City of Westminster

WESTMINSTER

LOCAL SAFEGUARDING CHILDREN BOARD

ANNUAL REPORT

2011/12

CONTENTS

Foreword

From Terry Bamford, Independent Chair

2011/12 was a year of transition. Nationally the Munro Report on child protection suggested a new approach which the Government decided to implement. Locally we were preparing for a smooth handover to the tri-borough Board charged with overseeing safeguarding work from April 2012. Operationally the Ofsted inspection confirmed the high quality of safeguarding work and the way in which the department had adjusted to the loss of some highly experienced staff.

The Munro Report was widely welcomed as setting a new and less prescriptive model for safeguarding. It recommended much greater flexibility in the use of timescales for assessment and a focus on the needs of the child. It supported a more reflective and inclusive approach to Serious Case Reviews and a strengthening of the role of the Safeguarding Children Board. The full implications will be felt in the next two years but Westminster has been piloting the flexibilities and found the freedoms helpful without compromising the quality of work.

The tri-borough Board will carry this work forward. The past year has seen much detailed work on the structure and responsibilities of the new Board. It will face some difficult challenges in keeping contacts with local community groups, schools and voluntary groups but the gains from a unified structure will be considerable enabling best practice to be shared and integrated. In difficult economic times the LSCB will need to be alert to ensure that safeguarding achieves the highest common factor rather than the lowest common denominator.

The Serious Case Review reported in last year's Annual Report was a severe pressure on the frontline staff affected as the inquest expected in the summer was delayed on a number of occasions finally being concluded in April 2012. The detailed and conscientious work carried out by Westminster-based staff in all agencies was recognised by the Coroner.

The announced Ofsted inspection went well with services being assessed as good. This was a reflection of the very hard work put into the process by management staff. External validation of the quality of services is always welcome although the process continues to generate anxiety. One positive outcome was an improvement in the information available on the LSCB website.

It has been a privilege to serve as Chair of the LSCB. Westminster is fortunate in the quality and commitment of staff working in safeguarding in all agencies. This year Michael O'Connor and Geoff Skinner retired from Children's Services taking with them well over half a century of child protection experience. That is not easily replaced but the calibre of those who have moved into more senior roles augurs well for the future. Ann Duncan's departure from the PCT was a further significant loss for the Board during the year. The Board has however continued to receive excellent support from designated health professionals.

The LSCB has been lucky in the quality of the support given to it by Jo Bevan-Taylor and Belinda Riley as Business Managers bringing to the role a delightful combination of charm and efficiency for which I thank them.

Terry Bamford

Independent Chair, Westminster LSCB

1. Introduction

Working Together to Safeguard Children 2010 required LSCBs to include in their annual report a comprehensive analysis of the effectiveness of safeguarding arrangements in place by each member agency and the outcomes for children from these arrangements. This report summarises the activity of the Board in its final year, including reports from the Board's subgroups, a summary of the findings from the Ofsted inspection of Arrangements for Safeguarding and Looked After Children and details of a multi-agency "safeguarding stock take" exercise completed to assess the strengths and risks as at March 2012. Using this information, the report identifies areas for further work and remaining challenges going forward into the tri-borough arrangements.

This report will be signed off by the new tri-borough LSCB and reported to the Lead Member as well as the Chief Executives of partner agencies. It will be published on the Westminster LSCB website following sign off.

2. Business Plan 2010/11 Achievements

The business plan for 2011/12 set out a number of key priority areas on which the LSCB would focus its work for the period:

- Dealing with the EG inquest and monitoring closely the EG Serious Case Review action plan

The background to the Serious Case Review was set out in the Westminster LSCB Annual report of 2010/11. The inquest into the death of EG was finally held in April 2012 and returned a verdict of accidental death. The verdict in relation to EG's mother was death by natural causes. No addendum to the SCR Overview Report was required following the inquests. The Executive Summary of the SCR was published on the LSCB website shortly after the inquest verdicts. The conclusion of the inquests

and publication of the report drew to a close a long and challenging period which had begun with the tragic deaths of EG and his mother back in March 2010.

The implementation of recommendations via the EG SCR action plan was overseen by the LSCB Quality Assurance subgroup (see report below) and noted by Ofsted within their inspection report. Learning from the case continues to be disseminated to multi-agency practitioners through workshop sessions offered across the tri-borough area. The case has also been subject to review by the Tri-Borough LSCB Case Review Group to consider whether there are any further opportunities for sharing lessons learned more widely. There is ongoing work continuing through the new tri-borough safeguarding arrangements looking to increase the effectiveness with which safeguarding services engage with families who require interpreters but where there may be barriers around using interpreting services effectively.

- Involvement in Tri-Borough developments

The period saw very substantial structural re-organisations taking place across a wide range of partner organisations including health and local authority services. The Board went beyond the consideration of the safeguarding implications for individual services and fully engaged in the proposals for developing a tri-borough LSCB. Through regular discussions, debates and consultations, proposals were shaped for new safeguarding arrangements which spanned not only Westminster but the Royal Borough of Kensington and Chelsea and the London Borough of Hammersmith & Fulham.

There were a range of views and contributions made to these deliberations and partners were keen to explore the potential risks and benefits of such an approach. For several member agencies already operating across the three boroughs, there were clear benefits. Some elements of the Board's work already took place within a tri-borough context i.e. CDOP activity and the LSCB training programme. Members were keen however to consider how the scrutiny and challenge required of local arrangements for Westminster children and young people would be maintained and strengthened within the new arrangements.

In the final weeks of the Board, member agencies were asked to participate in a safeguarding stock take. Key strengths and risks were identified by partners and

collated for discussion at the final meeting of the Board. These findings have been translated to the work programme of the new Board and the stock take document is provided as Appendix 1 to this report.

The Board successfully supported the transition to new tri-borough LSCB arrangements from April 2012. The new Board is supported by a small team based in Hammersmith within tri-borough Children's Services. An Independent Chair, Jean Daintith was appointed in March 2012 and Terry Bamford, the outgoing Chair of the Westminster LSCB supported an effective handover. Several members of the former Westminster LSCB are represented on the tri-borough Board.

- Responding to the Munro Review and considering the implications for safeguarding in Westminster

The Westminster LSCB and several of its constituent agencies were very involved in the Munro Review during 2011/12. Several Board members were involved in focus groups and participated actively in the consultation exercises linked to the review. Westminster Children's Services was one of the local authorities piloting a number of freedoms and flexibilities relating to assessments and child protection conferences which have been subject to evaluation and have contributed to the shaping of the revised proposals for statutory safeguarding guidance (Working Together 2012).

The Board heard regular reports relating to the progress of the pilot, ensuring that it was reassured as to the safety and wellbeing of children and young people throughout. In addition, work of the Prevention of Harm Subgroup (outlined below) maintained a focus on the early help offer available within Westminster through the delivery of services across the localities.

The Board received regular updates from the Chair on the progress of the Munro Review and the Government's response to it.

- Implementing the Strengthening Families Framework

The Strengthening Families model was introduced in Westminster in September 2011 following careful planning and preparation with the aim of improving the engagement of families in the child protection process and thus securing more effective child protection planning for children and young people. The initial phase was a pilot and the project was rolled out to all child protection case conferences from January 2012. The pilot was evaluated through questionnaire feedback, semi-structured interviews with parents and a focus group with children and young people. The qualitative feedback has been extremely positive. The introduction of the approach coincided with a decline in the numbers of children subject to a child protection plan and it is believed that this is related to the increased focus on risk assessment through the strengthening families approach.

Written materials for conference participants have been updated and an electronic whiteboard is now used in conferences. The project has naturally led to an increased focus on the participation of children and young people which is a core theme in the ongoing work.

Evaluation of the model is ongoing and plans are in place to share the learning from its implementation with colleagues from other areas in the autumn.

3. Governance and Accountability

Financial Contributions

Financial contributions towards the costs of the Board were received from the Inner North West London PCTs, Westminster City Council, the Metropolitan Police, CAFCASS and the Probation Service. The Board entered the new tri-borough arrangements with reserves which will be maintained for funding any necessary case reviews or Westminster specific activity in the future. A summary of the Board's accounts for 2011/12 is provided in Appendix 2.

Lead Member involvement

The Lead Member, Councillor Nichola Aiken engaged in the work of the Board via a monthly Cabinet Member briefing as well as a standing invitation to all the LSCB Main Board meetings. The Independent Chair of the Board met with the Cabinet Member and Chief Executives of the Member Agencies over the past year and was also a regular attendee and contributor at the Children's Trust Board meetings.

Partner organisations

Given the new Board arrangements in place from April 2012, the agency stock taking work which is referenced above, and the fact that a full inspection of safeguarding arrangements has taken place during the period covered by this report, additional contributions from each partner organisation have not been included in this report. At the time of writing, the new arrangements for the shared Board are in place and becoming embedded with good representation from agencies responsible for safeguarding in Westminster. Effective relationships established during the lifetime of the Westminster Safeguarding Children Board have greatly supported the evolution of the new arrangements.

4. Sub-Group summaries of activity

Training Sub-Group

The multi-agency safeguarding training offer has been operational across the area covered by the three local authorities for a year and the training subgroup steered this work. An LSCB Trainer has been in post and has been responsible for the direct delivery and commissioning of the programme in 2011/12. During this period of transition, a Westminster based training group has also met to ensure that local Westminster agencies are reassured that their workforce are able to access and benefit from the multi-agency training offer available. There has been close liaison between the two groups throughout 2011/12.

The programme aims to use, as far as possible, the expertise of professionals working within the tri borough area to deliver training although at times we have commissioned external trainers to supplement local resources. By using local knowledge we are able to provide tailor made packages for the professionals working within local agencies.

When embarking on the shared programme we envisaged training being run with an average of 80% of capacity and 80% attendance rate. We have exceeded our expectations and our courses are running on average at 90% capacity. Within this first year we offered 67.5 full days of training and have expanded to offer 12 different courses.

There have been some challenges in extrapolating data on individual agency engagement and participation. It has been agreed that within the new application and booking system due for implementation in 2012/13, agency categorisation will be more specific to ensure that our data is more helpfully available and robust.

However it has been a noted concern that certain sectors remain relatively poorly represented, such as police, probation and adult social care and we need to explore how to improve our communication with these sectors to increase attendance. It may be that these agencies continue to provide single agency training due to the large number of staff but the applicants who receive single agency training are not gaining the benefits that multi agency training offers, particularly in its contribution to improving working relationships.

The evaluations of individual courses by participants appear to be extremely positive with only a small proportion of candidates stating that objectives were only partially met or not met (0.5%). The LSCB training team need to continually revisit the course objectives and make sure that they are SMART and are reflective of the content of the course. Furthermore the training department is aware that we need to better understand how the training delivered is impacting on outcomes for children and young people.

In relation to the evaluations of the trainers' skills there has been positive feedback. Across all the courses, 80% participants have evaluated the trainers' subject knowledge as excellent. We continue to look at how we can achieve the correct balance between trainer input and group work and endeavour to provide more group learning activities within the training.

Within this programme it was agreed that we should charge for non attendance at courses. Work is underway to ensure that there are more efficient invoicing mechanisms in place to recoup charges from non-attendance in the future. In addition, arrangements are now in place to ensure that income from charging private profit making organisations is collected in respect of training.

Quality Assurance Sub-Group

The purpose of the Westminster LSCB QA sub group during 2011 to 2012 was to:

1. To develop the QA group action plan

This was achieved and guided the agendas for the group during the year

2. To develop a Practice Review core group

The group was not formally set up. However, key members of the QA group did coordinate or participate in reviews of practice in cases. Three cases were considered by the group during the year. The learning from these cases was taken to the QA group to develop an action plan. Instead of individual plans, a themed action plan was developed. This was transferred over to the Tri-borough LSCB Case review group for consideration in March 2012.

3. To review performance monitoring of all the agencies

The QA group scrutinised the performance reports from the local authority. Information from key agencies was requested and some of this was considered by the group. It is recommended that this be taken up by the Tri-borough LSCB QA group as good practice. The yearly performance data provided by the local authority is attached as Appendix 3 to this report. In addition, data relating to child deaths is also included as is some data relating to allegations against people working with children. The new shared Board has received reports on both of these areas in its early meetings.

4. To review SCR/joint reviews/Individual Management Reviews

The EG SCR action plan was monitored by the group. Any areas not within timescale were challenged. The action plan had not been signed off by March due to some outstanding actions, within timescale. The group tested completed actions and asked for further evidence where it was insufficient regarding the use of interpreters.

5. To monitor the ‘Strengthening Families Framework’ Review

The group received regular verbal updates on the progress of the 'Strengthening Families' model. It was viewed as being innovative and providing better outcomes for children.

6. To publicise learning from national and local SCRs via the dissemination of a regular briefing and analysis of all Westminster SCRs

This was not achieved during 2011 -12 due to the EG SCR not being published whilst the inquest was awaited. A briefing took place in June 2012.

7. Identify detailed areas of learning and transfer to Prevention of Harm group.

The QA group identified that practitioners seemed to have difficulties in engaging with vulnerable families from black and ethnic minority backgrounds. This was passed to the Prevention of Harm subgroup which looked into the issue in more depth.

The QA group undertook an audit of ECAF. This identified some concerns regarding the links between the ECAF and social care record system when the case transferred into the child protection system. This has been raised with the Prevention of Harm group to oversee. In addition, a CAF development group was established to review the system.

8. To review K&C and H&F Quality Assurance processes

This was achieved and highlighted differences in the processes which will be addressed by the Tri-borough LSCB QA group.

In addition to the work plan the QA group considered other issues that arose during the year such as the impact of the housing benefits' changes on vulnerable families in the city. The group received a report from the housing team and social care to check that there were sufficient safeguards in place for children subject to protection plan. The group considered that monitoring of this needed to continue within the tri-borough LSCB.

The group also considered domestic violence including forced marriage. It was agreed that oversight of these issues would be transferred to the Violence against Women and Girls Strategy Group.

The final meeting was held in March 2012. Outstanding areas were transferred to the Tri-borough LSCB.

Prevention of Harm Sub-Group

A number of themed meetings were undertaken over the course of 2011/12 to focus the work of the group and ensure that preventative issues identified in the LSCB Business Plan were fully covered. The meetings allowed for sufficient focus and discussion on the specific issues and for detailed action plans to be drawn up following the meetings to ensure that the sub-group could continue to monitor progress and ensure continued LSCB awareness of the issues.

In response to the reductions in management capacity in all agencies, 2 other partnership groups and their responsibilities have been absorbed into the Prevention of Harm sub-group – namely the Think Family Steering Group and the Adolescent Task Group. As a consequence, the Prevention of Harm sub-group revised its work plan in September 2011 for the following 18 months, and has sought to be more rigorous in focussing on a smaller number of priority areas and follow through with action plans that make a significant impact upon outcomes for children.

The priority themes and these work stream leads are as follows:

- Ensuring that children and young people are protected from Serious Youth Violence – Matt Watson, Service Manager, Integrated Gangs Unit;
- Improving Schools' capacity to recognise and respond to safeguarding concerns – Jo Green, Safeguarding in Schools Officer;
- Developing a more effective response to parental substance misuse – Natasha Bishopp, Head of Family Recovery, and Jill Britton, Senior Commissioning Manager;
- Developing a more effective response to parental mental health – Natasha Bishopp, Head of Family Recovery, and Alison Evans, Social Care AMHP Lead;
- Developing more effective protection of children across faiths and cultures – Debbie Raymond, Head of Safeguarding;
- Improving the awareness and take-up of services for vulnerable adolescents – Jill Britton, Senior Commissioning Manager.

Child Death Overview Panel (CDOP)

The Child Death Overview Panel operates across three boroughs, Westminster, Hammersmith and Fulham and Kensington and Chelsea. The Panel was accountable to three Local Safeguarding Children Boards (Westminster, Hammersmith & Fulham and Kensington & Chelsea) and as such was required to report to them on its work at the end of the year.

The work of the Panel itself has focussed on examining specific incidents of child deaths across the three boroughs, drawing conclusions about whether those deaths were preventable, and considering factors that seemed to have contributed to those deaths.

The CDOP has been fully functioning with key agencies contributing to the process during the last year. During 2011 the panel met on 4 occasions and completed full child death reviews on 36 children of children of families resident in the boroughs of Westminster, Hammersmith & Fulham and Kensington & Chelsea. These cases were from 2009-10, 2010-11 and 2011-12. It should be acknowledged that the CDOP is not effectively able to fully review a death until information is gathered and other processes have been completed such as inquests and serious case reviews. The full CDOP annual report was presented to the July 2012 LSCB meeting.

CDOPs only review the deaths of children resident in their local area so the majority of deaths within the boroughs are reviewed by CDOPs around the country. The high number of child deaths from outside the borough reflect the high level of specialist health provision both NHS and private sector.

Education Safeguarding Work

Whilst no formal subgroup operated, during 2011/12 work continued to strengthen the LSCB's engagement with schools.

The training offer for school staff entered its second year and has been well attended, with requests for places also being received from Independent Schools. Two courses are offered; a one day course for those senior staff in schools who hold designated responsibility for child protection and a half-day course for other school teaching and support staff. During the academic years 2010/11 and 2011/12 a total of 79 designated senior staff and 202 other school staff have attended these courses.

In collaboration with Westminster's Commissioning Officer for Governor Services a total of 54 school governors have attended Safeguarding training sessions delivered by the Education Safeguarding Lead Officer.

Working closely with the Child Protection Advisers a pro-forma was offered to all schools for their use when invited to Child Protection Conferences. The pro-forma enables school staff to submit the fullest information needed when a child's circumstances are being considered at an Initial Child Protection conference and was also intended for use at review conferences. Schools were initially slow to adopt use of the form, and it is now being included in the invitation to conferences sent to schools by Business Support Officers.

Lessons from Serious Case Reviews and other reviews both nationally and locally that are relevant to schools' Safeguarding and Child Protection practices have been brought to Headteachers and Governors' attention and also included in the training materials which are revised to include these learning points as they arise.

Two Headteachers representing the Primary and Secondary phase have been recruited to become part of the Prevention of Harm sub-group.

5. Serious Case and Management Reviews

2011/12 saw the conclusion of the various events and processes which had been started following the tragic death of child EG and his mother. The majority of the activity relating to the serious case review following the death of EG is detailed in the annual report for 2010/11. The Executive Summary of the SCR was published by the Westminster LSCB following the inquests into the death of EG and his mother as detailed in section 2 above.

In addition to the above, in 2011/12 a number of other cases were subject to review (although not subject to serious case review processes as set out in Chapter 8 of Working Together 2010).

In September 2011, the Westminster LSCB Serious Case Review Panel convened to consider the death of a fifteen year old young person. The Coroner recorded death by

suicide. A management review was undertaken with terms of reference agreed which would review the circumstances leading up to the young person's death including contacts with key agencies.

In another case, a joint Local Safeguarding Adults Board and LSCB case review was initiated following the apparent suicide of a parent (father) with mental health problems. The LSCB SCR panel agreed that the criteria for an SCR were not met but given the case involved both a vulnerable child and adults, it was felt that there could be some learning from the case.

Following another apparent suicide of a parent (mother) of a young baby, the Board's SCR Panel again convened in November 2011. Similarly, whilst the criteria for undertaking a serious case review were not met, it was agreed that a multi-agency practitioner group should meet to reflect on the learning across agencies from this case.

The findings from all three management reviews have been shared either through presentation at the Westminster LSCB or through consideration at the newly convened Case Review Subgroup within the new joint safeguarding arrangements. It is important that learning is transferred to frontline staff through these mechanisms and this is an area of focus for the new Board as well as overseeing the implementation of recommended actions arising from the reviews.

6. Ofsted Announced Inspection of Safeguarding and Looked After Children Arrangements

In September 2011, Ofsted and CQC inspectors arrived to undertake a fortnight's inspection of local arrangements in respect of safeguarding and looked after children services. Partners worked together well to demonstrate how local arrangements deliver improved outcomes to local children, young people and families.

After a rigorous fortnight of inspection activity including meeting with the Chair of the Board and a number of Board members, Ofsted concluded that local safeguarding

services were good in terms of their overall effectiveness and had good capacity to improve. Services for looked after children were similarly graded.

The full report is available via the following link to the Ofsted website:

http://www.ofsted.gov.uk/local-authorities/westminster

Safeguarding arrangements were rated as good in the following areas – ambition and prioritisation, leadership and management, performance management and quality assurance, partnership working, quality of provision, safeguarding outcomes for children and young people, equality and diversity. The contribution of health agencies to keeping children and young people safe was rated as outstanding.

The LSCB was deemed to provide good leadership and have representation at the appropriate level to enable the Board to hold partners to account. The training programme delivered by the Board was praised. The Board was reminded by inspectors that it needed to maintain private fostering arrangements as a priority (and subsequently received a report at it final meeting in March 2012) and a recommendation was made to endure the increased participation of the Probation Service in meetings and subgroups (this has been achieved in the new joint Board arrangements).

The inspection confirmed that local safeguarding arrangements were fit for purpose as preparation was made for sharing new arrangements in the coming months.

7. **Future Board Arrangements**

Westminster, Hammersmith and Fulham and Kensington and Chelsea LSCBs worked together to prepare for the new LSCB for Hammersmith and Fulham, Kensington and Chelsea and Westminster which came into operation on the 1st April 2012.

Westminster LSCB members fully participated in consultation events and workshops to ensure that they were involved in key decision making about future LSCB priorities and future board membership.

In preparation for the move to the tri-borough LSCB, each agency undertook a stock take exercise where they were asked to identify 3 top priority safeguarding risks with recommended actions for the new tri-borough LSCB to reduce the risk. Agencies were also asked to identify safeguarding strengths in Westminster. The full stock take report is referred to in Appendix 2 and provides a helpful self-assessment by member agencies of some of the issues facing the new Board going forwards.

Progress made in addressing some of these priorities will be detailed within the annual report for 2012/13 of the new LSCB for Hammersmith and Fulham, Kensington and Chelsea and Westminster.

November 2012

Appendix 1 LSCB Stock Take exercise table of information by Westminster LSCB partners

LSCB Stock Take March 2012

Each agency attending the LSCB Executive on the 27th March is expected to give some consideration to the following questions, complete and feedback (max) three key bullet points in the tables provided

1. During a time of transition and significant change within a number of organisations there may be some risks towards responsibilities in relation to Safeguarding. Can you identify a maximum of three top priority risks, Does it affect your own agency or the partnership? What is being done to reduce the risk? What support can the LSCB provide to reduce the risk?

2. What are the strengths of safeguarding in Westminster? How is this evidenced?

Children's Services

Risk	**What is being done to reduce the risk?**	**What support can the LSCB provide to reduce the risk?**	**Recommended actions for tri-borough LSCB annual plan**
Recent case reviews have high-lighted that community perceptions of services may deter families from B.M.E backgrounds from seeking early help, leading to poorer outcomes. This affects all agencies	Basic tracking and monitoring mechanisms around safe-guarding issues which affect BME communities have been increased. A plan to engage with local community groups is under development	Identify this as a priority for development across all agencies	Convene a short-life working group to develop good practice and to work in detail on local implementation of the Pan-London Safe-guarding Children Culture and Faith Project
Gang related serious youth violence and associated sexual exploitation have become significant issues affecting the safety and well being of adolescents in the borough	There is a comprehensive *Your Choice* strategy in place which addresses these issues	The LSCB can provide a point of co-ordination and inter-agency discussion on this issue	Compare and contrast services for girls at risk of gang related sexual exploitation and further develop strategy across the three boroughs
Changes in housing benefit are placing some families under stress, and may mean that they will have to move out of borough increasing the vulnerability of children as they move between services	Relevant families are being identified, with a view to providing support and advocacy	High-light the risk to children in need, where protocols around transferring cases between areas are less well established than for children subject to Child protection plans	Retain as a multi-agency priority across the three boroughs
Strengths	**How is this evidenced / captured**	**Can we promote this and how?**	**Recommended actions for tri-**

			borough LSCB annual plan
The Strengthening Families approach to case conferences is receiving positive feedback and stimulating more innovative ways of working	In an evaluation report which includes feedback from professionals and service users	There are a series of inter-agency briefings arranged and more are planned	The evaluation report should be shared with the board for review and discussion
Increased participation of children and young people in case conferences	End of year performance report Focus Group feedback	Support new ideas that are under development to further increase participation and feedback on services received	Commission a young people's web-page as part of the new website. This could include the opportunity to watch clips of a case conference for example
The number of children requiring child protection for two years has decreased and will continue to decrease	End of year performance report Regular Audits of cases at the 12 month point	The next audit is planned for May 2012 and will be multi-agency. There is a plan to trial Independent chairs meeting with the professional network for all cases approaching the 12 month point to assess whether the case is stuck	Endorse the multi-agency audit framework as a tool for quality assuring case-work and for preventing drift

INWL

Risk	**What is being done to reduce the risk?**	**What support can the LSCB provide to reduce the risk?**	**Recommended actions for tri-borough LSCB annual plan**
Ensuring effective safeguarding arrangements are in place whilst NHS reforms are in transition.	INWL safeguarding committee is monitoring the changes and reporting risks to the PCT Board and North West London, e.g in relation to future of role of Designated professionals. Existing arrangements remain in place until alternatives are established	Contribute to consultations regarding future of Designated role and provide challenge with regard to changes to organisational accountability e.g . CCG representation on LSCB.	Regular update reports on future health developments and challenges posed for the LSCB Request CCG representation on LSCB Exec.
Serious incidents or complex cases are monitored through the work of the Designated Professionals and reporting systems to the PCT and Strategic Health Authority. There is a risk that these systems will not be as effective during the transition phase of the NHS reforms and the LSCB	Recommendations and action plans from are reported to the INWL safeguarding committee. Designated professionals work with Head of Safeguarding for WCC and LSCB to coordinate multi agency reviews	Ensure that Designated professionals are included in case reviews. Receive reports of recommendations from cases. Monitor action plans	Establish a standing item for reports regarding potential or actual serious cases.

changes			
Capacity of Designated Doctor for Unexpected Deaths. Rapid response has to be done for out of borough cases.	Review of health arrangements for unexpected deaths. A report will be presented to the INWL safeguarding committee in May 2012.	Receive reports regarding child death review processes. Support and challenge to identify any gaps in provision.	For senior Business Support Officer to work in conjunction with Designated professionals to monitor and review effectiveness of child death review procedures
Strengths	**How is this evidenced / captured**	**Can we promote this and how?**	**Recommended actions for tri-borough LSCB annual plan**
Partnership working	Contribution to LSCB and sub groups / VAWG group	Report on attendance at LSCB and contribution to subgroup work.	Monitor attendance at LSCB and include in annual report. Include Designated professionals in agenda planning / key work
Contribution of GPs to safeguarding children. Work of Named GP and Safeguarding Lead GP network	Inspection report	Include in annual report. Contribution to Safeguarding Leads Network.	Develop links between LSCB and Safeguarding GP Leads' Network
Creation of INWL team of designated professional nurses allowing for improved cross cover and specialisation	Annual report	Include in annual report.	

CLCH

Risk	**What is being done to reduce the risk?**	**What support can the LSCB provide to reduce the risk?**	**Recommended actions for tri-borough LSCB annual plan**
EG Inquest and outcome	Managed through LSCB and in partnership with all agencies	Sustain ongoing communication , collaboration	Implement any recommendations and learning from the Inquest, and respond to any Coroner Rule 43
Changes to services in response to Health and Social Care Bill	Programme management internally to support changes and journey to Community Foundation Trust	Review progress through regular agenda items	Receive updates from CLCH
HV Implementation Plan Call for Action. Increase of HV workforce over next 4 years	Involvement of commissioning LA officers in deployment and roles of HVs. Programme of Quality Improvement	Discuss and review progress	Receive updates from CLCH
Strengths	**How is this evidenced / captured**	**Can we promote this and how?**	**Recommended actions for tri-borough LSCB annual plan**
Relationships with Safeguarding teams across health and social care	Ofsted reviews and committee working Audit cycle related to safeguarding	Support existing structures and resources for this work	Review actions from committees

	practice in CLCH		
Role of LAC nursing	Ofsted reviews and committee working	Promoting outcomes of work through annual reports from the service	Receive annual reports
Integration and co-location of HV staff in social care teams	Evaluation of locality working , Access team and Family Nurse Partnership	Public facing materials Positive responses from GPs	Receive evaluations of joint working

Housing

Risk	**What is being done to reduce the risk?**	**What support can the LSCB provide to reduce the risk?**	**Recommended actions for tri-borough LSCB annual plan**
Reduced availability of private rented sector housing for non-working households on benefits. This is having the effect of increasing homelessness and reducing the ability to prevent homelessness through in-borough private sector placement by Housing Options Service, thus increasing the likelihood of households in housing need being unable to find housing in-borough.	The updated Discretionary Housing Payment (DHP) policy is targeted at supporting vulnerable households, particularly those supported by Children's Services. Exercise undertake to identify all households affected by the HB changes who are supported by Children's Services, and services will be targeted at these households	Increased awareness raising across all partners at the LSCB to ensure that any household who approaches officers working in different agencies can be signposted to receive advice. Standard item on LSCB agenda in order that all agencies are aware of current developments.	Whilst each of the three borough's housing market is different, all will be facing impact from changes to Housing Benefit on the private sector. The impact of changes should be a standard item on LSCB agenda in order that all agencies are aware of current developments. Increased awareness raising across all partners at the LSCB to ensure that any household who approaches officers working in different agencies can be signposted to receive advice.
Significant pressures on availability of in-borough Temporary Accommodation (TA) for homeless households at a time of increasing demand. This leads to more use of bed and breakfast accommodation for longer periods and more out of borough TA provision for households for whom the Council has a statutory duty to house	Strong links between Children's Services and Housing Services officers, prioritises available in-borough TA stock for vulnerable households.	Westminster has set up a steering group to oversee the Council's response to the welfare benefits changes. This group includes representation from Children's Services, Health Services aswell as Housing Benefit Services and Housing Commissioning. The LSCB to ensure that members of this group are able report back to the LSCB.	As above, to ensure the issue of the impact of welfare benefits changes is a regular item on the agenda and front-line staff of all agencies represented are able to direct any client to appropriate advice.
Westminster has retained a large amount of supported housing provision for young people aswell as refuge provision for households	Tri borough developments will bring about an alignment of commissioning and contract management functions, with a reorganisation of staffing	Ensure that key staff are aware of new commissioning structure and contact processes and information is sent to providers on new	Ensure that members of LSCB have understanding of role and range of available supported housing services

escaping domestic violence and some young parent's provision. All services are targeted at priority groups and to function most effectively have benefited from strong links with commissioners. There is a low risk that operational issues relating to local safeguarding processes in supported housing services matters are not considered at a tri borough level	structures across 3 boroughs. All contracts have clauses setting out provider responsibilities in relation to safeguarding Strong links between commissioners and supported housing services.	commissioning arrangements	
Strengths	**How is this evidenced / captured**	**Can we promote this and how?**	**Recommended actions for tri-borough LSCB annual plan**
Stock of in-borough TA has been retained and there has been some new family sized units procured. Retaining and expanding in-borough TA availability is central to the response to the HB caps (although the market is challenging.)	Total number of in-borough TA units is closely monitored	This should form part of regular updates on homelessness and TA provision	To form part of standard LSCB update
Strong officer links between Children's Services and Housing Services	Partnership working on cases strong		Continued focus on response to front-line service delivery, ensuring that all agencies have focus on child-protection

CNWL

Risk	**What is being done to reduce the risk?**	**What support can the LSCB provide to reduce the risk?**	**Recommended actions for tri-borough LSCB annual plan**
1. Reduction in funding for contracts resulting in re-prioritisation of thresholds.	Reviewing estates utilisation and other corporate issues to reduce overheads and protect front line services. Service redesign of CAMHS care packages and care pathways.	Opportunities to discuss these issues and address the impact with partner agencies. Reviewing of services available and setting priorities for the future delivery of treatment.	Establish effective links between LSCB and commissioning functions to meet the needs of CAMHS safeguarding groups.
2. Reduction in posts providing services to adults with mental health problems may results in less "Think	Think Family Project being initiated by the Trust. Training for staff to ensure they know	A feedback loop where colleagues tell us where safeguarding is not working at a front line level so this is	Extension of lists of those children subject to Child Protection Plans to facilitate appropriate auditing.

Family" approach and increase safeguarding risks consequently.	where to gain advice in such cases. Additional training on Domestic Violence and routine questions. New risk assessment tool for CNWL . Strengthening Supervision Policy.	addressed promptly: to Named Nurse or LSCB lead.	Participation in multi-agency case auditing on regular basis.
3. In the last year 3 cases of parents made attempt /actually took their lives as a result of safeguarding processes with their children.	Case reviews in each case with lesson learnt, but this appears to be a theme given the number of cases.	Understanding of the consequences for vulnerable parents of removing their child/ an equivalent of this and better joint work to support these adults.	Possibility of internal thematic review over processes.
Strengths	**How is this evidenced / captured**	**Can we promote this and how?**	**Recommended actions for tri-borough LSCB annual plan**
1. Range of safeguarding support available for all CNWL services in Westminster	Telephone Helpline highly commended by the London Safeguarding Children Board. Support in Trust equated to £250K. High profile with CNWL Board of Directors.	Annual Report. Completion of Section 11 Audit on annual basis, known to Designated staff.	Completion of Section 11 Audit. Promotion of the SC Awards within the Tri-Borough
2. Excellent LAC team which is integrated with WCC.	Ofsted Inspection. Outcomes for children and young people. Feedback from colleagues in stakeholder agencies.	Annual Report.	Completion of Section 11 Audit.
3. Development of IAPT for children.	Early implementer of CIAPT, commissioned by DH in line with government policy to expand the IAPT service to other client groups. IAPT has strong evidence base and is a NICE compliant model of talking therapy.	Feedback to LSCB on the outcomes from the pilot. Children and young people involved in evaluating this innovative treatment model which aims to be less stigmatizing and more accessible to those from diverse communities.	Presentation to LSCB towards end of 2012/13.

Imperial

Risk	**What is being done to reduce the risk?**	**What support can the LSCB provide to reduce the risk?**	**Recommended actions for tri-borough LSCB annual plan**
EG Inquest and outcome	Managed through LSCB and in partnership with all agencies	Sustain ongoing communication and collaboration	Implement any recommendations and learning from the Inquest, and respond to any Coroner Rule 43
A review of infant abduction and baby tagging policy was required in	Full risk assessment and cost benefit analysis undertaken. Immediate and	Feedback to LSCB on outcome in ICHT annual report	

order to optimize security arrangements in both maternity units	long term solutions identified.		
Strengths	**How is this evidenced / captured**	**Can we promote this and how?**	**Recommended actions for tri-borough LSCB annual plan**
One of the Health agencies in Westminster whose contribution to safeguarding children and young people was found to be 'outstanding, with Health Partners communicating and working effectively together, supported by very good systems and processes which provide assurance that children and young people are being safeguarded.'	Ofsted reviews	Annual report	
Effective safeguarding children training programmes for 9,500 staff	82% of staff have been trained at the appropriate level, as a 3 yr rolling average.	Annual report	
Improved Liaison Health Visitor cover in the Trust's Emergency departments (ED'S)	New LHV post developed to cover the ED services at Hammersmith and Charing Cross hospital. This complements the LHV post in ED at St Mary's hospital	Annual report	

Police

Risk	**What is being done to reduce the risk?**	**What support can the LSCB provide to reduce the risk?**	**Recommended actions for tri-borough LSCB annual plan**
Children who have been on protection plans for 18months or more	Project Topaz - reviewing those plans with partners to identify multi-agency approach to meaningful reduction	Clear terms of reference for the QA sub group to identify emerging themes from SCIE/SCR and peer reviews to empower individual agencies to identify and reduce risk	
Children who have been on protection plans being put back on within twelve months of being	As above	As above	

reassessed as CIN or LAC			
Children on protection plan becoming repeat victims of crime	CPs not effective at removing/reducing imminent risk of significant harm	As above	
Strengths	**How is this evidenced / captured**	**Can we promote this and how?**	**Recommended actions for tri-borough LSCB annual plan**
Effective communication	LSCB, previous Ofsted inspections		
Willingness to engage			
Transparent performance monitoring	Performance data		

Probation

Risk	**What is being done to reduce the risk?**	**What support can the LSCB provide to reduce the risk?**	**Recommended actions for tri-borough LSCB annual plan**
Across the two boroughs (Westminster/K&C) there are 1400 offenders and identifying all children who may be at risk as a result of the contact they have with offenders is a major concern.	All staff have undertaken appropriate training but there are frequent inputs to staff to emphasise the importance of thinking about children when dealing with adult offenders.	Support LPT staff attending tri borough training on safeguarding.	Promotion of the tri-borough training arrangements.
Staff carry caseloads of 50+ which means that it is not always possible to work with the same intensity with all cases. High risk cases have more time devoted to them but it is important to get staff to focus on safeguarding even with lower risk cases.	Wherever possible caseloads are reduced and ways of bringing in resources to ensure every case has an appropriate amount of time devoted to it.		
It is not always possible to persuade staff to attend appropriate training on safeguarding issues because of the time constraints associated with the first two risks	An audit of all operational staff and there safeguarding training is being undertaken and all will be required in 12/13 to attend one of the tri-borough training events.	Ensure Probation staff attend training and ensure feedback from courses	Monitoring of attendance at training and discussion of findings at an LSCB Board meeting.
Strengths	**How is this evidenced / captured**	**Can we promote this and how?**	**Recommended actions for tri-borough LSCB annual plan**
There is strong support from line management for case managers over child protection and safeguarding issues.	Regular management oversight and referral to MAPPA and MARAC		

All sex offender and violent offenders are referred into MAPPA for a multi-agency approaches to be taken. There is close management of offenders who pose the greatest risk to children	MAPPA meetings are well minuted and decisions recorded. There is strong evidence of agencies working together to manage the most risky cases.	Ensuring a strong link up between the MAPPA and LSCB	Considering how the work of MAPPA is disseminated to the LSCB.
LPT is well linked to the MARACs in relevant boroughs. There is SPO presence at MARACs and the risk to victims is incorporated into work with offenders.	Strong evidence of attendance at MARACs and subsequent action on issues identified.	Ensuring a strong link between MARACs and the LSCB	Considering how the work of MARACs is incorporated into LSCB business.

Education

Risk	**What is being done to reduce the risk?**	**What support can the LSCB provide to reduce the risk?**	**Recommended actions for tri-borough LSCB annual plan**
Reducing LA involvement with schools in line with Government policy.	Continuation of work to strengthen engagement with LSCB via the Prevention of Harm sub-group	Increase accountability of schools to LSCB	Consider a tri-LSCB approach to strengthening engagement of schools over and above representation on exec. Board.
Likely increase of number of Academies and Free Schools.	Safeguarding training promoted across all categories of schools and bespoke course offered to senior designated leads.	Continue to offer bespoke training to all Academies and Free schools and monitor the effect of charging.	
Reduction in frequency of Ofsted inspection of schools and reduced emphasis on Safeguarding element of inspection.	Collaborative work with School Standards team in order to identify any early indicators that school leadership and management may impact on ability to safeguard. Support and challenge provided by Westminster Educ. Safeguarding Lead.	Audit schools safeguarding arrangements	Consider how tri-LSCB can increase its monitoring and reviewing role with schools.
Strengths	**How is this evidenced / captured**	**Can we promote this and how?**	**Recommended actions for tri-borough LSCB annual plan**
Westminster's Designated Lead Officer post.			Consider replicating this post across 3 boroughs.
Westminster Safeguarding Lead Officer collaboration with LSCB	Attendance and participation in relevant sub-groups		

Appendix 2 – Summary of accounts 2011/12

The budget for the Westminster Local Safeguarding Children Board for 2011/12 was £88,950. However, due to staffing vacancies during the year, there was an underspend against that budget. In addition, some income was generated from training activity. Therefore £25,200 of the partner contributions were transferred to the reserves at the end of the financial year with an agreement that these reserves are used to fund any necessary case reviews or Westminster specific activity under the new Board arrangements.

Westminster's LSCB expenditure during 2011/12 was as follows:

Salary costs (LSCB Manager and business support officer)	25,066	Includes on-costs. LSCB manager post was vacancy for part of the year and filled on a two day per week basis for the final month of the year. The Business Support Officer post was unfilled for much of the year.
Training costs	19,800	Westminster contribution to costs of tri-borough training programme
Consultancy costs	19,026	Relating to the independent chairing of the Board
Other	3,204	Administrative costs, printing, etc.
Total expenditure	67,096	
(Transfer to reserves)	(25,196)	

Partner contributions were received as follows for 11/12:

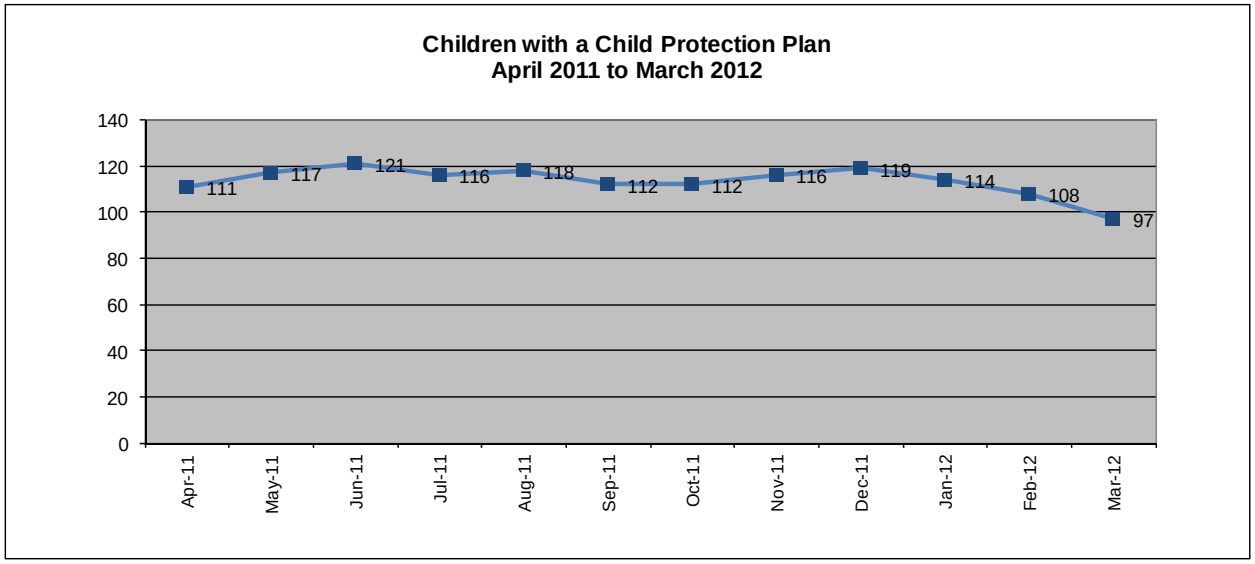
Health	41,481	
Metropolitan Police	5,000	
Probation	2,000	
CAFCASS	550	
Total	49,031	Of which 25,196 was transferred to LSCB reserves

In addition, there was £3,340 of income generated from charges related to LSCB training and the local authority made a contribution to the Board from its budgets of £39,921.

APPENDIX 3 – Performance data April 2011 to March 2012

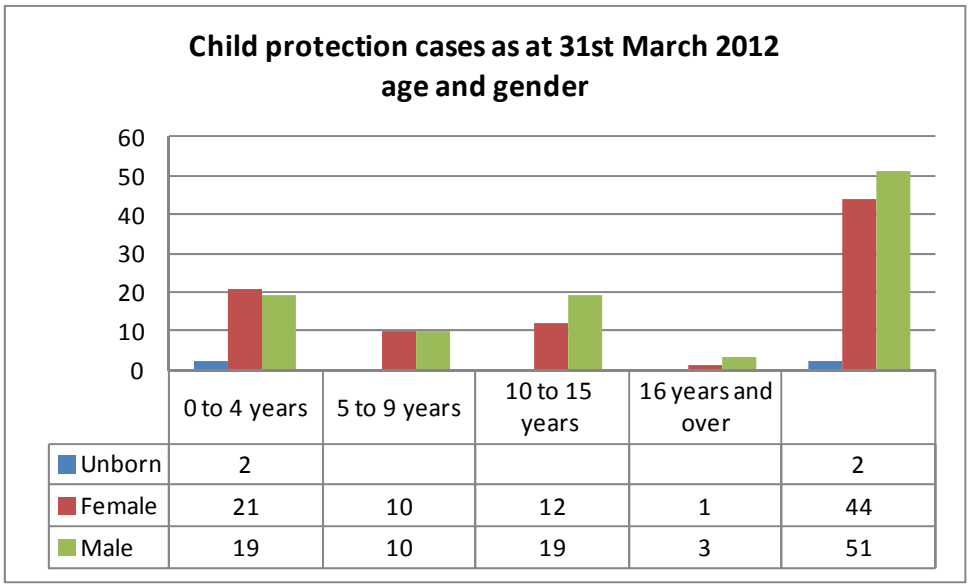
1. CHILDREN AND YOUNG PEOPLE ARE PROTECTED FROM ABUSE

1.1 NUMBER OF CHILDREN SUBJECT TO A CHILD PROTECTION PLAN



During 2011-2012 the number of children subject to a child protection plan remained consistent until March 2012 when the numbers began to reduced to the lowest since October 2008. Neglect or emotional abuse continues to be the main category of abuse.

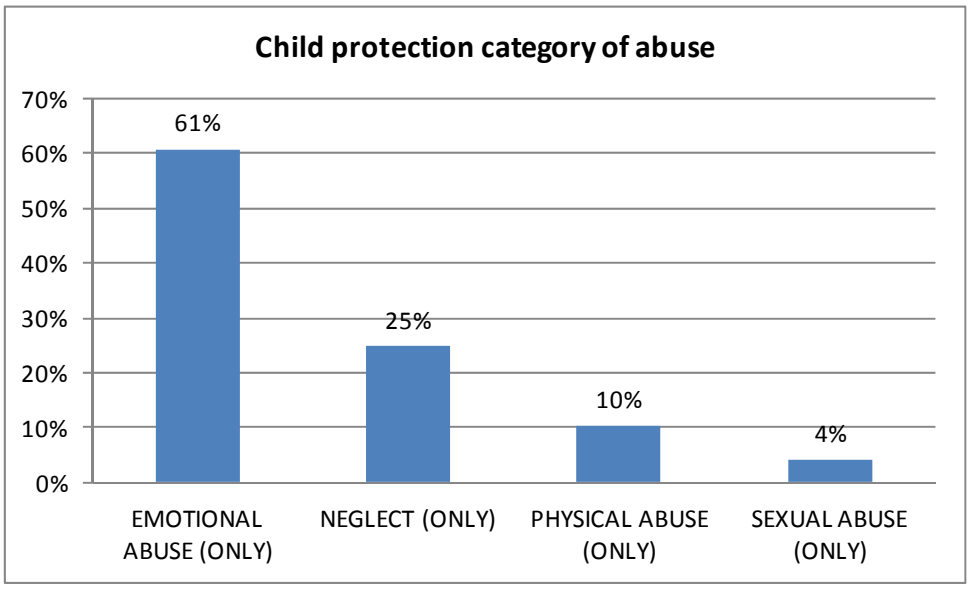
1.2 GENDER & AGE OF CHILDREN SUBJECT TO A CHILD PROTECTION PLAN



	0 to 4 years	5 to 9 years	10 to 15 years	16 years and over	
Unborn	2				2
Female	21	10	12	1	44
Male	19	10	19	3	51

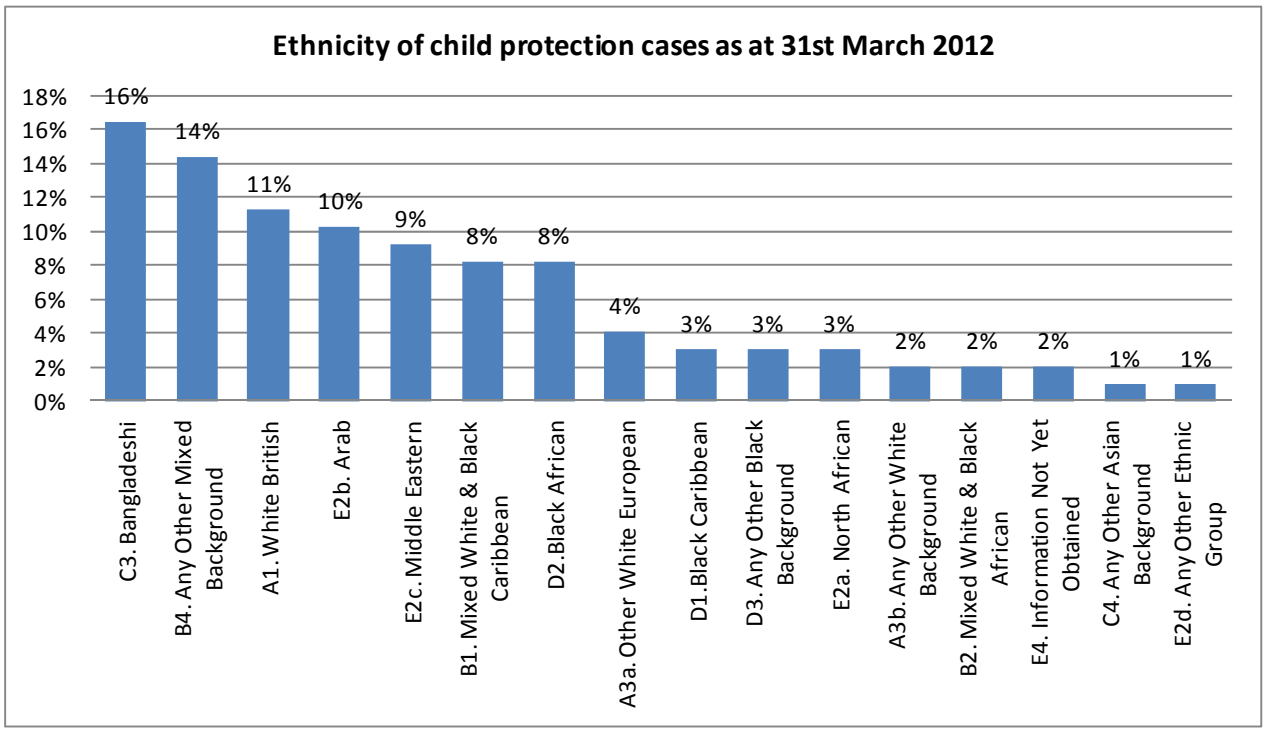
Of the children subject to a child protection plan on 31st March 2012 53% were male and 45% female. 43% were aged 0 to 4 years, 21% were aged 5 to 9 years, 32% were aged 10 to 15 years and 4% were aged 16 years and over.

1.3 CATEGORY OF ABUSE FOR CHILDREN SUBJECT TO A CP PLAN



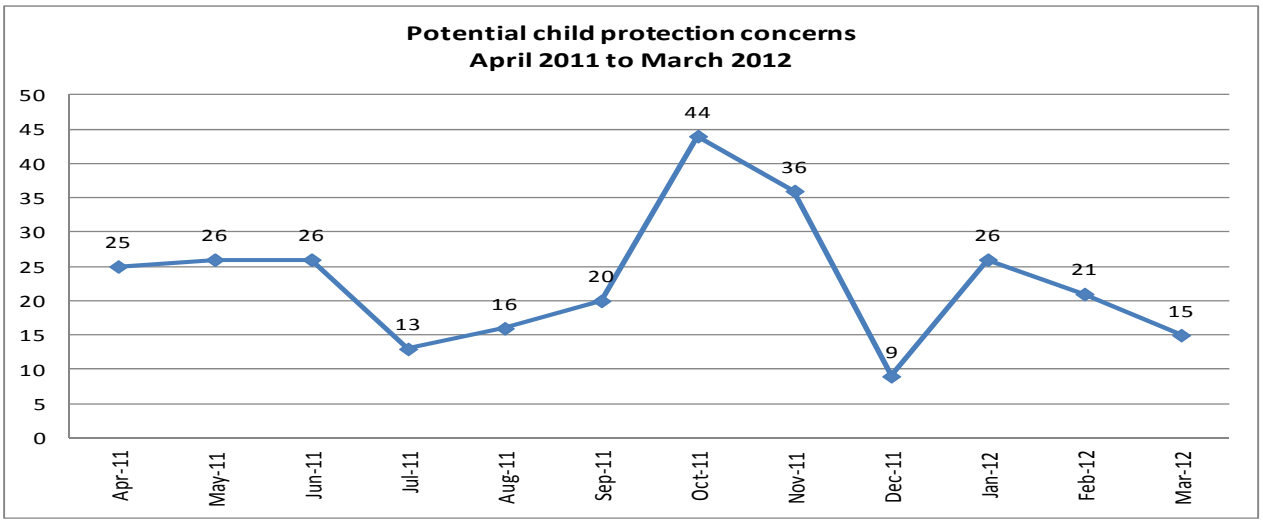
Of the children subject to CP plans the majority continue to be in the category of emotional abuse. During 2011-2012 there has been improved recording in relation to cases with a main category of sexual abuse.

1.4 ETHNICITY OF CHILDREN SUBJECT TO A CP PLAN



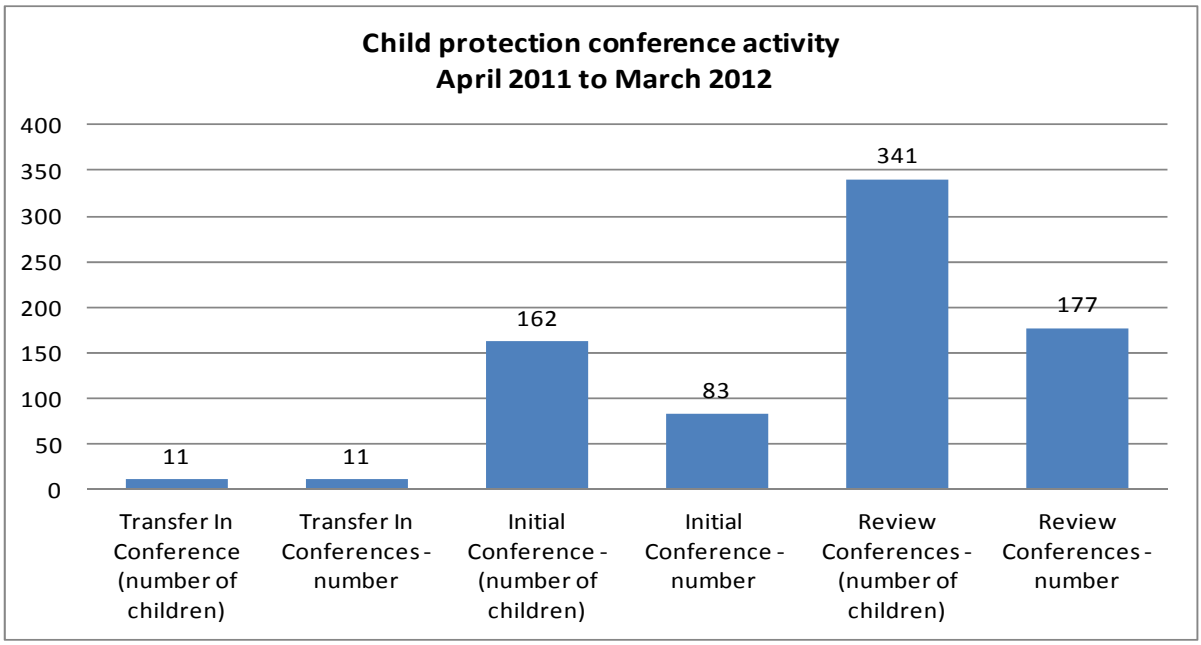
At 31st March 2012 the largest percentage of children subject to a child protection plan were of 'Bangladeshi', 'Any other mixed background' or 'White' ethnicity.

1.5 CONTACTS - POTENTIAL CP CONTACTS



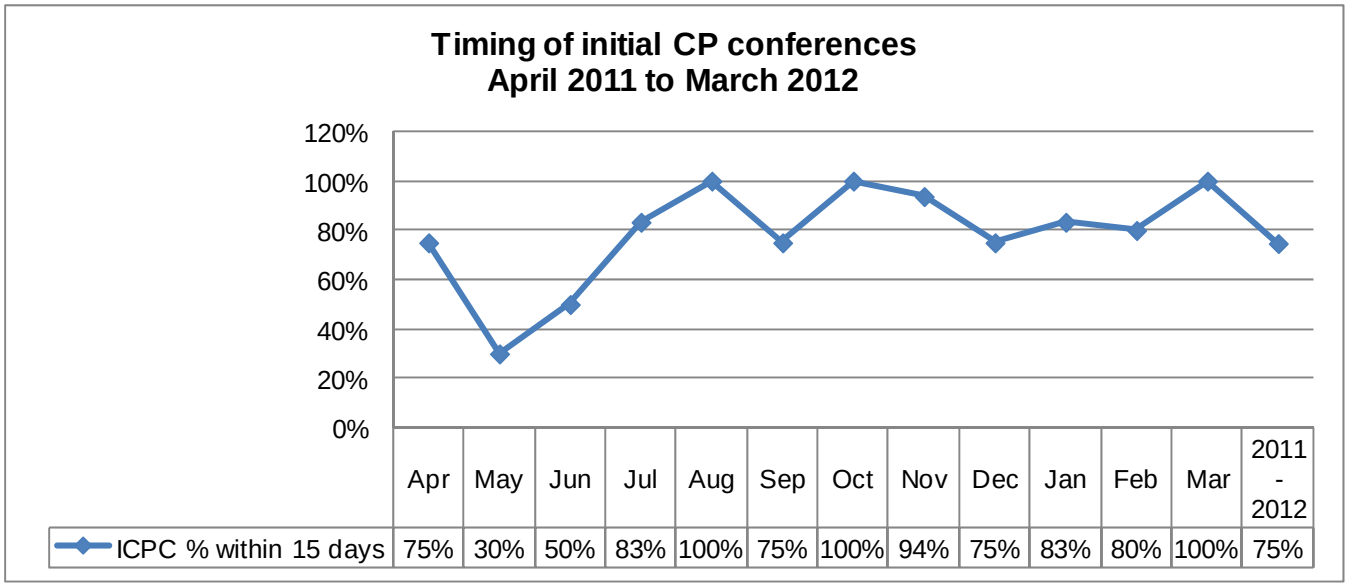
The number of contacts recorded as potential concerns continues to fluctuate month on month. April 2011 to March 2012 there have been 277 contacts recorded as potential CP concerns this represents a reduction from April 2010 to March 2011 when 345 contacts were recorded.

1.6 CHILD PROTECTION CONFERENCES – NUMBER



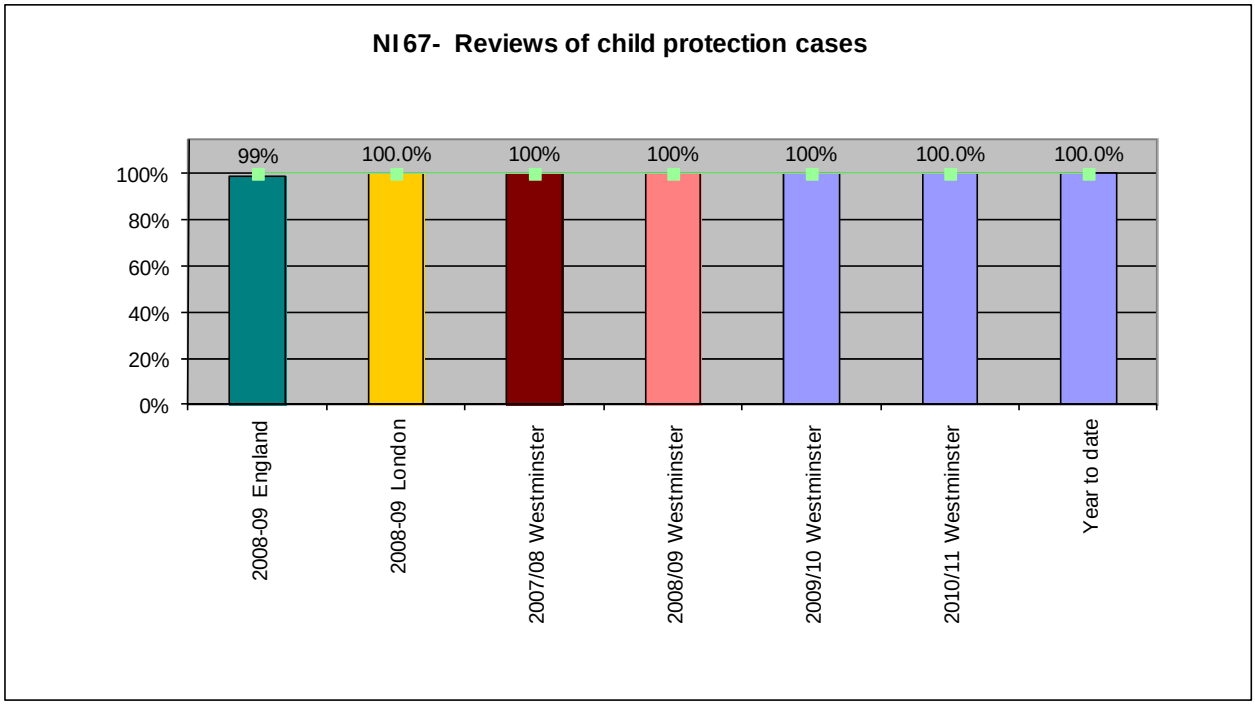
April 2011 to March 2012 there have been 271 conferences relating to 514 children. Eleven transfer-in, 83 initial and 177 review conferences.

1.7 INITIAL CONFERENCES HELD WITHIN 15 WORKING DAYS OF THE INITIATION OF SECTION 47 ENQUIRIES



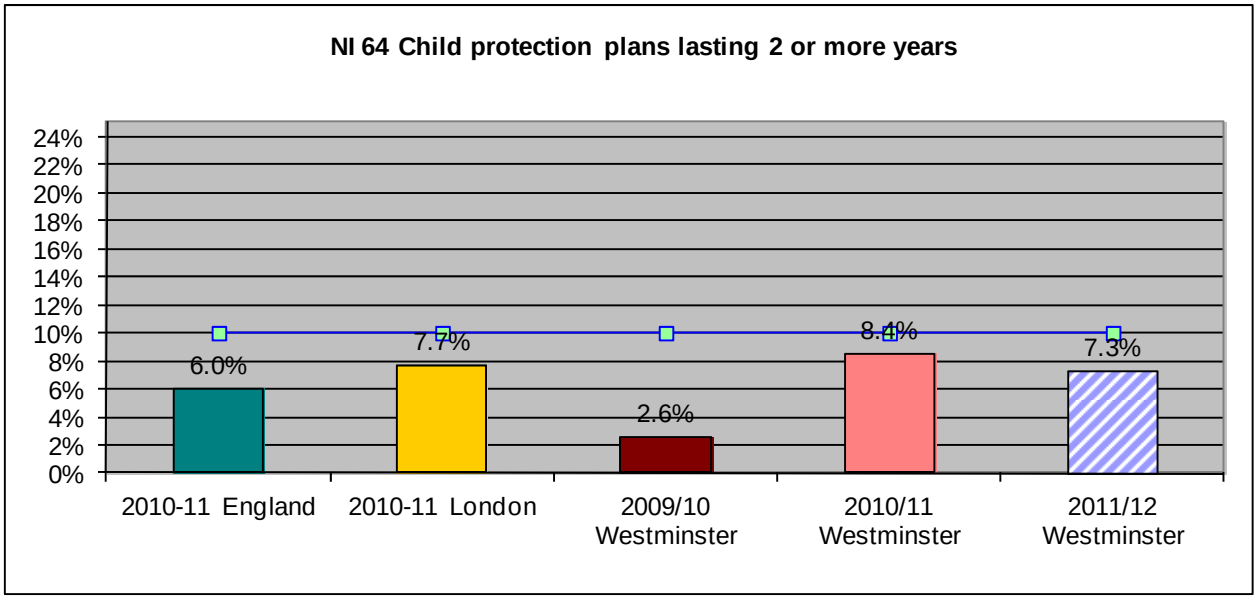
During 2011-2012 Westminster was invited by the Department of Education's (DfE) to participate in the 'freedoms and flexibilities' pilot, a national initiative in a small number of authorities which removed the need to conform to published timescales for the completion of assessments and initial child protection conferences. Overall during 2011-2012 75% of initial conferences were within 15 days.

1.8 NI 67 - REVIEWS OF CP CASES (TARGET - 100%)



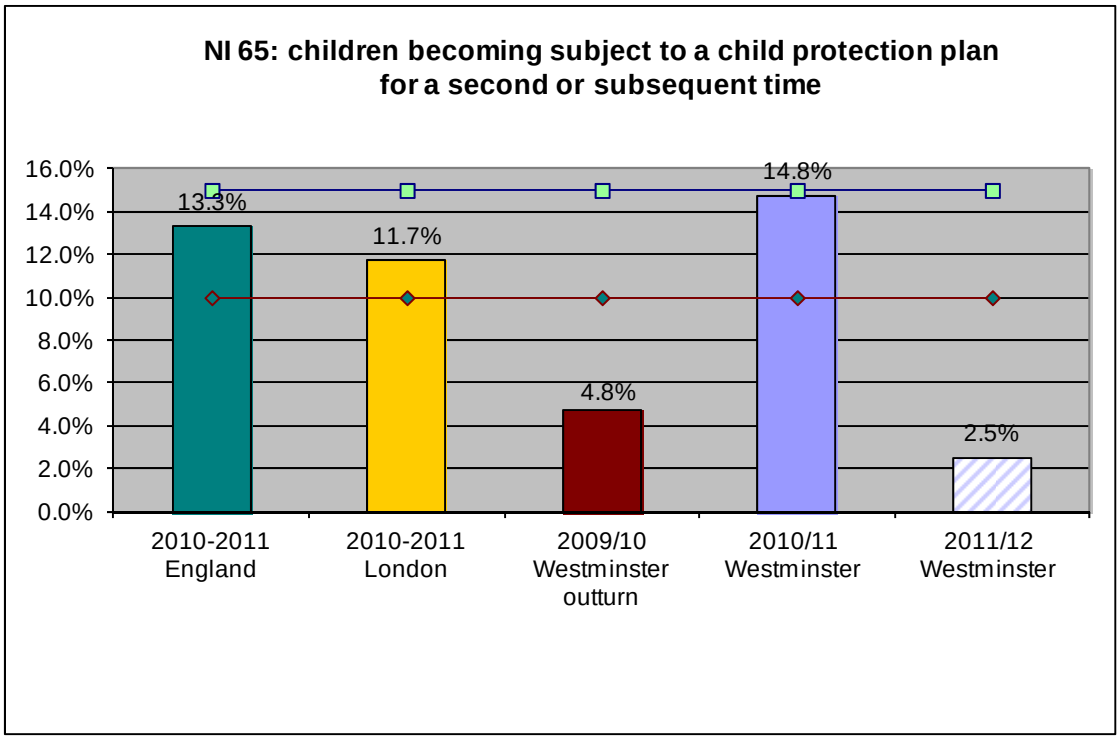
April to March 2012 all child protection reviews were completed within timescales.

1.9 NI 64 - DURATION OF CP PLAN



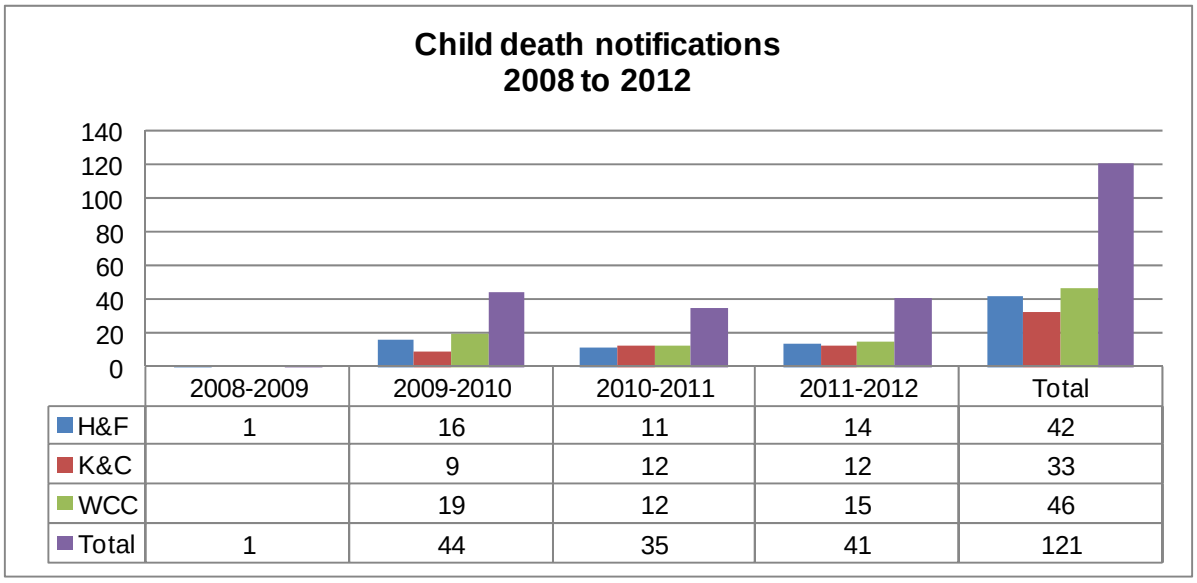
Of the 124 children whose CP plans have ended 9 (7.3%) had been subject to a CP plan for 2 or more years.

1.10 NI 65 - CHILDREN BECOMING SUBJECT TO A CP PLAN FOR A SECOND OR SUBSEQUENT TIME

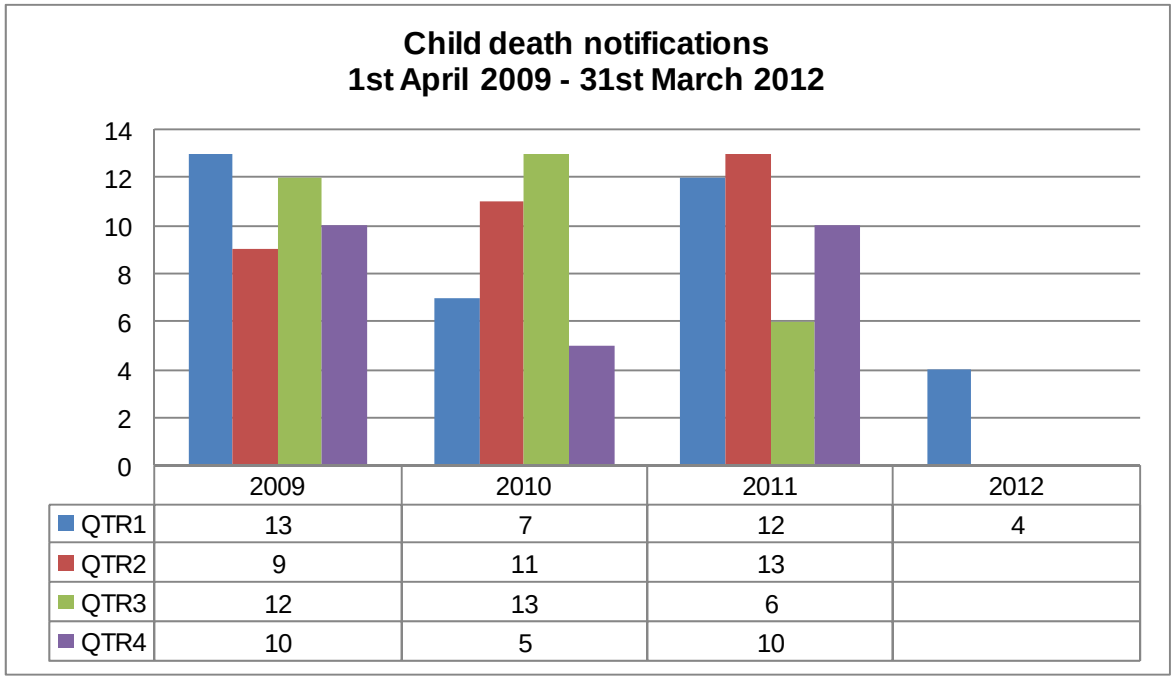


Since April 2011 there has been 119 children made subject to a plan of which 3 (2.5%) have previously been subject to a CP plan.

2. CHILD DEATHS



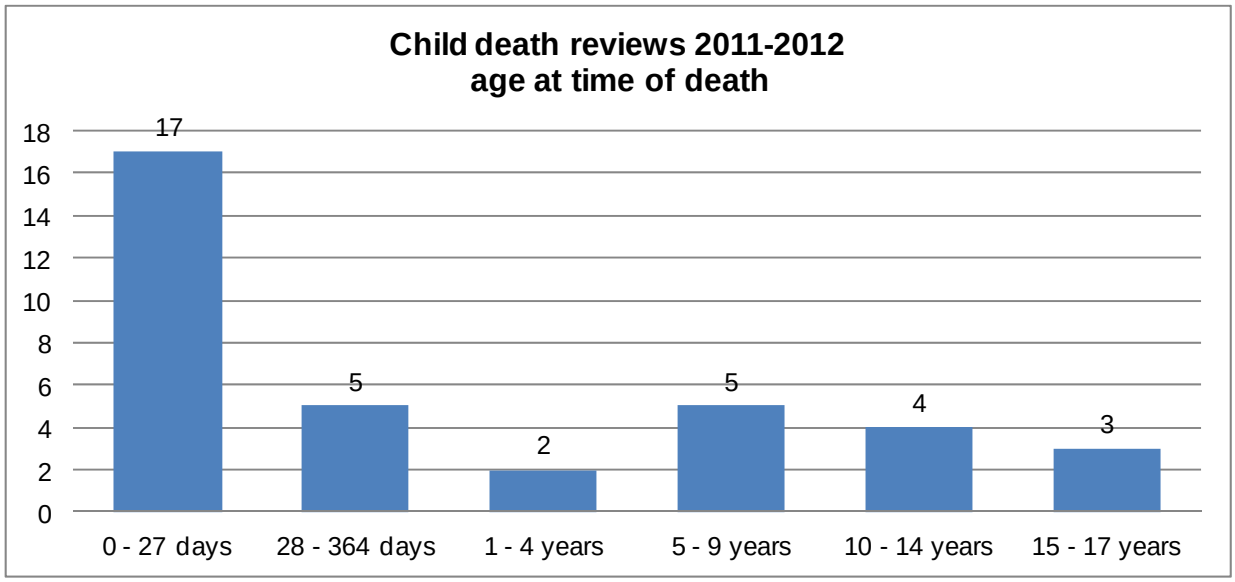
	2008-2009	2009-2010	2010-2011	2011-2012	Total
H&F	1	16	11	14	42
K&C		9	12	12	33
WCC		19	12	15	46
Total	1	44	35	41	121



	2009	2010	2011	2012
QTR1	13	7	12	4
QTR2	9	11	13	
QTR3	12	13	6	
QTR4	10	5	10	

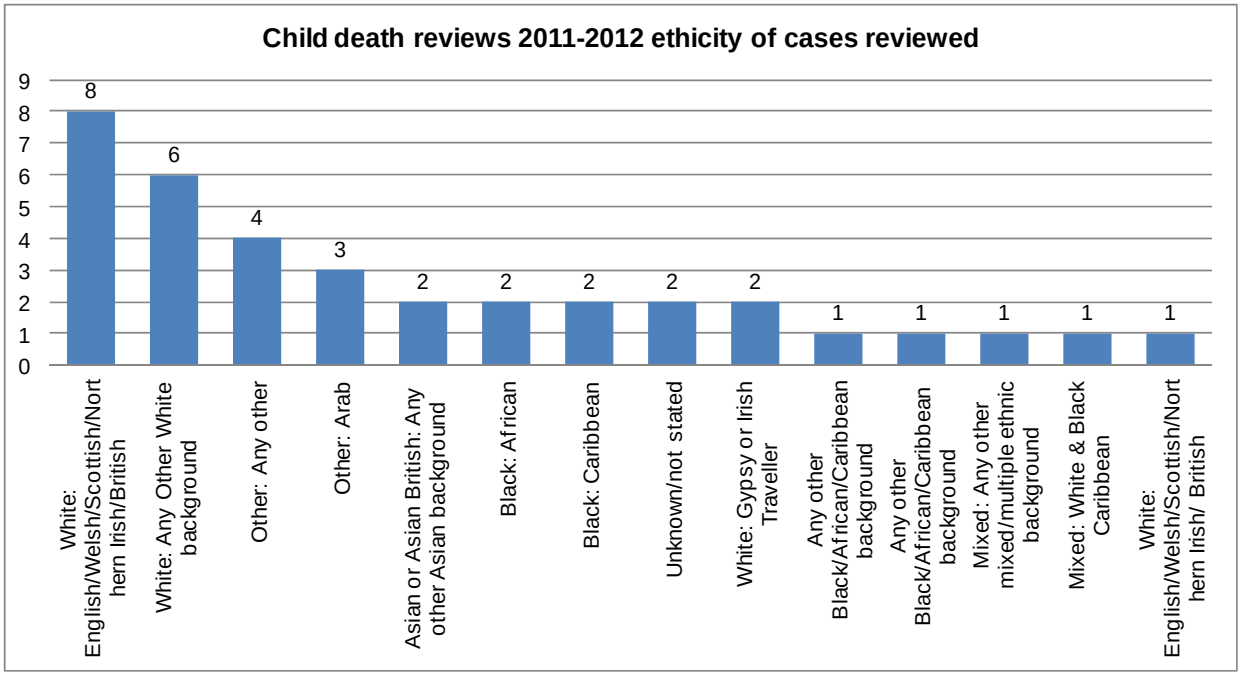
April 2011 to March 2012, there were 41 child death notifications which related to Hammersmith and Fulham (14), RB Kensington and Chelsea (12) and Westminster (15).

2.1 CHILD DEATH REVIEWS H&F, K&C AND WESTMINSTER – BY AGE



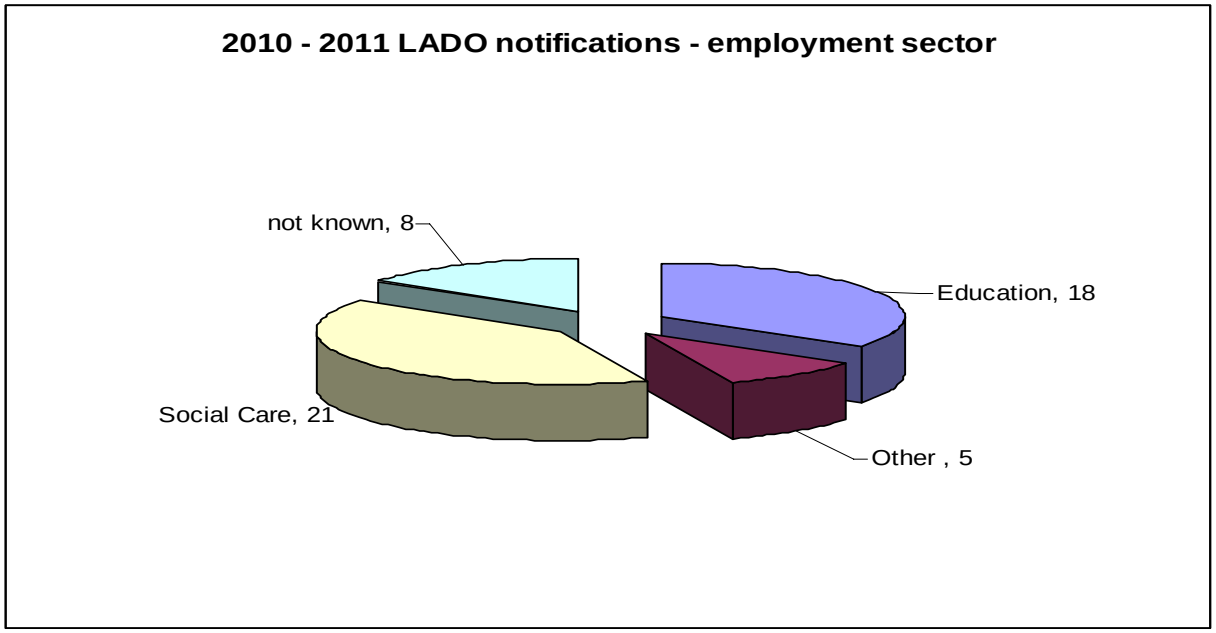
The majority of child death reviews (41%) related to children were aged 0 to 27 days.

2.2 CHILD DEATH NOTIFICATIONS H&F, K&C AND WESTMINSTER – ETHNICITY

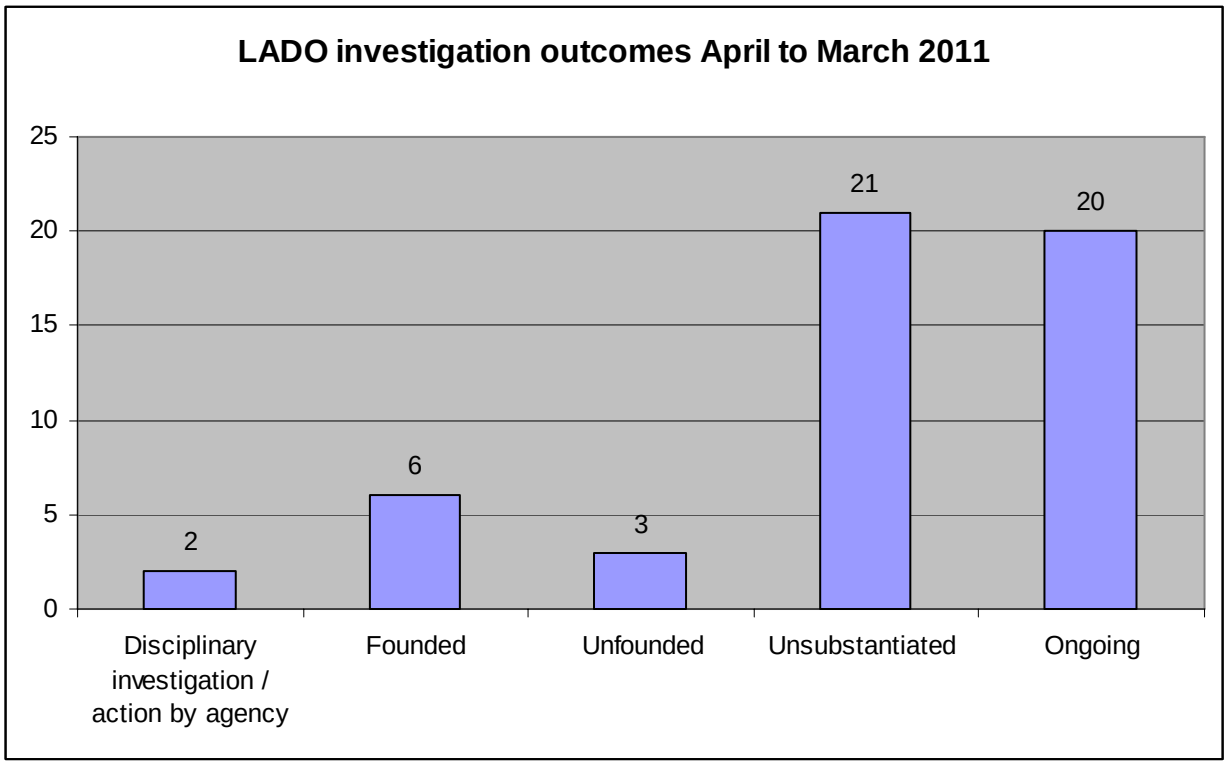


Of the child deaths reviewed during 2011-2012 the largest percentage were of White ethnicity.

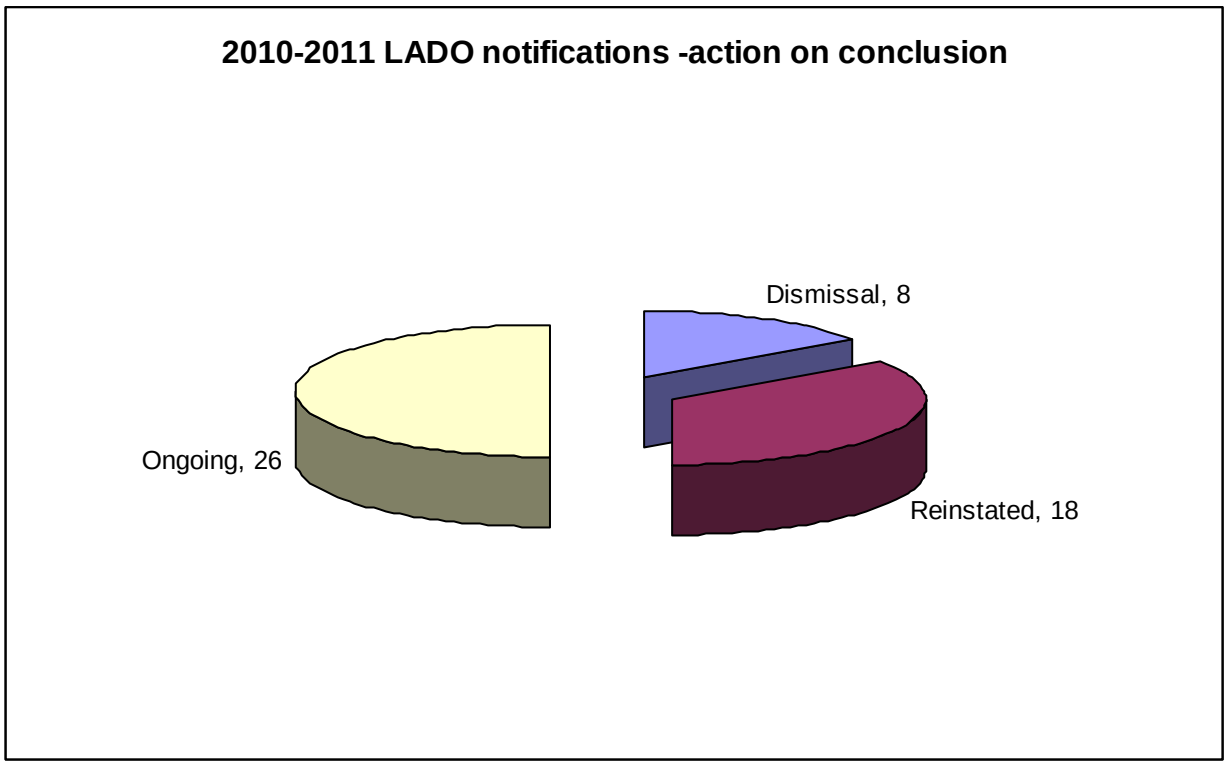
3. ALLEGATIONS AGAINST PEOPLE WORKING WITH CHILDREN



During 2010-2011 there were fifty-two LADO notifications received of these 40% related to social care.



Of the LADO investigations concluded 40% were unsubstantiated and 50% are ongoing.



Of the investigations concluded 69% of the actions identified on conclusion were to reinstate the person.