised, local authority social care teams, with the support of Standing Together, have considered the use of split case conferences in all situations where domestic violence is an issue. As a result there has been better information sharing in conferences and increased confidence that the assessment of risk from the pooled information in the conference is more accurate.

6.7 A further change, following a recommendation from the work of the Case Review Panel, has been to strengthen the response to children (aged 16 and 17) entering the care system due to homelessness. A case review found that the labeling of 'Southwark Judgement Cases' for these young people had in some incidences meant that best practice established in other LAC work was not always replicated for 'homeless' cases. As a result, for example in Hammersmith and Fulham, practitioners responding to the needs of these young people are now managed within social care rather than early help services.

6.8 Over the course of 2013/14 there have been three events for staff to disseminate the learning from Case Reviews and Serious Case Reviews. In addition, the Case Review subgroup presents a report to each LSCB Board meeting; agencies represented on the subgroup and board are expected to report findings and recommendations to colleagues within their organisation. The Chair of the subgroup has identified that the dissemination of learning, in particular to front-line staff, could be made more robust and at the moment it relies on each agency to take the messages forward to their staff. As a result, the chair will publish a 'key lessons' briefing following all subgroup meetings which will be disseminated to staff and placed on the LSCB websites.

6.9 Working across three boroughs does mean that the Board's case review sub-group is always very casework-heavy. Involvement in SCRs across London and beyond, as well as our own learning reviews and any SCRs, make for a significant workload for members of this group and for its Chair. Such a large geographical and busy area is always going to produce a lot of casework and being so 'busy' will remain a challenge and be resource-hungry.

6.10 The **Child Death Overview Panel** (CDOP), which has been operating as a tri-borough initiative prior to the formation of a Tri-borough LSCB, considers the circumstances relating to the deaths of children from the three boroughs and relevant practice implications. During 2013/14 the Panel reviewed 46 cases.

6.11 One of the themes arising from the cases reviewed at the Panel this year has been sudden deaths in infants and the impact of sleeping arrangements. Following the review of a number of sudden infant-death cases, the Panel recommended that Central London Community Healthcare undertake a stock-take of the advice given to parents on sleeping arrangements. As a result, Health Visitors and the Community Midwifery Team have reviewed the information they give to parents and have piloted a New Birth Information Pack, which includes advice on safe sleeping. This pack will be rolled out across all teams in 2014/15.

6.12 Following the multi-agency review into the death of a child with a life-limiting illness, the panel noted the high number of moves into new housing for the family. The CDOP challenged

the Local Authorities' Housing Services on their action in this case and their practice regarding families with children with disabilities. The issue was raised at the LSCB Board, as part of the regular CDOP reporting; follow-up of this sort of challenge can be complex for the LSCB. The Chair of the CDOP has identified that while systems for following up on recommendations for Health agencies are embedded, there is further work to be done to ensure the identified actions for other agencies are followed up.

6.13 During 2013/14 the Panel changed its model to reviewing neo-natal deaths. The benefits of this new model include providing CDOP members with a better understanding of medical and multi-agencies issues.

6.14 The Chair of the CDOP has developed strong links with the Clinical Commissioning Groups across the three boroughs which has created a more robust system to monitor Health agencies. The Chair of the CDOP has also established a strong working relationship with the borough's Partnership Boards and the Case Review subgroup.

6.15 Areas for development in 2014/15 include: Identifying areas for research, including neonatal deaths; review feedback mechanisms to parents; and revisit training programme to ensure all agencies are aware of the CDOP process.

7. Engagement and Participation of Children and Young People

7.1 Work to engage children and young people in the work of the Board has been considerably strengthened in 2013/14 since the recruitment in July 2013 of a dedicated LSCB Community Development Officer for children and young people.

7.2 Much of the focus of the officer's work has been to raise the profile of the LSCB, and safeguarding more generally, with children and young people. Particular projects, to raise awareness of the LSCB and safeguarding issues, have included: Epic Children's Forum Safety Tips which address safety at home, at school, outside and when using the internet; workshops at the Hammersmith and Fulham's 'Take Over Day' where young people discussed issues around online safety and 'sexting'; work with the Westminster City Boy's project debating a number of safeguarding scenarios; the development of a children and young people friendly version of the 2013/14 annual review; and the launch of a 'menu of services' for young people to contact if they have any safeguarding concerns. See also sections 11.5-8 for further detail.

7.3 For those who had been engaged in the projects, young people agreed that their understanding of specific safeguarding issues, and the role of the LSCB, had improved. However, these young people only represent a small proportion of the total child population. To improve reach the development officer has been exploring how the internet and social

media could be used. Plans are in place to conduct an online survey in July 2014 and the worker has been closely involved in the development of the LSCB website to ensure that it is children and young people friendly.

7.4 A new focus for the development worker in 2013/14 has been their involvement in section 11 audits, challenging agencies on how well their service development plans are informed by the views of children and families. The Development Officer has created a tracker to document the action and progression of agencies stemming from the children's collected views.

7.5 Individual agency examples of the engagement and participation of children and young people in safeguarding work include:

- Young people's involvement in a review of hostel provision across the three boroughs. Young people reported that they were able to recognise signs of abuse and felt confident in being about to report concerns to staff, social workers or the Police.
- The Epic Children's Forum in RBKC were asked and part-funded by the LSCB to draft a leaflet of 'top ten tips' for other children to 'stay safe': they produced this and DVD.

8. Equality and Diversity

8.1 The LSCB has enjoyed considerable success in strengthening links with communities following the appointment of a Community Development Worker – with a focus on communities – in May 2013. Tasked with building community partnerships, the worker has conducted a number of projects to enable statutory services to better understand the communities they serve, to strengthen the capacity of local voluntary, community and faith groups to safeguard and protect local children, and to help improve the community perception of statutory services with child protection responsibilities – see sections 10.13-10.25 for more detail.

8.2 Priority has been given to making links with voluntary organisations, faith groups and supplementary schools as anecdotal evidence indicated that local communities feel supported by these bodies and place great trust in them.

8.3 Specific developments include:

- Improving cultural competence of front-line practitioners: Each Borough now has a Lead Child Protection Advisor (CPA), who will develop expertise in the areas of safeguarding related to Faith and Culture. The CPAs will be a point of consultation for front-line practitioners across agencies for safeguarding issues relating to Faith and Culture. The CPAs together with the Community Development worker has also formed a working sub-group to drive forward actions in relation to raising awareness and competence of front-line practitioners when encountered with the above mentioned issues. In Westminster, the CPA now attends visits to families with social workers, where there are safeguarding concerns regarding faith and culture; this has ensured that social workers have access to specialist expertise and are supported to achieve the best outcomes for children and young people.

- Securing Voluntary sector representation at the borough level Partnership Groups. The representatives are in the early stages of establishing themselves on the board and impact of their membership should be evidenced in 2014/15.
- Cascading information from the LSCB to the Voluntary & Faith sector: Each of the umbrella organisations has agreed to disseminate information from the LSCB to individual organisations through their e-bulletins and distribution lists. A database of Voluntary and Faith organisations is also being compiled that can be used by the LSCB to promote information to the sector directly. Over the past year, the Development worker has held a number of presentations about the LSCB, including at Regents Park Mosque and the Islamic Cultural Centre and Shepherd's Bush Mosque, and held discussions with the Diocese of London and Dean of Westminster. As a result of these discussions there is an increased awareness of safeguarding issues among these agencies and relationships have been strengthened.
- A self-audit tool, designed specifically for the Voluntary & Faith sector to assess safeguarding practice, has been identified. This tool is being promoted amongst organisations already commissioned by the Local Authority and it has been agreed to embed these tools within future contracts. A series of workshops to support organisations to use these tools will also be provided.
- Planning for a number of training sessions for practitioners on the effective use of interpreters to front-line teams. The training will be supplemented by 'Best Practice Guidance' that has also been developed, in relation to the use of interpreters. The training has been developed in response to the identification that insufficient or inappropriate use of interpreters was an area of weakness of statutory services in serious case reviews.

8.4 An event in May 2014 is planned to bring the Voluntary & Faith sector and key agencies in the Statutory sector together to discuss how partnership working can be improved to strengthen safeguarding efforts across both sectors. This will follow a launch of a survey to the sector to assess areas of strengths and challenges that front-line practitioners in the Voluntary & Faith sector and statutory sector face in relation to safeguarding. The results of this survey will be used to inform the action plan for the Community Development worker for the next year.(See section10.22 for further detail)

9. Communication and Awareness raising

9.1 The LSCB communication strategy ensures that the LSCB fully discharges its responsibility to: 'Communicate to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so' (Working Together 2013 chapter 3).This strategy covers both 'reactive' (when the LSCB is approached, for example, by the media) and 'proactive' communication.

9.2 The key communication objectives for 2013/14 have been to:

- Promote awareness amongst frontline practitioners, children and young people and our communities of how everyone can contribute to safeguarding and promoting the welfare of children and young people
- inform children of the work of the Board and partner agencies.

9.3 Currently, information about the Tri-borough LSCB, including learning and development opportunities, key contacts, and publications, are located on the three Council's respective websites. This means (in theory) that there are three 'sovereign' representations of the Tri-borough LSCB on the council's individual websites. However, in practice there is no one multi-agency website which is fully developed and there is much duplication of effort to maintain three websites that do not reflect the multi-agency nature of the one LSCB. There have been continued difficulties in the establishment of a tri-borough LSCB website which has meant that the launch of a single micro-site has been delayed; this is expected now in 2014/15. A single online presence will bring together resources and support for parents, carers and professionals on safeguarding issues, as well as streamline the promotion of the work of the LSCB. This will also help develop a clear brand for the multi-agency LSCB and provide a suitable backdrop for articulating its current priorities.

9.4 The LSCB Newsletter is now published on a regular basis, emailed and placed on the three boroughs' LSCB websites. It needs a redesign by the Communication Team to ensure its likelihood of reaching a wider audience. There has been no evaluation of whether it reaches all front-line staff; this should be included in development priorities for 2014/15. The coordination of information could also be more pro-active and additional help has been requested.

9.5 The LSCB has held a number of themed events that encourages sharing of learning and good practice, including two LSCB development days to consider learning from recent SCIE reviews and the effectiveness of the LSCB, and workshops following short-life working groups for child sexual exploitation and young people at risk of self harm. There are plans for two further workshops in 2014/15 on child deaths and child sexual exploitation.

The key messages of the LSCB for 2013/14 were:

- Safeguarding children and young people is everybody's business
- The LSCB is focused on the priorities that improve outcomes for children and young people and is committed to giving every child the best start to improve their wellbeing
- The LSCB is transparent and open in its activities and will promote the sharing of information in order to safeguard children
- When information cannot be shared, the LSCB will make the reasons clear
- The LSCB will work to ensure that children and young people are included in its activities and decision making
- Communications from the LSCB will have a focus on making information available to frontline staff of all partner agencies and the wider community

9.6 On a day to day basis, LSCB officers provide briefings for interested parties on relevant subjects and on the work of the LSCB, to raise the profile of the LSCB and awareness of safeguarding issues. During 2014/15 presentations were made to the voluntary sector, private hospitals, as part of training to new

councilors, included as part of the Karma Nivarna Roadshow on forced marriage, and twilight training sessions for staff.

10. Early help and prevention of harm

2013/14 Business Plan priorities:

Development of outcomes framework for early help, to include a threshold document and protocol for assessment

Development of the MASH and improved information sharing

Improve safeguarding outcomes for children and young people within Black and minority families

to ensure that practice in respect of abuse linked to faith or belief is developed

Develop more effective safeguarding links within the voluntary sector and with young people

Improve links with adult safeguarding services

10.1 The LSCB has a statutory responsibility to assess the effectiveness of help being provided to children and families, including early help. Early help means providing help for children and families as soon as problems start to emerge or when there is a strong likelihood that problems will emerge in the future. The 2013/14 business plan priorities reflect multi-agency priorities towards improving early help services and the early identification and help of children at risk.

Early Help

10.2 The LSCB has overseen a major service review of early help across the three boroughs during 2013/14. The LSCB has been particularly interested in this work to ensure that it has a clearer oversight of early help services across the three boroughs; that the three boroughs have strong 'step-up' and 'step-down' procedures to and from social care services; and that there are transparent thresholds for assessment and support that are understood by all agencies.

10.3 Phase One of the review, completed in October 2013, was mainly focused on Local Authority early help services and included the development of an Early Help Vision; an Early Help Outcomes Framework - based upon six priority outcome areas for children and young people; an Early Help Offer; and an Early Help Thresholds and Local Assessment Protocol, as required by Working Together 2013. Whilst early help services will continue to be delivered and managed locally, the above aimed to identify the most effective processes and interventions and consistently apply them across the three boroughs.

10.4 The LSCB has developed and disseminated Threshold Guidance and a Local Assessment Protocol to complement the pan-London Child Protection Procedures. These provide the baseline guidance for induction and training of staff across all agencies, and act as points of reference for the multi-agency network. In practice, operational understanding of

consistent and shared thresholds and levels of assessment is delivered through the thread of meetings and working relationships that take place at all levels, with a particular focus upon clear and effective step-up and step-down arrangements.

10.5 In Phase One of the review, six working groups were set up to address the key outcomes areas from the Early Help Vision, in order to produce a report that compared and contrasted activities across the three boroughs to identify similarities, differences, good practice, and gaps, and to then put forward a series of recommendations that focus on improving practice. These outcome areas include: prevention of crime and serious youth violence; children to have strong and effective parents; healthy children who thrive at school; improved participation in education and training; prevention of harm and keeping children safe; and improving outcomes for children on the edge of care. An agreed set of performance indicators has been identified so that progress against these six priority outcome areas can be measured. Phase 2 focused upon implementing these recommendations or carrying out further compare and contrast.

10.6 The progress of the working group on 'prevention of harm and keeping children safe' has been of particular interest to the LSCB. During the year, the working group has narrowed its focus to identifying ways to improve the three borough's approach to responding to parental mental health, parental substance misuse, and domestic violence as significant factors in preventing harm and keeping children safe. This work will be taken forward by the Early Help partnership in 2014/15 with the support of the LSCB and the Health and Wellbeing Boards.

10.7 Where Phase 1 of the Review was inward looking, focusing on improved practice across the three local authorities, Phase two has turned outwards in order to engage with key partners to develop a joint vision and offer. A stakeholder event was held to determine better understand stakeholder contributions to the Early Help agenda, introduce the idea of co-ownership and co-design, obtain contributions and thinking from stakeholders about the Early Help Vision, and agree next steps to co-design an Early Help offer that will be jointly owned.

10.8 The commitment to effective Early Help has been driven jointly by the LSCB, the Health & Well-being Boards and the Children's Trust Board; and leadership has been provided by a number of members of the LSCB Board, as well as through its local borough partnership sub-groups.

Multi-Agency Safeguarding Hub (MASH)

10.9 The Tri-borough Multi-agency Safeguarding Hub (MASH) was initially developed in Westminster and then moved to becoming a full Tri-borough service in October 2013. The Tri-borough MASH is already demonstrating the benefits of improved decision-making at the point of referral - thanks to rapid and rigorous information sharing - so that some children benefit from an escalated child protection response when information indicates a higher level of risk, and other children and families benefit from a de-escalated response

which is focused more on assessment of need and support than an urgent child protection response.

10.10 There has been effective co-location of Social Care, Police, Health, and Education staff, together with good virtual engagement from other services such as Probation, Youth Offending and Housing. The MASH team works closely with the operational services in each borough to ensure good and close communication. As the service establishes itself, officers are now working on the added value that MASH can bring to a more consistent and effective approach to Child Sexual Exploitation and Missing Children.

10.11 A key achievement of the MASH has been to develop a consistent approach to threshold of risk for children across the three boroughs. MASH are able to challenge and focus risk thresholds from a subjective, and intelligence based model ensuring that the child remains paramount and that information held by all agencies inform the risk assessment. MASH ensures that children and families receive targeted services which are necessary and proportionate reducing unnecessary intervention. The LSCB receives quarterly quality assurance reports from MASH: information demonstrates that there has been improved information sharing between agencies' which is reflected in the analysis of referrals, compliance with timescales and tracking of cases.

10.12 There is the potential risk that MASH recommendations are not endorsed by boroughs and intervention/services provision is not in line with risk assessments; a 'One size fits all' could result in borough front doors changing the RAG rating or not endorsing MASH recommendations. To ensure that this risk is managed, the MASH will review the Tri-borough Threshold document regularly and update in line with changes and procedures for each boroughs. MASH and

How MASH has improved information sharing.....

Case example 1:

Confidential information sharing in MASH resulted in a statutory assessment, and a change in rag rating from green to amber, when Probation referred to MASH due to concerns that their client had recently begun a relationship with a mother of two children (aged 7 and 6 months). The client was awaiting attending court following a violent assault on family members. As a result of MASH Police checks on the Police National Database, MASH was informed that the client was also involved in the sexual assault of a 14 year old female child for which he was not subject to the Sex Offenders List. Without this information sharing via MASH risks to the children would not have been identified and managed.

Case example 2:

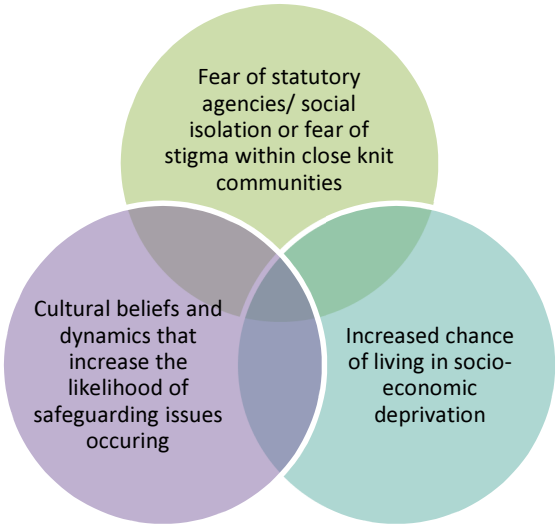
A GP raised concerns to MASH about pregnant mother and 4 yr old child having moved in to the area from Newham fleeing domestic abuse and living in a refuge. MASH was able to ascertain from other professionals details for the unborn baby's father following refusal from mother to give this information. MASH discovered that the father was known to the Police for violence towards previous partners, Robbery and Possession of class A drugs. MASH gave a final rag Amber due to safeguarding concerns for unborn and 4 yr old.

partners continue to build upon relationships and communication to ensure that thresholds are better aligned and any differences are escalated appropriately to relevant managers.

10.13 The LSCB has provided strong scrutiny of MASH as it has developed, with a particular focus upon the performance data in relation to the impact of improved information sharing, the speed with which partner agencies are responding to information requests, and the capacity that the MASH requires from key partners.

Safeguarding outcomes for black and minority ethnic children

10.14 The short-life working group on safeguarding across Faith and Cultures reported to the LSCB in July 2013. The group highlighted that available demographic and front-line practice information indicated the need to consider that some vulnerable children from Black, Asian and other minority ethnic backgrounds were at increased risk by a mixture of socio-economic and cultural factors.



10.15 The working group recommended that the LSCB prioritised building community partnerships in order to strengthen the capacity of communities to safeguarding and protect local children, and to improve perceptions of statutory services. The LSCB Development Worker, appointed in May 2013, has lead a number of initiatives to build community partnerships including direct work with faith groups to raise awareness of the LSCB, improving voluntary sector engagement at the borough level partnership groups, developing self-audit tools for voluntary and faith groups to evaluate their safeguarding processes, improving the cultural competence of front-line practitioners; and delivering training sessions on the effective use of interpreters (see section 8 for more details). It should be noted that this is a long-term piece of work for the LSCB as, by their nature, relationships and perceptions do not develop and change overnight.

10.16 Following a case review in 2012, which identified the need to improve the assessment of children from families where English is not the spoken language, the LSCB has prioritised improving the quality of interpreting services offered to families. Focus groups with community groups and front-line staff identified that the many families are wary of using interpreters because of a fear that private information will be leaked into the community, that they had a poor quality of English and a lack of knowledge of safeguarding terms, and there was little guidance or training for practitioners on how to use interpreters effectively. Guidance, and training sessions, have now been developed and will be ready to roll- out from October 2014.

Safeguarding in relation to faith or belief

10.17 The Safeguarding Across Faith and Cultures working group identified five areas of child maltreatment affecting children from Black, Asian and minority ethnic backgrounds including: so-called honour based violence, forced marriage, female genital mutilation, accusations of spirit possession and witchcraft, and child trafficking. The LSCB Development worker, with a focus on communities, has been taking forward multi-agency action responding to the recommendations highlighted in the report.

10.18 There is often a high correlation with domestic violence in cases of honor based violence and forced marriage. The Faith and Communities subgroup has developed a toolkit to support social workers where concerns are raised and a leaflet for young girls who may be at risk. Advice is also offered to social workers, where appropriate, in a number of cases across Tri-borough where risks have been identified.

10.19 In regards to spirit possession and witchcraft action has been taken to encourage social workers to look more closely at how faith and culture underpin how a family functions and the role of religion in parental response to accepting issues such as illness, bedwetting, and mental health in their children. A toolkit for practitioners has now been created, following an audit of cases in Westminster, to ensure that social workers have a better understanding of how to assess risk and the different cultural considerations that need to be made. Training has also been commissioned for staff on these issues.

10.20 The LSCB has promoted training in child trafficking issues, and in feedback following the course attendees reported an increased awareness and ability to be able to identify cases. Tracking of potential cases is now in place but numbers are very low. The Community Development worker works closely with the Private Fostering Social Worker to ensure that possible benefit trafficking is identified.

10.21 Child Protection Advisors (CPA) are now tracking social work cases where faith and culture issues are a factor. Putting systems in place to track cases has taken considerable effort and although in its early stages of development the tracking has helped to identify: a baseline for further monitoring; gaps in skills or provision of services through the tracking of agency input; and best practice in addressing issues identified. An area for focus in 2014/15 will be developing the expertise of the CPA role and identifying resources to support this work.

Spotlight on..... Female genital mutilation (FGM)

Until 2013, Female Genital Mutilation (FGM) was an area that had received limited attention in terms of developing inter-agency awareness. The Safeguarding in Faith and Cultures Working Group identified that there had not been any criminal investigations across Tri-borough in relation to FGM and that practitioner understanding of the issue was low.

It is incredibly difficult to estimate prevalence when FGM is so rarely disclosed by survivors or routinely asked about by professionals or community groups. FGM is practiced by a number of ethnic communities; in some countries - Egypt, Ethiopia, Somalia and Sudan - prevalence rates can be as high as 98 per cent of the female population. With high levels of migrants from these communities in the three boroughs this represents a significant challenge for local services to prevent FGM and protect children and young people affected by the practice.

Specific pieces of work regarding FGM have been undertaken by the Westminster and Hammersmith & Fulham partnership boards in 2013/14, with the support of the LSCB Community Development Worker. In Hammersmith and Fulham a local Multi-Agency Strategy has been drafted. In Westminster, action has been taken to raise awareness, develop tracking systems, and create an agreed protocol on the response to FGM. Child Protection Advisors in the three boroughs also provide consultation and advice for front-line staff on FGM.

In March 2014 the LSBC agreed to establish a FGM Implementation group with the aim of coordinating local agencies, across the three boroughs, response to FGM, which will be a significant priority for action for the LSCB in 2014/15. The first phase of the group's work will be 'recognition and referral' which will establish an agreed threshold for referral when victims of FGM are identified through maternity, gynaecological or GP services if they have or are expecting a female child. The group will also ensure that the three boroughs have a consistent system in place for recording and tracking FGM cases and referrals so that patterns and outcomes can be identified. Phase two of the group will be a wider focus on embedding good practice, including the full implementation of the Tri-borough FGM strategy and ensuring that the strategy is embedded as part of working culture and mainstreamed as safeguarding practice.

Links with the voluntary sector

10.22 The Community Development Worker has secured agreement from the three borough's voluntary sector umbrella organisations to disseminate information from the LSCB to individual organisations through their e-bulletins and distribution lists. A database of Voluntary and Faith organisations is also being compiled that can be used by the LSCB to promote information to the sector directly. Over the past year, the Development worker has held a number of presentations about the LSCB, including at Regents Park Mosque and the Islamic Cultural Centre and Shepherd's Bush Mosque, and held discussions with the Diocese of London and Dean of Westminster. As a result of these discussions there is an increased awareness of safeguarding issues among these agencies and relationships have been strengthened.

10.23 An awareness raising module, as part of the LSCB Community Development Worker's role, has been developed for staff from faith, community and voluntary groups. The modules have been designed to raise awareness of 'safeguarding' and improve communities' perceptions of statutory services. So far 3 groups have completed the module (including the BME Health forum, Midaye, and Church Street Library) with a further sessions planned in 2014/15. A questionnaire to all known community, voluntary and faith organisations is planned in May 2014 which will inform the work programme of the Community Development Worker in 2014/15.

10.24 To ensure that faith and voluntary organizations meet safeguarding requirements in relation to working with children and young people a standard tool has been developed that all organizations are being encouraged to adopt. The LSCB and Tri-borough Children's Commissioning team are promoting the use of this tool, within all contracts held with these groups, and in 2014/15 will be tracking the progress of organisations in using this tool. Furthermore, following demand guidance has been produced that supplementary schools, voluntary/faith organisations schools can use when writing their safeguarding policies.

10.25 An event in May 2014 is planned to bring the Voluntary & Faith sector and key agencies in the Statutory sector together to discuss how partnership working can be improved to strengthen safeguarding efforts across both sectors. This will follow a launch of a survey to the sector to assess areas of strengths and challenges that front-line practitioners in the Voluntary & Faith sector and statutory sector face in relation to safeguarding. The results of this survey will be used to inform the action plan for the Community Development worker for the next year.

Strengthening links to the Adult Safeguarding Board

10.26 The LSCB has developed a Joint Protocol with Adult Safeguarding Board which has promoted engagement of both boards with each other's work. In particular, there has been joint working within the short life subgroups on domestic violence and in respect to tri borough responses to women and girls affected by domestic violence. There is also now greater sharing of Section 11 feedback from agencies that work specifically with adults.

10.27 The LSCB Chair and the Chair of the new Tri-borough Safeguarding Adults Board attend one another's Boards on an annual basis. They also meet several times a year to ensure key issues are worked on together. This year they met with a Governor from Wormwood Scrubs to ensure Prison Service linkages were established with both Boards. This led to a Prison Service representative joining both Boards. They also pursued together the linkages with Community Safety and there is now a Community Safety representative on the LSCB. Further joint work led to a protocol with the Health and Wellbeing Board and some shared priorities for 2014/15. (See also Section3.7)

11. Better outcomes for children subject to child protection plans and those looked after

2013/14 Business Plan priorities:

Achieve good data collection and review

Promote the engagement of children, young people, families and frontline practitioners with the work of the Board and their increased participation in safeguarding practice

Increase the effectiveness of safeguarding arrangements and improved outcomes for children subject to child protection plans, ensuring we collaborate well in relation to areas of neglect

Ensure learning from OfSTED Inspections, Serious Case Reviews and other case reviews

Data collection and review

11.1 During 2013-14 work has continued on the development of the Quality Assurance Framework based on the 2011 London Safeguarding Children Board and Local Government Improvement and Development guidance on developing a 'Strategic Quality Assurance Framework'. The outcomes framework is considered a way of looking at how multi-agency services contribute to improving outcomes in relation to safeguarding children and is intended to help commissioners and providers in the development of services which promote a culture of safeguarding and evidencing improved outcomes for children and young people.

11.2 The Quality Assurance group has provided quarterly reports to the Board which help to understand multi-agency activity data and a thematic approach has been taken in relation to some of the priority areas, in particular domestic violence. See section 4 for a more detailed overview of the work of the Quality Assurance Subgroup in 2013/14.

11.3 The LSCB quality assurance group has worked towards improving information sharing between agencies to enable multi-agency reporting to the Safeguarding Board, but as highlighted in section 4 there have been a number of hurdles to making information truly multi-agency. A thematic approach to the collection of this information has proved to be a valuable way of agencies being able to contribute to the Quality Assurance Group discussion and the report to the board. The Board may wish to adopt this approach more formally over the coming year by developing a schedule of thematic areas for consideration by Quality Assurance group and reporting on a quarterly basis to the Board.

11.4 As the identity of the QA group has developed over the year, agencies have become more active in submitting data. As well as the routine multi-agency data on child protection planning, the quarterly report has included data from the following agencies: the police who have provided crime statistics; the MARAC in relation to numbers of families for whom this multi-agency forum has been working with; routine reports from the MASH; housing information including numbers of families who are homeless or in temporary accommodation; and health performance data.

Engagement of children, families and practitioners with the work of the board

11.5 Work to engage children and young people in the work of the Board has been considerably strengthened in 2013/14 since the recruitment of a dedicated LSCB Community Development Officer for children and young people (see section 7 for more information). Particular projects, to raise awareness of the LSCB and safeguarding issues, have included: a 'top safety tips' DVD; workshops at the Hammersmith and Fulham's 'Take Over Day' where young people discussed issues around online safety and 'sexting'; work with the Westminster City Boy's project debating a number of safeguarding scenarios; the development of a children and young people friendly version of the 2013/14 annual review; and the launch of a 'menu of services' for young people to contact if they have any safeguarding concerns.

11.6 Further work is needed to ensure that the meetings of the Board and subgroups are at times that are suitable for children and young people to attend. The Board has however attended events and activities that have been specifically set up for children.

11.7 Parents and families are not directly engaged with the Board, although one of the lay members is a local parent; however, through the Section 11 audit process the LSCB has sought to scrutinise agencies' engagement with families and the use of their feedback in the development of services.

11.8 Practitioners have been engaged in the work of the Board though: the LSCB's short-life working groups on CSE, missing children, domestic violence and children at risk of self-harm; local partnership boards; through LSCB feedback and surveys; at learning events; feedback in respect of training; and through engagement in reviews, e.g. case reviews.

Safeguarding arrangements and improved outcomes for children

11.9 The QA subgroup has conducted a number of multi-agency themed audits of front-line practice concerning specific Board priorities: in 2013/14 this included domestic violence, children at risk of self-harm and suicide, and children returning home following a period in care. The audits have been instrumental in providing insight into strengths and weaknesses in practice across the three boroughs. Audits identified for 2014/15 will focus on themes of sexual exploitation and neglect.

11.10 Identifying the early signs of neglect has been a focus for agencies on the Board. As part of this, during 2013/14 Imperial College NHS Trust has reviewed its 'do not attend' policy for children; now GPs and referrers are notified of all children who are not brought for

their out-patient health appointments so that cases of potential neglect can be identified at an early stage. Social workers are also informed when the child is on a child protection plan. A discussion paper on neglect is planned for presentation at the Board in July 2014.

11.11 Achieving better outcomes for children subject to child protection plans and those Looked After is the core business of the three local authorities children's services. During 2013/14 a number of senior appointments have been made to secure further Tri-borough improvements to service delivery and standards, including the Tri-borough Assistant Director for LAC and Care Leavers, and Children with Disabilities. The Safeguarding, Review and Quality Assurance Service is looking to further restructure on a Tri-borough basis, initially at a service management level.

11.12 In addition to the above, the three boroughs' Family Services embarked on a new initiative titled 'Focus on Practice', a major programme for the next two years. The programme, for all tri-borough practitioners, will focus on a range of areas to improve practice and outcomes for children and families, including re-referrals and reducing demand on high need/high cost services. The programme will involve a review of evidence-based practice and will involve identifying opportunities for partners to work together to strengthen and improve practice.

11.13 Within the central Child Abuse Investigation Team (CAIT) there are three Police Conference Liaison Officers (PCLO) who attend initial and repeat case conferences on behalf of the Police. Due to a recruitment freeze the team is currently under-capacity, and while a PCLO attended all initial case conferences, attendance rates at repeat conferences was lower than expected. A priority for 2014/15 will be recruiting two new PCLOs and improve attendance at repeat child protection conferences.

11.14 Individual agency contributions to improving outcomes for children with child protection plans or who are looked after include:

- The production of a DVD for young people, as part of Housing's Homeless Prevention Programme. There has also been a strong focus on mediation to ensure that where possible, and safe, young people can remain at home. This work has fed into edge of care work and has seen a reduction in the number of homeless presentations, particularly for 16/17 year olds.
- Negotiations between NHS England (NWL Team) and prisoner and offender health teams to improve services and support on offer for children becoming looked after through being placed on remand and for LAC who offend.
- The Metropolitan Police Service, with partner agencies, is currently evaluating the effectiveness of the Child Risk Assessment Model (CRAM) in accurately assessing the risk in cases and what improvements can be made, if any. Results will be shared with the LSCB in 2014/15.
- The CCGs have commissioned a review to look at the effectiveness of LAC Health provision in 2014/15. This will build on the review of the LAC Nurse role in 2013. The LSCB should scrutinise the outcome of the review at a future board meeting.

Learning from inspections and case reviews

11.15 The LSCB has held two development days for Board members during 2013/14: one to help the LSCB examine the standards expected of a good children's service, and attended by a member of the Ofsted team; and one to promote learning from case reviews. In the forthcoming year there are two further days planned to learn from Peer Review and work in respect of Children at risk of Sexual Exploitation.

11.16 Over the course of 2013/14 the Case Review subgroup has finalised one Serious Case Review (SCR), started one SCR, and finalised one multi-agency review in Westminster (See Section 6 of the report outcomes from the Case Review Subgroup in 2013/14). Learning from the subgroup is disseminated through learning events, briefings, and messages forwarded within agency newsletters and bulletins. The reach and effectiveness of current communication methods with front-line staff should be reviewed in 2014/15. Key learning from the subgroup has been:

- The development of a formal response to safeguarding risks posed by being in a gang, outside of the child protection and case conference structure;
- The need for embedded youth workers in acute settings to support victims of gang related violence and sexual exploitation;
- The review of advice given to new parents about sleeping arrangements
- The need to improve the engagement of men in safeguarding work, in particular where domestic violence is a significant safeguarding issue.
- Strengthening the safeguarding response to young people presenting as homeless.

11.17 In December 2013 Tri-borough Children's Services Senior Leadership Team commissioned a 'mock' Ofsted Inspection of the three Local Authorities Children's Services as part of their preparation for the real thing – both to evaluate the performance of services in the light of the new single inspection framework and also to test their readiness to handle the demands of an inspection. The LSCB will also undertake a similar exercise in June 2014.

12. Practice areas to compare, contrast and improve together

2013/14 Business Plan priorities:

Improve practice in respect of children who go missing

Improve practice in respect of children at risk of serious self-harm and suicide

Improve the safeguarding of children and young people at risk of sexual exploitation

to improve outcomes for children who are vulnerable from adults within the Criminal Justice System

12.1 Since 2012, organisations working across the three boroughs have sought to strengthen practice by using a compare and contrast process, to identify the best practice across and outside the three Local Authorities and where there is a business case for it, to merge services so that they provide a single Tri-borough service. A secondary aim of 'Tri-borough' arrangements has been to preserve front line services in the face of budget reductions through efficiencies generated by shared management, merged services and more effective practice.

Missing children

12.2 At the start of 2013/14 the LSCB initiated a short life working group focusing on missing children. This followed the local and national interest in outcomes for missing children, an Ofsted peer review on practice in Westminster, and work undertaken nationally by ACPO and Ofsted. The initial focus of the group was to agree on a definition of a 'missing' child, identify responses of different agencies to missing children, and suggest improvements to multi-agency working. This phase of work was reported back to the LSCB in January 2014.

12.3 The Group generated a protocol and a new dedicated post for missing children. The Group identified that MASH, on behalf of the LSCB, with their multiagency risk assessment responsibility, is in a strong position to asssist front line staff and the Police Missing Persons Team.The working group suggested that this improvement in multi-agency working as well as other practice initiatives will promote an improvement in the engagement of both police and Social Care with young people and lead to a reduction in the numbers of children at risk of going missing. There has also been effective collaborative work with the Police to ensure good risk assessments and plans for when a child returns.

12.4 The LSCB agreed that the Family Services Director for Westminster would take forward phase two of this work in 2014/15, including the following activities: to agree a tri-borough work flow for missing children; to lead on engagement with the Police and other agencies; to implement a multi-agency Missing Children Protocol; and ensure multi-agency practice

is implemented. It is anticipated that this will create a more robust system for children reported missing from care and home.

Spotlight on..... domestic violence

Following findings from case reviews and a subsequent multi-agency audit of child protection cases during 2013/14 the LSCB initiated a short-life working group (SLWG) on Domestic Violence. While domestic violence has been a long known common theme in safeguarding work, the LSCB agreed that a targeted SLWG would provide focus for progressing change in this important area.

Arising from case reviews, there were questions raised about the need for different practice in child protection conferences given the potential for family members to be silenced or subject to further violence. The review report commented "Case conferences with the perpetrator attending undermined information sharing...because of the risk of triggering further violence". It also raised another issues regarding local agencies policies having the effect of prioritising confidentiality over information sharing. The reviews also raised questions about the role of perpetrators of domestic violence and if it was realistic to include requirements in CP plans that the perpetrator should not be in the home.

The multi-agency audit of nine cases found that in the small sample of children who are at risk of harm from domestic violence, services had demonstrated some improved outcomes, especially in relation to physical health and ability to engage and learn at school. However, in other cases improved protection from violence is yet to be secured. However, the overall approach to work is characterised by an absence of engagement with a key party - that is the abusive partner/ father. This necessarily limits ability to manage risk and certainly to confront and resolve it.

Considering the evidence from the case review, audit and consultation with LSCB members the SLWG will be tasked with: evaluating the impact that multi agency work has on improving the outcomes for children and young people who live with domestic violence; identifying areas for improvement and establish an implementation plan to drive forward these improvements; ensuring that children and young people are included in the work of the group; and considering equality and diversity needs of children and young people living with domestic violence

By October 2014, the SLWG is expected to: present findings to the LSCB outlining areas of practice to develop for 2014-16; develop a brief LSCB Best Practice Guidance document; provide a briefing based on the findings for Partnerships and agencies responsible for commissioning services in relation to domestic violence; and develop a protocol to establish links between Strategic Partnerships for DV, Safeguarding Adult Board and the LSCB to ensure that there is a clear pathway for sharing data collection.

Self-harm and suicide

12.5 In April 2013, the LSCB identified the need for a specific working group to review multi-agency practice in relation to deliberate self-harm and suicide prevention among children and young people. This followed the tragic deaths of two adolescents which had been

reviewed by the Case Review Sub group, and concerns across London in dealing with children exhibiting self harm behaviours with a risk of suicide.

12.6 The SLWG engaged with partners working with CYP to identify good practice, gaps in provision, and identify multi-agency solutions. Particular areas for focus included the review of the outcomes of two incident reviews; the lack of coherent data on local needs in relation to self harm; the rise in deliberate self-harm reported nationally; and the risks to partnership working following various national and local reorganizations in a number of agencies.

12.7 The final report of the working group was presented to the LSCB in April 2014. A number of actions – including the producing of practice guidance, an agreed dataset, engagement with schools, and training package – are being taken forward by the group which is due to report back to the Board on progress made at a 2014 meeting.

Child Sexual Exploitation and sexual violence

12.8 A short-life working group to review multi-agency practice in relation to young people affected by sexual violence and gangs and sexual exploitation provided its final report to the LSCB in June 2013. The group was initiated as local agencies recognised that the three boroughs each had a range of initiatives underway and that the safeguarding needs of adolescents, especially looked-after young people and care leavers, are complex and challenging, requiring a different approach from child protection work in younger age groups.

12.9 The group identified three key strands of work to promote a reduction in youth violence and sexual exploitation across the three boroughs, noting that these strands of work need to be considered alongside other related LSCB workstreams such as children who go missing and children at risk of self-harm. These strands included: a need for improved preventive work through the engagement of schools and local communities; improve multi-agency partnership working around youth violence and sexual exploitation; and improve the wider framework for agencies working together.

12.10 Alongside this, the LSCB commissioned the development of a Child Sexual Exploitation (CSE) Strategy, which was published in early 2014, and agreed to adopt the new Pan-London Child Protocol. This was to ensure that a shared approach to tackling child sexual exploitation was taken across all agencies.

12.11 The work plan arising from the short-life working group is now being coordinated through the Multi-Agency Safeguarding Hub (MASH) & CSE Sub-Group (of the LSCB). Since being established, the group has developed and published guidance on CSE referral pathways and the role of the newly created Multi-Agency Sexual Exploitation (MASE) Panel meetings. The MASE Panel, which started to meet monthly from January 2014, is jointly chaired by the Police and Tri borough sexual exploitation lead within social services; the panel has a strategic over view of cases and provides quality assurance in respect of investigations, case work and outcomes for children and young people.

12.12 Multi-agency training on CSE has been incorporated into the LSCB training and development schedule to ensure staff have an improved awareness of to identify and respond to cases. Individual briefing sessions on CSE have also been held for staff working in Housing.

12.13 The Metropolitan Police Service has created a dedicated Child Sexual Exploitation team to deal with the most serious allegations of CSE. The team works closely with partner agencies and employs a number of tactics to protect children. These include full intelligence and background profiling, disruption techniques to thwart those trying to exploit children, interviews with victims and provision of support and safeguarding, as well as the prosecution of offenders.

12.14 The first Tri-borough 'Problem Profile' has been produced to provide the LSCB with a clearer analysis of the prevalence and nature of CSE that local services are currently addressing.

Outcomes for children who are vulnerable from adults within the Criminal Justice System

12.15 Children are vulnerable to adults within the criminal justice system (CJS) in generally two ways: first, and most common, children of adults involved in the CJS may be more vulnerable to poverty, abuse and poor life chances. The siblings of those involved in serious youth violence and gang activity may be vulnerable by association. Secondly, children may be vulnerable to adults who target children for the commission of offences, often of a sexual nature, and may either be known to the offender or randomly targeted through circumstance.

12.16 Outcomes for the first group of children are improved when the agencies working with a family unit communicate well and openly and that there is face to face liaison between the agencies. By working with the adults and seeking to improve their life circumstances, the Probation Service can also improve the prospects for the children involved. The key to improved outcomes for children in these circumstances is:

- Effective identification of the children involved with adults in the CJS
- Competent and comprehensive assessment of the risks posed
- Identification and liaison with other agencies involved with the children and their families
- Effective intervention with the adults to improve their circumstances and by association those of the children.

12.17 For the second group of children, the victim may be a random selection and therefore protection of the child relies on good management of the perpetrator concerned. Most of these offenders will be subject to the local Multi-Agency Public Protection Arrangements (MAPPA) facilitated by the Local Authority, Police, Probation Service and Prison Service. A management plan will be in place for each MAPPA case and the risks are assessed on a sliding scale. Those cases with the most serious risks are managed at Level 3 and this involves a regular review at a minimum of every six weeks with all agencies involved

meeting together. Where specific children are identified as being at risk, liaison with relevant LA services can take place.

12.18 A continued gap in the effective identification of children involved with adults in the CJS is the Probation Service's case recording systems; at present the case record system does not quantify how many cases are flagged for a contact with children's services nor how many cases have contact with children. The Assistant Chief Officer of London Probation is raising this with the national probation service as a priority area for addressing.

13. Continuous improvement in a changing landscape

2013/14 Business Plan priorities:

Good representation of all agencies at LSCB and within its subgroup activities. This should include the strengthening of links between the LSCB and the local partnership boards, Health and Well Being Boards, Public Health and with the Judiciary

To strengthen links with Youth Offending Services and develop an understanding of the issues for children in the secure estate

Continue to identify and respond to the safeguarding implications of Housing Reform on vulnerable children

Establish and respond to changes in the local safeguarding arrangements for Probation and Police

promote improved safeguarding practice in schools, ensuring learning from case reviews, and the development of quality assurance, support, challenge and training

13.1 The landscape of services delivered and commissioned locally for children and families has gone through unprecedented change over the past few years. Understanding the implications of and identifying any risks for the safeguarding of children, which are presented by these changes, is complex and ever evolving. The LSCB has prioritised a number of activities within its business plan to ensure that the LSCB plans and continually reviews the quality of services, and that risks presented by the changing landscape are mitigated.

Good representation and strengthening of links

13.2 Over the course of 2013/14 the Board recruited four Lay Members, a representative from Wormwood Scrubs (the local Category B men's prison in Hammersmith and Fulham), and improved the commitment from schools. This wider membership has expanded the basis for engagement of local agencies but also presents a challenge to ensure that each is able to contribute and demonstrate their impact at Board meetings.

13.3 The three Clinical Commissioning Groups' (CCGs) membership of the LSCB has been strengthened through the presence of the Director of Quality and Patient Safety and the Associate Director for Safeguarding. The CCGs' Safeguarding Team development has also increased capacity of health representation at the LSCB subgroups. The CCG Safeguarding Team host a range of health groups focusing on safeguarding children at operational and strategic levels. The key purpose of these meetings is to disseminate LSCB messages, challenge Health response to LSCB priorities, and consider wider national safeguarding priorities.

13.4 The Board has identified the need to be more rigorous in respect of monitoring the attendance of individual agencies and their contributions. Formal arrangements to monitor attendance, at the main Board and subgroups, are being developed, so that there is more formal evidence to present to challenge partners on non-attendance.

13.5 The well established Westminster 'Prevention of Harm' partnership group is led by Westminster's Director of Family Services and has a strong business plan. It has taken a lead role in developing Tri-borough initiatives including early help, parental substance misuse, sexual exploitation, and work in the area of faith and culture The Kensington and Chelsea and Hammersmith & Fulham partnership groups are well represented multi-agency groups that discuss and disseminate key LSCB documents. It is expected that the Partnership groups will share best practice and review their terms of reference to ensure that they are more challenging and focused on the priorities of the main LSCB.

13.6 To ensure the robustness of governance arrangements a protocol of joint working has been drafted between the LSCB and key partners and partnerships. This document, and steps to secure these arrangements, needs to be agreed by the Board at the earliest opportunity in 2014/15. Opportunities for senior officers outside of the three local authorities, to challenge the LSCB and Chair, at other agencies' board meetings have not been fully utilised. However, recent work to engage Health and Wellbeing Boards gives an impetus to mutual challenge and will need to be followed up by HWBBs as well as the LSCB.

Strengthen links to Youth Offending Service and issues for children in the secure estate

13.7 The LSCB Independent Chair, the Youth Offending Service (YOS) Manager, and one of the Directors for Family Services met with the Governor, and several of their team, at Feltham (Young Offenders Institute). The LSCB Chair had requested this meeting to be organised by the Chair of Hounslow LSCB, specifically because of the fact that the Tri-borough LSCB covers an area that has the highest number of young people in Feltham of any other LSCB. The outcome has been not only an improvement in engagement about young offenders from the YOI but better planning for transfer and release. The YOS was concerned about gang-related activity by young offenders in the YOI and has now delivered training programmes for staff at the YOI about 'handling' this with our young offenders.

Responding to Housing Reform

13.8 Safeguarding vulnerable children and families has had a strong focus across the wide range of housing services provided across the tri-borough. This includes all boroughs having robust protocols in place to work with Children's Services for the most vulnerable households in housing need, providing young people leaving care with a wide range of housing and support options, using bed and breakfast accommodation now only as a last resort, providing a co-ordinated service providing housing advice and employment services to those households affected by welfare reform, ensuring all front-line staff are trained in safeguarding practice and prioritising overcrowded households for moves into larger accommodation.

Spotlight on housing.....

There is an acute shortage of accommodation across the three boroughs which is affordable to households on low or modest incomes. House prices and private sector rents have risen dramatically over the last few years and the three authorities are the most expensive places in the country to live. This has intensified the pressure on the limited affordable accommodation available and on the three housing services. To this has been added the impact of the Government's welfare reform programme;

- Local Housing Allowance and caps on Housing Benefit payments which have restricted the benefit available to private sector tenants, with the effect that many of these tenancies have become unsustainable;
- The Introduction of the Overall Benefit Cap of £500pw for families and couples and £350pw for single people, with the difference between these amounts and previous entitlement being made up effectively by reductions in Housing Benefit;
- Removal of the Spare Bedroom Subsidy for social housing tenants, which for those deemed to be under-occupying their home has led to a reduction of 14 % (1 spare room) or 25% (2 spare rooms) in their Housing Benefit;
- The imminent introduction of Universal Credit (a limited rollout has already started in LBHF) which will replace a number of different benefits and credits with one single monthly payment and will eventually affect tens of thousands of households in the three boroughs.

In Housing terms, the combined impact over the last few years of the housing market position and the welfare reform programme has been:

- The loss of private sector tenancies by households on low incomes;
- Increased pressure on the homelessness services of the three authorities;
- Increased difficulty in securing good quality temporary accommodation in-borough and the need to procure it primarily in other parts of London;
- Increased difficulty in avoiding the use of Bed and Breakfast accommodation for homeless families;
- Greater demands from social tenants to downsize and to move overcrowded families into more suitable accommodation.

13.9 Provisions for safeguarding vulnerable children and families across the wide range of housing services provided within the three boroughs have been sustained against a background of challenging changes in the local housing environment. In response to these pressures the three Housing services in 2013/14 have:

- Dramatically reduced or (in two cases) eliminated the use of B&B for families;
- Reached a position in which there are no families in B&B which have been there for over 6 weeks;
- Adopted systems of suitability assessments in which before placements of families are made into either temporary or permanent accommodation there is a full assessment of the suitability of the offer in terms of its quality, type, size, location and cost, taking into account the needs of the family, including children; Adopted

protocols which involve Childrens and Adults services in decisions about individual households affected by welfare reform;

- Implemented moves for under-occupying and overcrowded households;
- Sustained programmes for the provision of supported accommodation for people with particular housing requirements, e.g. children leaving care, people with mental health issues or people with a physical or learning disability.

Establish and respond to changes in the local safeguarding arrangements for Probation and Police

13.10 The Probation Service has provided a number of updates to the Board during 2013/14 concerning the split of the service into two separate organizations. From 1 June 2014 the National Probation Service (NPS) will manage all court work, any high risk offenders and those subject to MAPPA. The Community Rehabilitation Company (CRC) will manage medium and low risk offenders. Currently both organisations are in public ownership but the Government plans to sell the CRC to the private sector and the tendering and bidding process is underway. This sell off is likely to occur at the end of 2014 with an effective start date of April 2015.

13.11 Both new organisations are currently working to the policies of the former Probation Trust but in time both will need to develop their own. This split will present challenges for safeguarding and child protection as the LSCB and three local authorities will have to develop liaison arrangements with both organisations. Both organisations will be managing cases where work with children is necessary. Indeed it is expected that many domestic violence perpetrators will be managed within the CRC.

13.12 Locally, within the Tri-Borough, it is expected that all Probation staff responsible for case management of offenders will partake in the training programmes offered through the LSCB. This expectation is written into the appraisal planning cycle. These arrangements will need to be developed with both new organisations (CRC and NPS).

13.13 The Health Service has also undergone a year of establishing itself, following significant changes in its structure. The key lesson for CCGs has been to develop leadership across the health economy in an increasingly complex commissioning environment. This is a recognised challenge for the CCGs in ensuring that appropriate links and influences are maintained in order to continue to develop the golden thread of safeguarding throughout the whole health system. This should be reviewed by the LSCB in 2014/15.

Promote improved safeguarding practice in schools

13.14 The Tri-borough Safeguarding in Schools and Education Officer has taken a lead role in promoting improved safeguarding practice in schools.

13.15 A number of maintained and independent schools have conducted audits of their safeguarding practice during 2013/14. Maintained Schools are participating in self-audits

(Section 175) regarding the effective delivery of their safeguarding responsibilities. This provides the opportunity to share good practice across schools and to pick on any emerging themes or gaps to inform future training. The audit programme also includes Independent Schools (section 157). The outcomes are being reported back to the LSCB via the Q&A Subgroup. To promote the use of the audit tool, and to improve the number of schools engaging in this agenda, the Safeguarding in Schools and Education Officer will be focusing on a different phase of schools each school term during 2014/15. All schools will be asked to complete the audit tool which will then be followed up with learning events to share best practice, identify gaps or where further support is needed, and to share current guidance and information on priority areas for the LSCB, such as FGM, CSE, e-safety and work around faith and culture.

13.16 A case review workshop was held in November 2013 for head teachers and school staff regarding the learning from the Daniel Pelka serious case review in Coventry. As a result of the workshop staff more schools are developing or strengthening a Team Around the School approach, identifying children where there are emerging patterns of potential chronic neglect, through assessment of risk factors, consideration around thresholds for safeguarding and child protection and improving timely referrals to Early Help Services and /or Safeguarding Services. This specific workshop complemented the ongoing safeguarding /CP training at an individual school level, for Designated Teachers and Designated Governors which also incorporated the learning from the Daniel Pelka SCR.

13.17 The Team Around the School approach has also afforded the opportunity to consider more complex issues across a particular school population regarding risk factors associated with eating disorders, social networking, cyberbullying and suicidal ideation through an enhanced Team Around the School approach by extending the agency representation to include CAMHs and streamlining referral pathways.

13.18 Representatives from MASH have contributed to single agency training for Child Protection training for schools. Schools have very much valued this input and have reported a much clearer idea of the role of MASH which has in turn strengthened schools' engagement and communication with the MASH.

14. Conclusion and future priorities

14.1 This information submitted and presented in this annual review demonstrates that the LSCB for Hammersmith & Fulham, Kensington and Chelsea, and Westminster fulfils its statutory responsibilities in accordance with Children Act 2004 and the Local Safeguarding Children Board Regulations 2006. This Review is evidence that the LSCB has coordinated the work of agencies, represented on the Board, for the purposes of safeguarding and promoting the welfare of children in the area. The review also captures the mechanisms the LSCB has in place to ensure and monitor the effectiveness of what is done by agencies to safeguard and promote the welfare of children across the three boroughs.

14.2 The role and scope of the Tri-borough LSCB is considerable. Key achievements from 2013/14 include:

The publication of the Threshold Guidance and a Local Assessment Protocol.

The roll out of MASH across all three boroughs.

Development of CSE strategy and MASE panel.

The work to strengthen agencies response to missing children and child sexual exploitation.

Strengthening of local safeguarding networks through the three local Partnership groups.

Establishment of Section 11 panel which has promoted improved standards of safeguarding within partner agencies.

Development of training program that includes E learning and new specialist courses.

LSCB Newsletter promoted across all agencies.

The strengthening of relationships with the community, faith and voluntary sector.

Young people contributing more significantly to the safeguarding work of the Borough.

Publication of SCR in January 2013 with associated learning events.

14.3 Areas for development, or where progress is not as good as the LSCB would want it to be, are highlighted throughout the document. Below is a summary of these development points and other observations captured while compiling this report.

Governance arrangements:

- Safeguarding is a priority for statutory members of the LSCB; this is evidenced by the strong commitment and contribution to subgroups and short-life working groups. Actions for improvement have been identified where individual agencies have not fully engaged in the past.
- There is evidence that partners hold each other to account for their contribution to the safety and protection of children and young people but there is no formal way in which this is collated. The Chair prioritised this for action during 2013/14 and further initiatives during 2014/15 will see challenge better promoted and evidenced.

- The Tri-borough Board and subgroup structure enables partners to assess whether they are fulfilling their statutory duties to help, protect and care for children and young people. The Board wants to capitalise on joint working with the three Health and Wellbeing Boards, and this should be strengthened during 2014/15 following the agreement of a joint working protocol. Relationships with other partnerships also need to be articulated.
- The LSCB Business Plan should be made more 'SMART' in future. In particular the business plan should identify what impact it intends to have on improving outcomes for children and young people. Consideration should also be given to streamlining the number of actions to make the Board more focused. This needs to be balanced with ensuring the LSCB does not overlook key areas of importance for children and young people's well-being.
- The LSCB should consider commissioning a Joint Strategic Needs Analysis (JSNA) of local safeguarding needs - that is owned and shared by partners - to strengthen the LSCB's priority setting process.
- There should be a concerted effort by all standing and short-life subgroups of the board to evidence the impact the LSCB is having on outcomes for children and young people. This could be supported by a review of how groups report to the Board and how the subgroups manage and evidence their work.
- It would be useful for the chairs of the three local partnerships groups to review the strengths and weaknesses of their groups and share learning and best practice

Quality and Effectiveness:

- The Quality Assurance Framework is now established which is starting to evidence 'how much, how good, and what difference'; however the 'what difference' aspect of this needs further development so that the LSCB is able to evidence with some confidence the impact it is having on outcomes for children and young people.
- The case audits undertaken by the Quality and Assurance Subgroup demonstrate that the LSCB is able to understand the quality of practice and areas for improvement.
- The LSCB should develop its performance monitoring to focus more on outcomes and the impact of services on outcomes. Adopting a more 'thematic' approach may help strengthen this focus on outcomes.
- There are continuing challenges to data collection and performance monitoring from some partner agencies, this should be escalated to the Board for discussion and action.
- The 2014/15 audits on sexual exploitation and neglect are likely to inform future LSCB priorities.
- Section 11 reporting could be made more prominent at the Board.

Learning and development:

- The LSCB has a comprehensive framework of learning opportunities for staff working with children in the three boroughs as evidenced through the training programme and learning from case review and audits. The LSCB training offer is regularly reviewed and demonstrates that it is quick to respond to local demands
- The evaluation of training is mainly focused on the take-up and quality of training; the Learning and Development Subgroup should develop mechanisms to evaluate its

effectiveness and impact on improving front-line practice and the experiences of children, young people and families as soon as possible.
- The LSCB needs to assure itself that key messages and lessons from case review and audits are reaching frontline staff across all agencies.

Communication and dissemination:
- The development of the standalone LSCB website should help to ensure that the LSCB has a strong identity and that it is able to effectively communicate the local 'safeguarding story'.
- The LSCB needs to assure itself that key messages and lessons from case review and audits are reaching frontline staff across all agencies.

LSCB Priorities:
- Neglect is a cross-cutting theme that needs to be highlighted across all the other priorities.
- Child sexual exploitation, gangs, missing young people, suicide risk are linked further high priorities
- Responding to national issues at a local level, such as female genital mutilation, will also be high on the LSCB's priorities.

Early help
- The LSCB ensures that high quality policy and procedures and in place, as evidenced by the publication of the Threshold Guidance and a Local Assessment Protocol. The LSCB should assure itself that policies and procedures are regularly monitored and evaluated for their effectiveness and impact, possibly through a rolling audit programme.
- There should be further consideration given to how the Board will monitor and challenge the effectiveness of early help services, including MASH, in the future.
- The work around faith and culture is a significant; further work by the LSCB is required to ensure that this is fully embedded and its effectiveness evaluated. Further resources may need to be identified to support this work long-term into the future.
- Female Genital Mutilation is an area that has been consistently raised by partners as a priority for further action. The work of the standing (implementation) group, set up in March 2014, should be included in the business plan for 2014/15, and challenged by the Board.
- Shared priorities for action between the LSCB and Adult Safeguarding Board should be identified – this may be a good forum to take forward priorities around domestic violence, parental mental health and parental substance misuse.

Better outcomes for children subject to child protection plans and those looked after
- The impact of the LSCB in this area is not as clear as other priority areas of the Business Plan. Further consideration should be given to the added value the LSCB can bring to improving the impact of services on outcomes for children and young people and how it should hold agencies to account in this priority area.

- An audit of cases regarding practice in relation to neglect is planned for 2014/15. Recommendations for the LSCB should be incorporated into the Business Plan in this section.

Compare and contrast

- The close relationship between partners ensures that the LSCB understands the nature and extent of local issues for children and young people. Significant developments have taken place over the past year to progress work on missing children and sexual child exploitation and further work is planned on FGM.
- In order to avoid any drift in any of the working groups (in regards to scope and timescales) stronger project management support needs to be put in place, with more clearly defined timescales, purpose and specified outcomes of work. The LSCB will need to ensure that it has the appropriate resources to support this activity.
- Probation and the CRC should take steps to ensure that children involved with adults in the Criminal Justice System are identified in recording systems.

Changing landscape

- The LSCB and Chair has demonstrated challenge to agencies – such as Health, Police and Probation – in regards to the effectiveness of safeguarding during structural change. The LSCB should ensure that it continues to challenge the Local Authority following structural change.

Appendix A

Members of the Tri-borough Local Safeguarding Children Board (2013/14)

Name	Position	Organisation
Jean Daintith	Independent Chair	n/a
Andrew Christie	Executive Director of Children's Services	Tri-borough Children's Services
Liz Bruce (deputy for Board was Gill Vickers)	Executive Director of Adults' Services (DASS) Director for Operational Adults' Services	Tri-borough Adults Services
Cllr Heather Acton	Deputy Cabinet Member for Children & Young People	Westminster City Council
Cllr Helen Binmore	Cabinet Member for Children and Education	Hammersmith and Fulham Council
Cllr Elizabeth Campbell	Cabinet Member for Family and Children's Services	Royal Borough Kensington and Chelsea
Clare Chamberlain	Director of Family Services	Royal Borough of Kensington and Chelsea
Steve Miley	Director of Family Services	Hammersmith & Fulham
James Thomas	Director of Family Services	Westminster City Council
Debbie Raymond	Head of Safeguarding, Review and Quality Assurance Service	Tri-borough Children's Services
Tim Deacon	LSCB Business Manager	Tri-borough Children's Services
Will Jones	Assistant Chief Officer	London Probation Trust
Paul Monk	Chief Inspector	Metropolitan Police (CAIT)
Lucy D'Orsi	Chief Superintendent	Metropolitan Police (LBHF)
Peter Harwood	Head Teacher of Special school	Woodlane School
Sally Whyte	Secondary Head Teacher	Lady Margaret School
Wayne Leeming	Primary Head Teacher	Melcombe School
Ian Heggs	Director for Schools Commissioning	Tri-Borough Children's Services
Greg Roberts	Housing Services	Westminster City Council
Adam Taylor	Community Safety Partnerships	Westminster City Council
Liz Royle	Head of Safeguarding	Central London Community Health Care, Chair of L&D Group
Dr Louise Ashley	Director of Nursing, Quality and Assurance,	Central London Community Health Care
Eva Hrobonova	Deputy Director for Public Health	Tri-borough Councils
Nicky Brownjohn	Associate Director for Safeguarding	Central London ,West London, Hammersmith and Fulham, Hounslow and Ealing Clinical Commissioning Groups (CWHHE)
Senga Steele	Deputy Director of Nursing	Imperial Healthcare NHS Trust
Zafer Yilkan		CAFCASS
Andrea Goddard/Paul	Designated Doctor for Safeguarding	Central London, West London,

Hargreaves		Hammersmith and Fulham CCGs Medical Adviser to LSCB
Patricia Grant / Sarah Hamilton/ Sian Thomas	Designated Nurse for Safeguarding	Central London, West London, Hammersmith and Fulham CCGs Health Adviser to LSCB
Libby McManus (deputy for Board is Vanessa Sloane)	Director of Nursing and Quality.	Chelsea and Westminster Hospital
Jonathan Webster	Director of Quality, Patient Safety and Nursing	CWHHE CCG Collaborative representative for Central London/ West London/ Hammersmith and Fulham CCGs
Catherine Knights	Associate Director of Operations	Central North-West London Mental Health Trust
Johan Redelinghuys	Director of Safeguarding	West London Mental Health Trust
Denise Chaffer (previously Janet Shepherd)	Director of Nursing	NW London Area Team NHS England
Steve Lennox	Director of Quality and Health Promotion	London Ambulance Service
Sally Jackson	Voluntary sector representative	Standing Together
Elizabeth Virgo, Tola Dehinde, Poppy Scott-Plummer, Andrea Andriou	Lay Members	n/a
Mark Emmett	Head of Safer Prisons, Equalities and Diversity.	Wormwood Scrubs Prison

Appendix B

Tri-borough LSCB Statement as at 31st March 2014 for 2013/14 Financial Year

	LBHF	RBKC	WCC	Total
Reserves 13/14	(72,000)	(67,370)	(167,635)	(307,005)
Reserves available 13/14	**(29,050)**	**(110,320)**	**(167,635)**	**(307,005)**
Total Partner Contributions	**(88,950)**	**(82,290)**	**(85,250)**	**(256,490)**
LSCB Expenditure in 2013/14				
Salary expenditure	86,156	82,721	83,355	252,232
Training	14,236	4,290	5,652	24,178
Case Reviews	10,151	0	25,125	35,275
Multiagency Auditing	5,781	5,781	5,781	17,343
Other Expenditure	3,955	0	0	3,955
Total expenditure	**120,279**	**92,792**	**119,913**	**332,983**
1314 Outturn Variance	**31,329**	**11,422**	**7,840**	**50,590**
Reserves Closing balance	(29,050)	(111,240)	(140,812)	(281,102)

The considerable reserves (totalling £307k) was carried forward from 2012/13 from the three previous Boards, with a previous agreement for these fund to be used to resource case reviews, and where sufficient funds exist in the respective reserves, on cross-borough LSCB projects. In 2013/14, the Board decided to fund the Community Development Worker post, resource multi-agency LSCB audits and to fund a number of case reviews.